Oregon Heath Authority Behavioral Health Residential+ Facility Study

June 2024 Final Report

Public Consulting Group LLC

June 2024

PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

This document is the Final Report for the Oregon Health Authority (OHA) Behavioral Health Residential+ Facility Study which complements the initial January 2024 Report.

It is important to note that this report should be viewed through the lens of a point in time, based on the selected facilities in scope. While the report is based on the current continuum of care, population, capacities, rules and regulations, it serves to initiate discussions at the State and local level for further evaluation and planning based onto the direction of need defined by bed and facility capacities. However, capacity needs should not be the sole focus when discussing the expansion of the behavioral health continuum. The broader behavioral health system encompasses more than just facility capacities; it also includes the availability of additional community programming, outpatient programs, staffing, and other supportive services, all of which impact the actual utilization of facility capacity. These programs and facilities play a crucial role within the behavioral health continuum and significantly influence capacity needs.

The data presented in this report may differ from the initial preliminary January 2024 report due to additional refinement and analysis in collaboration with OHA. Public Consulting Group (PCG) used a more recent data set provided by the OHA team and conducted further analysis to determine the current capacity for this June 2024 Final Report.

PURPOSE AND SCOPE

Governor Kotek directed OHA to lead a new study to evaluate adult behavioral health facility capacity in Oregon. PCG contracted with OHA in July 2023 to complete a Behavioral Health Residential+ Facility Study to assess adult behavioral health facility capacity and unmet need for mental health residential, substance use residential, and withdrawal management facilities across the State. The following key tasks were the major components of this project:

- Collect data on the number and type of behavioral health facilities and their associated capacities and identify the gaps in the continuum by trauma system area.
- Conduct community engagement sessions with individuals in the State.
- Review available data and prioritize facility types by trauma system area.
- Develop funding allocation methodology to inform capital funding requests and distribution processes.
- Develop a final recommendations report that communicates the work completed and planning recommendations.

The following clinical facilities are within scope for this study and will be explored in more detail throughout the report:

- Hospitals
  - State Hospitals
  - Inpatient Psychiatric Facilities - Freestanding
  - Inpatient Psychiatric - Unit in Community Hospitals or General Hospitals
- Residential Mental Health Facilities
  - Residential Treatment Facilities (RTF)
  - Secure Residential Treatment Facilities (SRTF)
  - Residential Treatment Homes (RTH)
  - Adult Foster Homes (AFH)
- Substance Use Disorder (SUD) Facilities
  - Residential SUD Facilities
  - Clinically Managed Withdrawal Management Facilities
  - Medically Monitored Withdrawal Management Facilities
- Crisis Facilities

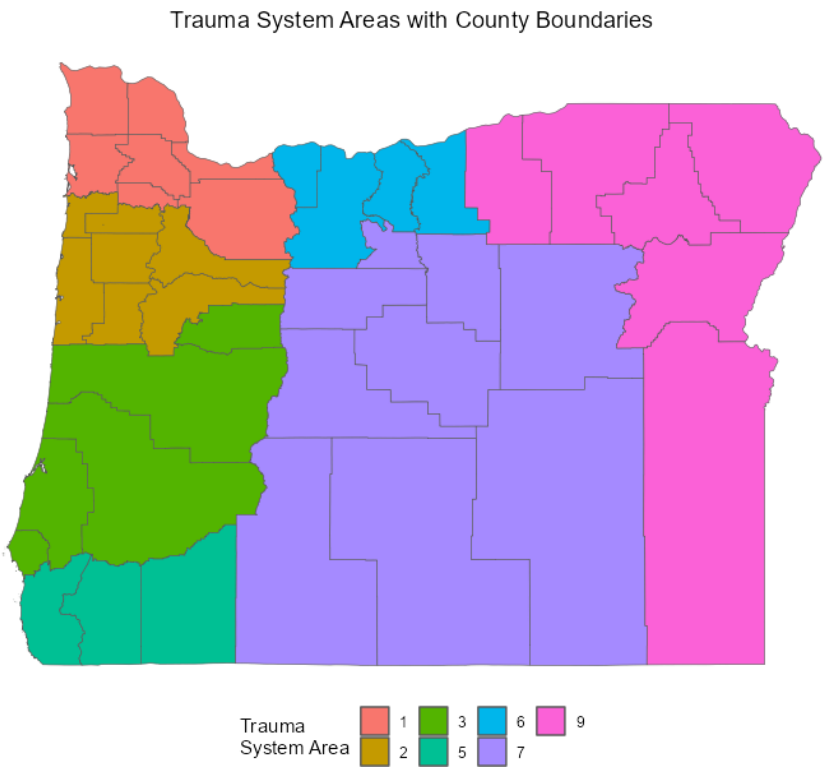
PCG was directed to use the trauma system areas in Oregon to map facilities across the State. Trauma system areas are based on patient referral patterns, resources, and geography and are defined by administrative rule (OAR 333-200-0040.[i]) Each area has an Area Trauma Advisory Board (ATAB)[i] which is responsible for acting as a liaison between providers and the public as well as participating in trauma system area planning. There are seven trauma system areas in Oregon:

Figure 1. Trauma System Areas

Area 1 (ATAB 1) - Portland / N Coast	Clackamas County; Clatsop County; Columbia County; Multnomah County; Tillamook County (zip codes 97141, 97102, 97107, 97118, 97130, 97131, 97134, 97136, 97144, 97147); Washington County; and Yamhill County (zip codes 97111, 97115, 97119, 97123, 97132, 97140 and 97148 only);
Area 2 (ATAB 2) - Mid-Willamette Valley / N Central Coast	Benton County; Lincoln County; Linn County (zip codes 97321, 97322, 97327, 97333, 97335, 97336, 97346, 97348, 97446, 97350, 97352, 97355, 97358, 97360, 97374, 97377, 97383, 97389, 97392); Polk County; Marion County; Tillamook County (zip codes 97108, 97112, 97122, 97149, 97368, 97135); and Yamhill County (zip codes 97101, 97114, 97127, 97128, 97304, 97347, 97378, 97396);
Area 3 (ATAB 3) - S Willamette Valley / S Central Coast	Coos County; Curry County (zip codes 97450, 97465, and 97476 only); Douglas County, Lane County, and Linn County (zip codes 97329, 97345, 97386, 97413)
Area 5 (ATAB 5) - Southern Oregon / S Coast	Curry County (zip codes 97406, 97415 and 97444 only); Jackson County; and Josephine County;
Area 6 (ATAB 6) - Columbia Gorge	Gilliam County; Hood River County; Sherman County; and Wasco County (zip codes 97021, 97037, 97040, 97058, 97063);
Area 7 (ATAB 7) - Central Oregon	Crook County; Deschutes County; Grant County; Harney County; Jefferson County; Klamath County; Lake County; Wasco County (zip codes 97001 and 97057) and and Wheeler County; and
Area 9 (ATAB 9) - Eastern Oregon	Baker County, Malheur County, Morrow County; Umatilla County; Union County; and Wallowa County.

Figure 2 below graphically depicts the trauma system areas in Oregon.

Figure 2: Oregon Trauma System Area Map[ii]



CURRENT AND PENDING FACILITY CAPACITY

While the qualitative data is imperative to our report and final recommendations, PCG focused on the quantitative data to understand the capacity and locations of Oregon behavioral health facilities across the State. Data collection and analysis for the Behavioral Health Residential+ Facility Study used a two-pronged approach consisting of the following key activities:

- Collect existing data on the inventory of Oregon's behavioral health facilities and capacities within the scope of this project.
- Develop and administer a provider survey to understand additional details about facilities, capacities, and challenges.

Current capacity for State Hospitals was received by the Oregon State Hospital. The current capacity for inpatient psychiatric facilities – freestanding and inpatient psychiatric units in community hospitals or general hospitals – was provided by the Public Health Division/OHA. The current capacity for mental health residential facilities, substance use disorder residential facilities, and withdrawal management facilities was provided by the Licensing & Certification team of the OHA. Data collected by OHA was used to identify state-funded facilities in progress and/or under construction. Based on this data, Table 1 summarizes the current and pending bed counts for the facilities within scope across all trauma system areas through March 1, 2024. Census data for beds per 100,000 population was retrieved from the United State Census Bureau.[iii]

Key Findings:

1. Residential Substance Use Disorder Facilities have the highest bed count per capita with 1,418 total beds across the State representing 33.48 beds per 100,000 population.

2. Only one freestanding inpatient psychiatric facility is present in the State and is located in trauma service area 1 (Portland Metro/North Coast) with a total of 98 beds and 2.31 beds per 100,000 people.
3. There are 317 withdrawal management beds across the State which is inclusive of 8 clinically managed withdrawal management beds and 309 medically monitored withdrawal management beds representing .19 and 7.30 beds per 100,000 people, respectively.
4. Trauma system area 6 (Columbia Gorge) has the fewest number of total beds in the State with 0 Residential Treatment Facility beds serving the region.
5. Trauma system area 1 (Portland Metro/North Coast) has 1,921 total beds which is the highest number of beds compared to the other areas. Additionally, trauma system area 1 has 683 Residential SUD beds which is the most of any area in this facility category.

Table 1: Current and Pending Capacity in Oregon

Trauma System Area		ATAB 1 (Portland / N Coast)	ATAB 2 (Mid-Willamette Valley / N Central Coast)	ATAB 3 (S Willamette Valley / S Central Coast)	ATAB 5 (Southern Oregon / S Coast)	ATAB 6 (Columbia Gorge)	ATAB 7 (Central Oregon)	ATAB 9 (Eastern Oregon)	Total
State Hospitals	Beds	0	502	75	0	0	0	0	577
	Beds per 100k	0.00	65.84	12.99	0	0	0	0	13.62
Inpatient Psychiatric Facility - Freestanding	Beds	98	0	0	0	0	0	0	98
	Beds per 100k	4.91	0	0	0	0	0	0	2.31
Inpatient Psychiatric - Unit in Hospital	Beds	213	51	60	24	0	15	0	363
	Beds per 100k	10.67	6.69	10.39	7.24	0	4.38	0	8.57
Residential Treatment Facility (RTF)	Beds	332	109	88	18	0	51	43	641
	Beds per 100k	16.64	14.30	15.24	5.43	0	14.91	24.89	15.13
Secure Residential Treatment Facility (SRTF)	Beds	127	106	131	72	0	96	55	587
	Beds per 100k	6.36	13.90	22.69	21.71	0	28.06	31.83	13.86
Residential Treatment Home (RTH)	Beds	154	94	65	40	0	15	20	388
	Beds per 100k	7.72	12.33	11.26	12.06	0	4.38	11.58	9.16
Adult Foster Home (AFH)	Beds	159	103	44	108	0	48	36	498
	Beds per 100k	7.97	13.51	7.62	32.57	0	14.03	20.84	11.76
Residential SUD Facility	Beds	683	100	202	116	0	127	190	1418
	Beds per 100k	34.23	13.12	34.99	34.98	0	37.12	109.96	33.48
Clinically Managed Withdrawal Management Facility	Beds	4	0	0	0	0	0	4	8
	Beds per 100k	0	0	0	0	0	0	2.32	0.19

Medically Monitored Withdrawal Management Facility	Beds	151	43	55	12	0	36	12	309
	Beds per 100k	7.57	5.64	9.53	3.62	0	10.52	6.95	7.30
Total	**Beds**	**1,921**	**1,108**	**720**	**390**	**0**	**388**	**360**	**4,887**

COMMUNITY ENGAGEMENT

To provide important context to this project, PCG conducted community engagement activities through interviews, focus groups, and discussions that engaged participants across Oregon. The objective of community engagement was to glean insights into the behavioral health care continuum from individuals with diverse experiences, knowledge, and involvement in behavioral health. It sought to grasp how their needs and challenges mirror the opportunities for enhancing and expanding the behavioral health landscape across the State. PCG conducted 23 key informant interviews, nine interviews with crisis facilities, two focus groups, and one tribal discussion during the community engagement period. PCG and OHA also conducted nine interviews with Community Mental Health Programs (CMHP's) focusing specifically on crisis services.

Key Findings:

- Thirteen respondent types were included in the key informant interviews to ensure a diverse range of perspectives and experiences. This included individuals with lived and living experience. Across all respondent types, key thematic challenges emerged. The following themes centered around residential facilities, but also extended across the behavioral health continuum:
    - ***Staffing.*** Staffing issues have hindered the facilities' ability to operate at full capacity and recruit and retain necessary staff. Addressing workforce issues needs to be prioritized when considering any capacity expansion.
    - ***Facility Access, Availability, and Experience***. A lack of access to facility-based care has led to long wait-times and a mismatch between the level of care needed and the level of care received. Certain critical populations face unique challenges when accessing care because of facility criteria and exclusions. Participants with lived experience also report negative experiences during residential treatment.
    - ***Funding and Facility Expansion Priorities.*** There is a need to expand availability of services across the behavioral health continuum, but specifically SUD services, culturally specific services, care to meet complex and overlapping needs, services in rural areas, and peer-based services. Community partners stress that even with increased capacity, many vulnerable populations may remain underserved due to criteria exclusions. To address this issue, suggestions were made for the establishment of "no refusal" facilities, ensuring that critical mental health care services are accessible to all who need them, regardless of their circumstances or background.
    - ***Considering the Behavioral Health Continuum in Expansion Priorities.*** Community partners emphasize the significance of strengthening community-based support and health-related social needs, particularly in housing. This approach can pave the way for robust community-based paths to care, reduce acuity among individuals seeking services, and shorten their length of stay.

- Two focus groups were convened during the Stakeholder Engagement period with the Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC) and with Caregivers with Lived Experience. The following key themes emerged from these focus group sessions:
    - Racism and Stigma
    - Leadership
    - Support for Small Organizations and Culturally Specific Providers
    - Communication with Families
    - Quality of Care

    - Hopelessness
- Many of the key themes from the key informant interviews and focus groups were also discussed during the tribal discussion, which included representatives from the nine federally recognized tribes of Oregon. The following key themes emerged:
    - Prioritizing Use of Culturally Specific, Tribal-Based Practices
    - Relationship-Building
- PCG and OHA also conducted nine interviews with CMHP's that are currently operating crisis services and/or plan to open facilities in the future. These conversations aimed to understand the services being offered, the delivery model, the number of people served, the challenges and barriers, the staffing models, and the plans for expanding crisis services in their county. In addition to understanding the services provided, the following key themes emerged when discussing operational experience:
    - Staffing and Workforce Issues
    - Funding Limitations
    - Unavailability of beds at the level of care needed.

CAPACITY NEEDS

PCG conducted a statewide capacity analysis related to crucial community-based services identified by OHA as high priorities which includes mental health residential treatment facilities and homes, secure residential treatment facilities, and SUD residential treatment and withdrawal management treatment facilities. During the capacity analysis, key areas emerged as opportunities to increase capacity to improve access to care and provide the right treatment at the right time to those in need. Highlights for each service modality and capacity needs are reflected below in Table 2 and discussed in more detail further in the report.

In terms of inpatient psychiatric bed capacity, limited analysis was completed on current capacity of general hospital distinct psychiatric units, freestanding psychiatric hospitals and State hospital beds at the direction of OHA due to prioritized treatment facility types. However, it appears this treatment modality requires additional beds to support Oregon's infrastructure according to data used to analyze treatment capacity. The target figures derived from our analysis, categorized as capacity opportunities, aim to establish a foundation for addressing gaps in the State's care continuum and mitigating regional discrepancies in access to specific types of beds. While PCG has determined the required number of beds, our methodology specifically assigns additional inpatient bed capacity to general, community, or freestanding facilities, rather than State inpatient psychiatric beds. We chose not to designate the allocation of facility bed types, believing that such decisions are best made by the State or communities where bed needs are identified, based on the acute psychiatric inpatient requirements of each geographic region.

Key Findings:

1. Inpatient psychiatric - freestanding and inpatient psychiatric - unit in general hospitals account for 461 of the inpatient psychiatric beds in the State, which are not evenly distributed across the trauma service regions. Trauma system areas 6 (Columbia Gorge) and 9 (Eastern Oregon) have zero inpatient psychiatric beds with a combined population of 226,458. A projection of 486 beds is needed to increase the number of beds in inpatient psychiatric inpatient facilities to support the infrastructure.
2. Funding from HB 5202[iv] and HB 5024[v] has supported the creation of 356 new mental health residential (exclusive of adult foster homes), SUD residential, and withdrawal management beds, which are currently under construction and scheduled to be open by 3rd quarter 2025.
3. Oregon is projected to have 1,029 mental health residential treatment facility or home beds, equivalent to 24.29 beds per 100,000 population by the 3rd quarter of 2025, meeting the anticipated needs. Nevertheless, considering an average of 26.71 patients in this type of facility over a 10-year period, an additional 102 beds could be added to further expand capacity.

4. Oregon is projected to have 587 SRTF beds by the third quarter of 2025. 198 beds are needed across the State to equate to a total of 785 total SRTF beds in Oregon.
5. SUD residential treatment facilities appear to need the largest number of beds—2,357—based on estimates derived from the Substance Abuse and Mental Health Services Administration's Calculating for an Adequate System Tool (CAST), as reported in the 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis.[vi]
6. Withdrawal Management is projected to need an additional 571 beds based on the same Substance Abuse and Mental Health Services Administration's Calculating for an Adequate System Tool (CAST) model, as reported in the 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis. [vi]

Table 2. Capacity Analysis Statewide

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Includes State & Community Hospital Beds)*	1,038	0	1,038	486	1,524	46.81%
Mental Health Residential Facility *(RTF & RTH only)*	810	219	1,029	102	1,131	9.94%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	510	77	587	198	785	33.77%
SUD Residential Facility	1,374	44	1,418	2,357	3,775	166.22%
Withdrawal Management Facility *(Clinical & Medical)*	301	16	317	571	888	180.13%
Totals	4,033	356	4,389	3,714	8,103	84.63%

Table 3. Capacity Analysis ATAB 1 (Portland / N Coast)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	311	0	311	229	540	73.63%
Mental Health Residential Facility *(RTF & RTH only)*	419	67	486	48	534	9.88%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	127	0	127	93	220	73.23%
SUD Residential Facility	639	44	683	1,110	1,793	162.52%
Withdrawal Management Facility *(Clinical & Medical)*	139	16	155	269	424	173.55%
Totals	1,635	127	1,762	1,749	3,511	99.26%

Table 4. Capacity Analysis ATAB 2 (Mid-Willamette Valley / N Central Coast)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	51	0	51	87	138	170.59%
Mental Health Residential Facility ***(RTF & RTH only)***	140	63	203	18	221	8.87%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that re part of Oregon State Hospital)*	106	0	106	36	142	33.96%
SUD Residential Facility	100	0	100	424	524	424.00%
Withdrawal Management Facility *(Clinical & Medical)*	43	0	43	103	146	239.53%
Totals	440	63	503	668	1,171	132.80%

Table 5. Capacity Analysis ATAB 3 (S Willamette Valley / S Central Coast)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	60	0	60	66	126	110.00%
Mental Health Residential Facility ***(RTF & RTH only)***	84	69	153	14	167	9.15%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	115	16	131	27	158	20.61%
SUD Residential Facility	202	0	202	321	523	158.91%
Withdrawal Management Facility *(Clinical & Medical)*	55	0	55	78	133	141.82%
Totals	516	85	601	506	1,107	84.19%

Table 6. Capacity Analysis ATAB 5 (Southern Oregon / S Coast)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	24	0	24	38	62	158.33%
Mental Health Residential Facility ***(RTF & RTH only)***	38	20	58	8	66	13.79%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	72	0	72	16	88	22.22%
SUD Residential Facility	116	0	116	185	301	159.48%
Withdrawal Management Facility *(Clinical & Medical)*	12	0	12	45	57	375.00%
Totals	262	20	282	292	574	103.55%

Table 7. Capacity Analysis ATAB 6 (Columbia Gorge)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	0	0	0	6	6	*
Mental Health Residential Facility ***(RTF & RTH only)***	0	0	0	1	1	*
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	0	0	0	3	3	*
SUD Residential Facility	0	0	0	30	30	*
Withdrawal Management Facility *(Clinical & Medical)*	0	0	0	7	7	*
Totals	0	0	0	47	47	*

*Percentage increase not available when Total Projected Capacity by 3rd Qtr 2025 is zero.

Table 8. Capacity Analysis ATAB 7 (Central Oregon)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	15	0	15	39	54	260.00%
Mental Health Residential Facility ***(RTF & RTH only)***	66	0	66	8	74	12.12%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	48	48	96	16	112	16.67%
SUD Residential Facility	127	0	127	190	317	149.61%
Withdrawal Management Facility *(Clinical & Medical)*	36	0	36	46	82	127.78%
Totals	292	48	340	299	639	87.94%

Table 9. Capacity Analysis ATAB 9 (Eastern Oregon)

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Does not include State Hospital Beds)*	0	0	0	20	20	*
Mental Health Residential Facility ***(RTF & RTH only)***	63	0	63	4	67	6.35%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds that are part of Oregon State Hospital)*	42	13	55	8	63	14.55%
SUD Residential Facility	190	0	190	96	286	50.53%
Withdrawal Management Facility *(Clinical & Medical)*	16	0	16	23	39	143.75%
Totals	311	13	324	151	475	46.60%

*Percentage increase not available when Total Projected Capacity by 3rd Qtr 2025 is zero.

FUNDING NEEDS

PCG provided estimates for the forecasted costs to expand behavioral health capacity in Oregon for the facilities within our project scope in this Report. These numbers solely encompass capital expenses and do not encompass other costs like staffing or operational expenses. Our analysis utilized national research on capital costs, data from the behavioral health investment team, data from RFIs submitted to OHA, and RS Means Data Online[vii] to estimate the capital costs of new facilities in Oregon between all sources. These estimates serve as a starting point for Oregon to determine the projected capital investment costs.

Key Findings

The table below represents the estimated capital investments costs needed to address the projected capacity needs in Oregon.

Table 10. Forecasted Need and Capital Costs

Facility Type	Projected Capacity Needed	Average Capital Cost per bed	Total Projected Capital Investment Costs
Mental Health Residential *(RTF & RTH)*	102	$187,777	$19,153,254
Secure Residential Treatment Facility	198	$352,720	$69,838,560
SUD Residential Facility	2,357	$249,952	$589,136,864
Withdrawal Management Facility *(Clinical & Medical)*	571	$275,580	$157,356,180
Total	3,228		$835,484,858

PCG recognizes that this figure surpasses our initial estimate from the January 2024 Draft Report. The upward revision stems from two key reasons. First, a more recent data set and a precise assessment of existing and anticipated capacity throughout the State resulted in an elevated requirement for beds needed in Oregon. Second, at the direction of the OHA, PCG utilized CAST scores solely for the SUD residential facility and withdrawal management bed needs, which increased the total number of beds needed in the State. Furthermore, our conclusive analysis incorporates supplementary data points related to capital expenses, offering a more comprehensive perspective for evaluating the projected capital costs. It is essential to note that these forecasted costs are estimations based on the data provided, with the acknowledged limitations outlined in this report.

FUNDING METHODOLOGY AND FIVE-YEAR PLAN

At the direction of OHA, PCG outlined a five-year plan based on the analysis of state and national benchmarks used within this report to identify capacity goals for each bed type assessed within scope. Our roadmap for capacity planning outlines essential milestones yearly by bed type and ATAB region to lay the groundwork for developing capacity to meet the needs of Oregonians based on numerous factors. The five-year plan should be used to create situational awareness, develop practical solutions, and identify potential implications and funding strategies for each geographical region and facility type. The outlined five-year plan is designed to successfully add capacity each year to support the needed bed growth outlined within this report; however, the creation or adding new beds or building new facilities may not solve all access or capacity issues identified through our research, community engagement sessions, and analysis.

While new beds or facilities may alleviate some of the pain points accessing services at the time of need, the following items should be considered by the State to successfully implement a five-year capacity plan to the fullest extent possible:

- Workforce capacity to support the addition of new beds or facilities.

- Other behavioral health or SUD service availability, access, and funding which supports individuals to remain in the community.
- Supportive and transitional housing availability and access.

Key Findings

PCG's 5-year plan includes the following target milestones for increasing capacity for the facilities within scope:

Table 11. Five Year Plan for Increasing Capacity – Statewide with Inpatient Psychiatric Facility Beds

Calendar Year	CY25	CY26	CY27	CY28	CY29
Bed Capacity	757*	748*	745*	734*	728*

**Includes inpatient psychiatric facility beds*

The five-year plan funding allocation uses the total number of beds from our five-year capacity plan and the average cost per bed from our analysis to determine the total estimated funds for each calendar year. As noted above, inpatient facility capacity needs were included in the five-year plan for expanding capacity across each calendar year. However, the primary focus of this report is on capacity and funding for residential facility needs, rather than inpatient psychiatric beds. Consequently, the funding allocation plan is based on the total number of beds earmarked each calendar year within the five-year plan related to mental health residential facilities (RTF, RTH, and SRTF), SUD residential facilities, and withdrawal management facilities (both clinical and medical). The total number of beds for the five-year plan for these facilities and their associated costs is noted below in Table 12.

Table 12. Projected Five-Year Plan Funding Allocation

Calendar Year	CY 25	CY 26	CY 27	CY 28	CY 29
Capacity Total	657**	650**	648**	638**	634**
Funding Total	$170,308,595	$168,287,174	$167,658,873	$165,022,865	$164,121,780

***Does NOT include inpatient psychiatric facility beds. These numbers solely reflect residential beds.*

PCG understands that Oregon is prioritizing increasing its facility capacity to serve individuals across the State seeking behavioral health services. Oregon can use the following 5-year plan as a roadmap to guide decisions to increase mental health residential, SUD residential, and withdrawal management facilities. Though the plan is for five years, there are several "quick wins" from this plan which are noted below:

- In the first year (Calendar Year 25), the plan details adding 657 residential facility beds across the State of Oregon.
- In the first year (Calendar Year 25), 67 of those 657 residential facility beds will benefit those seeking mental health residential services in RTFs, RTHs, and SRTFs.
- In the first year (Calendar Year 25), 590 of the 657 residential facility beds will serve those seeking SUD residential or withdrawal management services.
- Additionally, those 657 beds are distributed appropriately across the State to serve Oregonians in **every** trauma system area in the State.
- The first year (Calendar Year 25) includes additional capacity for mental health residential facilities (RTFs, RTHs, SRTFs,), SUD residential facilities, and withdrawal management facilities in every trauma system area in Oregon which will allow individuals in every region of the State to see additional capacity built across the behavioral health services.

- The five-year plan also allocates mental health residential and SUD residential capacity in every calendar year so capacity in each area is expanding for the individuals in Oregon who are seeking these needed services.

RECOMMENDATIONS

Evaluating the entire behavioral health care continuum is a complex process that requires a comprehensive understanding of a range of factors that contribute to the delivery of effective care. This report analyzes a portion of the facilities within the behavioral health continuum in Oregon and our recommendations are based on the data collected and analyzed as part of this study, coupled with feedback and input from community partners.

Key Findings:

PCG's high level key findings and recommendations are included below and explained in more detail in our *Recommendations* section later in the report.

- **Development of Care Model and Strategy**
- **Analyze and Prioritize Workforce Development**
- **Expand Additional Facilities and Supports for Certain Populations**
    - Mental Health Residential Treatment Facilities
    - Mental Health Residential Treatment Homes and Secure Residential Treatment Facilities
    - Substance Use Disorder Residential Treatment in general and populations with co-occurring diagnosis.
    - Withdrawal Management Facilities
    - Develop Crisis Center Models, Strategies and Rules
- **Create Transparency, Awareness, Education, and Engagement**
- **Priority Areas for Further Analysis**: PCG understands there are a multitude of factors and considerations when identifying recommendations to expand behavioral health capacity in the State. There are many pieces of information that are outside of scope for our current report but should be further explored and reviewed to provide a more holistic representation of the behavioral health landscape in the State. These considerations are noted below:
    - Youth Population
    - Geriatric Population
    - Complex Needs
    - Forensic Population
    - Staffing and Workforce
    - Crisis Facilities
    - Quality of Care
    - Housing and Outpatient Programs
    - Insurance Payor/Type Acceptance
    - Operating Costs
    - Public Messaging
    - Strategic Planning
    - Advisory Committee

INTRODUCTION

This document is the Final Report for the Oregon Health Authority (OHA) Behavioral Health Residential+ Facility Study which complements the initial January 2024 Report.

It is important to note that this report should be viewed through the lens of a point in time, based on the selected facilities in scope. While the report is based on the current continuum of care, population, capacities, rules and regulations, it serves to initiate discussions at the state and local level for further evaluation and planning due to the direction of need defined by bed and facility capacities. However, capacity needs should not be the sole focus when discussing the expansion of the behavioral health continuum. The broader behavioral health system encompasses more than just facility capacities; it also includes the availability of additional community programming, outpatient programs, staffing, and other supportive services, all of which impact the actual utilization of facility capacity. These programs and facilities play a crucial role within the behavioral health continuum and significantly influence capacity needs. The data presented in this report may differ from the initial preliminary January 2024 report due to additional refinement and analysis in collaboration with OHA. Public Consulting Group (PCG) used a more recent data set provided by the OHA team and conducted further analysis to determine the current capacity for this June 2024 Final Report.

PROJECT SCOPE & REPORT OVERVIEW

Governor Kotek directed OHA to lead a new study to evaluate adult behavioral health facility capacity in Oregon. PCG contracted with the OHA in July 2023 to complete a Behavioral Health Residential+ Facility Study to assess behavioral health facility capacity and unmet need for mental health residential, substance use residential, and withdrawal management facilities in the State. The following key tasks are the major components of this project:

- Collect data on the number and type of adult behavioral health facilities and their associated capacities and identify the gaps in the continuum by trauma system area
- Conduct community engagement sessions with individuals in the State
- Review available data and prioritize facility types by trauma system area
- Develop funding allocation methodology to inform capital funding requests and distribution processes
- Develop a final recommendations report that communicates the work completed and planning recommendations

PCG worked closely with OHA to determine the facilities in the behavioral health care continuum that are within scope. After careful consideration, the following facility types have been included within scope for this engagement. PCG and OHA are aware that this does not represent the full care continuum in Oregon, however, these are the licensed clinical facilities explored in more detail throughout this report:

- Hospitals
  - State Hospitals
  - Inpatient Psychiatric Facilities – Freestanding
  - Inpatient Psychiatric – Unit in Community Hospitals or General Hospitals
- Residential Mental Health Facilities
  - Residential Treatment Facilities (RTF)
  - Secure Residential Treatment Facilities (SRTF)
  - Residential Treatment Homes (RTH)
  - Adult Foster Homes (AFH)
- SUD Facilities
  - Residential SUD Facilities
  - Clinically Managed Withdrawal Management Facilities
  - Medically Monitored Withdrawal Management Facilities
- Crisis Facilities

As part of this engagement, PCG was tasked with reviewing the behavioral health landscape in Oregon and making recommendations to the State that culminates in a 5-year plan to expand capacity across the State and meet the needs of Oregonians in their communities. The Behavioral Health Residential+ Facility Study is broken down into the following five phases:

Figure 3. Project Phases

Data Collection & Analysis: The first phase of this project was the Data Collection & Analysis phase. During this phase, PCG collected available data on the number and type of adult behavioral health facilities in each trauma system area and their associated capacities. To supplement the existing data, PCG also collected original data by designing and distributing a survey to identify behavioral health facilities across the State and their associated capacities and challenges. The methodology and analysis details are described below in the *Capacity Analysis* section.

Community Engagement: The second phase of this project was the Community Engagement phase. PCG completed focus groups, key informant interviews, and discussion sessions to learn more about the behavioral health care continuum from those who have diverse experiences, knowledge, and involvement in behavioral health across the State. The methodology, participants, and key themes from those conversations are detailed below in the *Community Engagement* section.

Recommendations & Prioritization Review: The third phase of this project was the Recommendations & Prioritization Review phase which involves reviewing available data sources and community engagement themes to determine the needs in each trauma system area. PCG reviewed the current facility capacities, survey responses, and the priorities identified through community engagement discussions to identify the priority areas for behavioral health facilities in the State. The recommendations are included below in the *Recommendations* section.

Funding Methodology & Forecast: The fourth phase was the Funding Methodology & Forecast phase. Following the Recommendations & Prioritization phase, PCG determined the costs and funding needs associated with the recommendations proposed for expanding capacity for behavioral health facilities within scope. The funding allocation methodology will inform future capital funding requests and the distribution processes. The funding needs are detailed below in the *Forecasted Behavioral Health Funding Needs* section.

Final Report & Materials: The fifth and final phase of this project was the Final Report & Materials phase. PCG completed this Final Report that effectively communicates the work described above and clearly articulates planning recommendations.

LIMITATIONS, CONSIDERATIONS, & KEY ASSUMPTIONS

PCG presents the following limitations, considerations, and key assumptions for this report:

- This study is focused on facilities in Oregon. Facilities in other states were not included in the capacity analysis.
- The capacity data includes facilities licensed by the State. Facilities licensed at the local level may not be fully represented in this analysis.
- The capacity analysis is focused on the adult population. Child, Youth, and Adolescent facilities are not included in this report.
- The following facility types are not included within our current scope – they were reviewed and discussed with OHA and community partners but are not included in the capacity analysis due to

time limitations. Oregon should consider funding future studies that examine need and capacity in these settings:
    - Supported Housing
    - Supportive and Transitional Housing
    - Community-Based Structured Housing
    - Sobering Centers
    - Recovery Housing
    - Sober Living Facilities
    - Outpatient Treatment Programs
    - Facilities Licensed by the Oregon Department of Human Services (Aging and People with Disabilities; Intellectual and Developmental Disabilities)
- Problem Gambling Residential Treatment and Recovery Services are included in the Substance Use Disorder Residential Facility inventory list.
- Community Hospitals are smaller local hospitals, which serve a localized population for general medical conditions usually without offering specialized services. While Community Hospitals serve a purpose and are vastly needed in the continuum of care, in the realm of behavioral health and substance use disorder treatment, they usually serve as an entry point to access care. Community Hospitals typically do not have specialized services or units for behavioral health and/or substance use treatment and are not included in this study and report. However, during the survey portion of the study, PCG did solicit feedback from Community Hospitals in relationship to behavioral health and substance use disorder patients, and sought information including diagnoses, wait times, dispositions, and challenges experienced to better understand if there are unmet needs in this setting.
- Inpatient Psychiatric Facility-Freestanding, Inpatient Psychiatric-Unit in a Hospital and State Psychiatric Hospital capacity, needs and analysis were limited during this project's scope. OHA determined the primary focus of this project needed to be on community treatment options including mental health residential treatment, substance use disorder residential treatment and withdrawal management.
- The project's scope was confined to facilities and bed capacities within the State of Oregon, focusing on bed capacity that could potentially be influenced by funding from the State. As of this Final Report, the data and scope did not include considerations for Oregonians seeking treatment across state lines or payments for services provided within or outside the State.
- The data points represent a momentary measurement and a snapshot of Oregon's facilities and capacities. Facility data was recorded up to March 1, 2024, and should be approached as an ongoing iterative process, considering the incorporation of new information, facilities, or beds. Furthermore, data on investments from HB 5202 and HB 5024 was derived from the information received and calculated through the 3rd quarter of 2025.

FACILITY OVERVIEW

Table 13. Facility Overview

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
Adult Foster Homes	Adult Foster Homes (AFH)	Adult Foster Homes (AFH) are residential environments, providing services and assistance with activities of daily living to adults diagnosed with mental illness. Providers or a resident manager live on site, with up to 5 residents per home.	Licensed annually by Oregon Health Authority, Behavioral Health Division	Referral through Community Mental Health Program (CMHP)	https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=5279. Oregon Secretary of State Administrative Rules
Mental Health Residential Treatment Facilities	Residential Treatment Homes (RTH)	Unlocked residential environment, providing treatment services and support for activities of daily living to adults diagnosed with mental illness, which are staffed twenty-four hours a day with a capacity of up to 5 residents.	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division	Persons seeking treatment at an RTH, RTF or SRTF may contact their local CMHP.	https://oregon.public.law/statutes/ors_443.400. https://oregon.public.law/statutes/ors_443.405. https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1029. https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Oregon.pdf. https://www.artausa.org/residential-mental-health-program-types.

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
					https://oregon.public.law/rules/oar_309-035-0105
	Residential Treatment Facilities (RTF)	Unlocked residential environment, providing treatment services and support for activities of daily living to adults diagnosed with a mental illness, which are staffed twenty-four hours a day with a capacity of 6-16 residents. *One non-contracted licensed RTF facility has more than 16 residents (fully funded by Kaiser Permanente).	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division		https://oregon.public.law/statutes/ors_443.400. https://oregon.public.law/statutes/ors_443.405. https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1029. https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Oregon.pdf. https://www.artausa.org/residential-mental-health-program-types. https://oregon.public.law/rules/oar_309-035-0105
	Secure Residential Treatment Facilities (SRTF) Class 1 or 2	Provide locked residential environment, treatment services and support for activities of daily living to adults diagnosed with a mental illness, which are staffed twenty-four hours a day with a	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division		https://oregon.public.law/statutes/ors_443.400. https://oregon.public.law/statutes/ors_443.405. https://secure.sos.state.or.us/oard/displayDivisi

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
		capacity of 6-16 residents. *Two licensed SRTF facilities within OSH have more than 16 residents.			onRules.action?selectedDivision=1029. https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Oregon.pdf. https://www.artausa.org/residential-mental-health-program-types. https://oregon.public.law/rules/oar_309-035-0105
	Class 1 Certification	Class 1 certification is approved under applicable administrative rules to be locked to prevent a person from leaving the facility, to use seclusion and restraint and to involuntarily administer psychiatric medications.	Certified every 2 years by Oregon Health Authority, Behavioral Health Division		
	Class 2 Certification	Class 2 certification is approved under applicable administrative rules to be locked to prevent a person from leaving the facility.	Certified every 2 years by Oregon Health Authority, Behavioral Health Division		
Hospitals	Inpatient Psychiatric Facility - Freestanding	A hospital that provides inpatient psychiatric services, has an inpatient psychiatric unit, and is devoted to the primary diagnosis and treatment of persons with mental illness.	Licensure is completed by the Public Health Division, Health Care Regulatory and Quality Improvement, and certification is completed by the Behavioral Health Division.	Accessed through emergency department, urgent care, crisis center, or through behavioral health evaluation by psychiatric provider or general practitioner.	https://www.cms.gov/medicare/health-safety-standards/certification-compliance/psychiatric-hospitals. https://www.hhs.gov/guidance/document/psychiatric-hospitals.

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
	Inpatient Psychiatric – Unit in Hospital	A hospital classified as a general or low occupancy acute care hospital that may provide inpatient psychiatric services and has a distinct inpatient psychiatric unit.	Licensure is completed by the Public Health Division, Health Care Regulatory and Quality Improvement, and certification is completed by the Behavioral Health Division.	Accessed through emergency department if the hospital has a dedicated inpatient psychiatric unit or by direct referral from another hospital emergency department, urgent care, crisis center, or through behavioral health evaluation by psychiatric provider or general practitioner.	https://www.cdc.gov/nchs/hus/sources-definitions/hospital.htm https://www.britannica.com/science/hospital/The-general-hospital
	State Psychiatric Hospital	A hospital which provides the highest level of intensity of psychiatric inpatient care by limiting admissions to those most severely symptomatic individuals whose treatment and recovery needs cannot be met in a community treatment setting. State Hospital means any campus of the Oregon State Hospital (OSH) system.	Licensure is completed by the Public Health Division, Health Care Regulatory and Quality Improvement, and certification is completed by Behavioral Health Division.	(a) Direct referral by provider for a patient meeting one of the following categories and the criteria listed below: 1. Civil Commitment 2. Voluntary by Guardian 3. Guilty except for Insanity 4. Aid and Assist; and (b) The individual's condition or symptoms have not improved in an acute care setting despite having received a comprehensive psychiatric and medical assessment and treatment with medications for at least 7 days at an adequate dose and (c)the individual continues to require hospital level of care services, as evidenced	https://www.cms.gov/medicare/health-safety-standards/certification-compliance/psychiatric-hospitals. https://www.hhs.gov/guidance/document/psychiatric-hospitals. The Vital Role of State Psychiatric Hospitals Technical Report_July_2014.pdf (nasmhpd.org) https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1053.

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
				by failure to meet the state hospital's criteria for readiness to transition; and (d) the individual's condition is not related to a primary medical condition, or a diagnosis outlined in OARs.	
SUD Facilities (Withdrawal Management Facilities)	SUD Residential Treatment & Problem Gambling Residential Treatment	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders for individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division	Persons seeking professional substance use disorder or problem gambling treatment can locate providers by 1. Contacting an individual's health plan to find providers. 2. Finding local providers in the Oregon Substance Use Disorders Treatment Provider Directory.	*https://doi.org/10.1176/appi.ps.201300242* https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015. *https://doi.org/10.1176/appi.ps.201300242* https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1015.

	Facility Type	Brief Description	Licensing Authority	Service Access	Source
	SUD Withdrawal Management-Clinical	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders, under the guidance of clinical management, for individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division		Withdrawal Management - Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings - NCBI Bookshelf (nih.gov) https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1924.
	SUD Withdrawal Management-Medical	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders, under the guidance of medical management for individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Behavioral Health Division		*Withdrawal Management - Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings - NCBI Bookshelf (nih.gov)* https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1924.

OREGON BEHAVIORAL HEALTH FACILITY CAPACITY ANALYSIS

In this section, PCG explores the adult behavioral health facility capacity in Oregon across the facilities in scope. Our methodology is detailed below, as well as the bed capacity analysis. The current and pending bed counts for each facility category are presented along with the number of beds per 100,000 population and a map of the beds in each trauma system area.

DATA COLLECTION METHODOLOGY

PCG employed a triangulation approach, i.e., multiple data sources and methods were used to inform the results of this Behavioral Health Residential+ Facility Assessment. Quantitative data informed the extent to which there is a gap in services, for example, while qualitative data was used to better understand the challenges that facilities, providers, and those with lived experiences encounter. Together, the combined data sources help inform decisions for expanding capacity in the State. The data sources which have been used to inform the assessment are listed below:

Figure 4. Data Collection Sources

Quantitative Data Collection	Qualitative Data Collection
•Licensing and Certification Data •Public Health Division •Hospital Data •Survey Data •Geolocations of Facilities And Providers	•Community Engagement •Key Informant Interviews •Focus Groups/Listening Discussions •Facility Visits •Survey Responses •Literature Review

While the qualitative data is imperative to our report and final recommendations, PCG focused on the quantitative data to understand the capacity and locations of the Oregon behavioral health facilities across the State. Data Collection & Analysis for the Behavioral Health Residential+ Facility Study used a two-pronged approach consisting of the following two key activities:

- Collect existing data on the inventory of Oregon's adult behavioral health facilities and capacities
- Develop and administer a provider survey to understand additional details about facilities, capacities, and challenges

Existing Data Collection

To complete this scope of work, PCG collected available data on the number and type of behavioral health facilities in each trauma system area and their associated behavioral health bed capacities. PCG met with over 50 individuals across Oregon to identify data sources and capacity counts for Oregon behavioral health facilities. While the list below is not exhaustive of every conversation that has taken place, PCG communicated with individuals from the following teams to gather information on behavioral health facilities and the behavioral health care continuum in Oregon:

- Oregon Health Authority, Office of Behavioral Health:
  - Office of Recovery and Resilience
  - Behavioral Health Equity and Community Partnership
  - Licensing and Certification
  - Social Determinants of Health
  - Intensive Services
  - 988 & Crisis System
  - Measure 110
  - Addiction Treatment, Recovery and Prevention Services
  - Older Adult Mental Health Services

- Oregon Health Authority, Medicaid
- Oregon Health Authority, Certified Community Behavioral Health Clinics Team
- Oregon Health Authority, Equity and Inclusion Division
- Oregon Health Authority, Office of Tribal Affairs
- Oregon Health Authority, Business Information Systems
- Oregon Health Authority, Health Policy and Analytics Division
- Oregon Health Authority, Public Health Division
- Oregon Housing and Community Services
- Oregon State Hospital
- Oregon Department of Human Services
- Oregon Health and Science University
- Blackbox Healthcare Solutions
- Apprise Health Insights (Data Subsidiary of Hospital Association of Oregon)
- Oregon Council for Behavioral Health
- Association of Community Mental Health Programs

In addition to the conversations noted above, PCG also communicated and aligned with other projects that are running concurrently:

- **Public Consulting Group SUD Financial Inventory**: A separate team within PCG is also contracted with OHA to provide an analysis and report on Oregon's SUD funding and investments. The study will include an inventory of public funds spent across the continuum of care (prevention, harm reduction, substance use treatment, and recovery services and supports), cost estimates to address unmet SUD needs, and revenue options for addressing unmet needs.
- **Oregon Behavioral Health Coordination Center (OBCC) Study**: OBCC is a state funded project, guided by Oregon Health & Science University (OHSU), in a collaborative approach with other health systems, community partners, and OHA. The Coordination Center will efficiently, effectively, and ethically:
    - Facilitate placement of adult & pediatric individuals within Oregon in need of acute or residential behavioral health services
    - Provide real-time data to improve transparency, efficiency, and placement coordination efforts
- **Oregon State University Public Analysis Laboratory (OPAL) Community Engagement**. OHA contracted with Oregon State University's Public Analysis Laboratory (OPAL) for continued community engagement efforts which began with HB 5024 Planning Grants to prioritize projects based on local need. OPAL's emphasis is on culturally specific and smaller grassroots organizations that face challenges competing for funding awards. The OPAL team has focused on a regionally based, community engagement effort through listening sessions. A consistent theme emerged, through the original planning grants progress reports and through the qualitative data obtained through the regionally based listening sessions, that collaborative, community-focused regionally based funding hubs would maximize housing development investments.

Information and existing data were collected from these conversations and used to inform the inventory of facility data for the facilities in scope. OHA and PCG determined that the Licensing and Certification (L&C) data would be the primary source of existing facility information along with the supplemental information from Oregon State Hospital and the Public Health Division. PCG worked hand-in-hand with the L&C team to review the data they maintain and determine the existing facilities and capacities in the State.

To collect additional information on facilities across the State, their associated capacities, and the challenges and barriers in the behavioral health care continuum, PCG and OHA decided to collect original data to inform the recommendations to expand behavioral health in Oregon.

Original Data Collection

In addition to collecting available data from sources in Oregon, PCG created and disseminated a provider survey to collect original data for analysis. The survey was reviewed by the OHA team, the Oregon Council for Behavioral Health, and the Hospital Association of Oregon. The questions in the survey aimed to gather the following information about behavioral health facilities in Oregon:

- Name and location
- Licensure type
- Level of care provided
- Populations served
- Licensed capacity
- Full operational capacity (operational capacity is defined as the number of beds a facility intends to make available, assuming no staff or resource constraints.)
- Average staffed capacity (staffed capacity is defined as the maximum number of beds a facility is able to operate based on available staff and resources.)
- Staffing data and challenges
- Admission and discharge information
- Additional information on facility challenges or needs

The survey was distributed through the Hospital Association of Oregon, the Oregon Council for Behavioral Health (OCBH), and the Association of Oregon Community Mental Health Programs (AOCMHP). Additional details on the survey results in included in the *Provider Survey* section of this report.

MAPPING

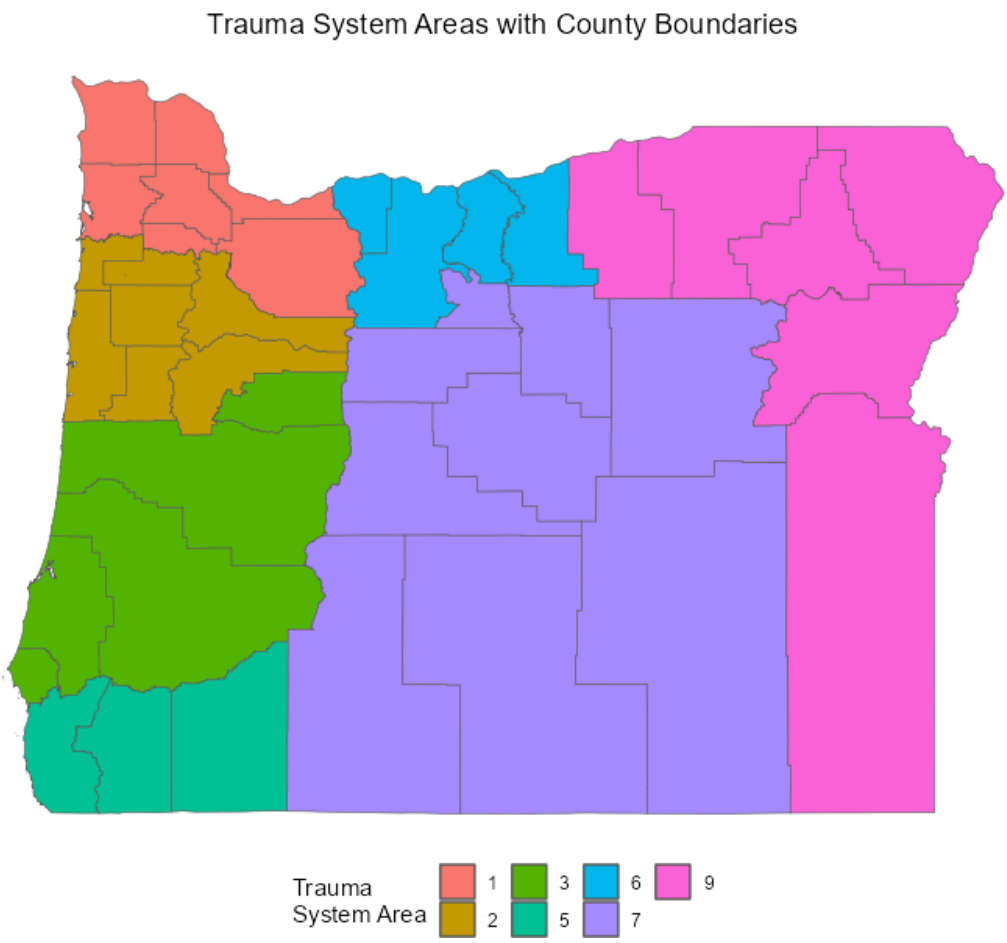
PCG was directed to use the trauma system areas in Oregon to map facilities across the State. Trauma system areas are based on patient referral patterns, resources, and geography and are defined by administrative rule (OAR 333-200-0040[viii]). Each area has an Area Trauma Advisory Board (ATAB),[ix] which is responsible for acting as a liaison between providers and the public as well as participating in trauma system area planning. There are seven trauma system areas in Oregon:

Figure 5. Trauma System Areas

Area 1 (ATAB 1) - Portland / N Coast	Clackamas County; Clatsop County; Columbia County; Multnomah County; Tillamook County (zip codes 97141, 97102, 97107, 97118, 97130, 97131, 97134, 97136, 97144, 97147); Washington County; and Yamhill County (zip codes 97111, 97115, 97119, 97123, 97132, 97140 and 97148 only);
Area 2 (ATAB 2) - Mid-Willamette Valley / N Central Coast	Benton County; Lincoln County; Linn County (zip codes 97321, 97322, 97327, 97333, 97335, 97336, 97346, 97348, 97446, 97350, 97352, 97355, 97358, 97360, 97374, 97377, 97383, 97389, 97392); Polk County; Marion County; Tillamook County (zip codes 97108, 97112, 97122, 97149, 97368, 97135); and Yamhill County (zip codes 97101, 97114, 97127, 97128, 97304, 97347, 97378, 97396);
Area 3 (ATAB 3) - S Willamette Valley / S Central Coast	Coos County; Curry County (zip codes 97450, 97465, and 97476 only); Douglas County, Lane County, and Linn County (zip codes 97329, 97345, 97386, 97413)
Area 5 (ATAB 5) - Southern Oregon / S Coast	Curry County (zip codes 97406, 97415 and 97444 only); Jackson County; and Josephine County;
Area 6 (ATAB 6) - Columbia Gorge	Gilliam County; Hood River County; Sherman County; and Wasco County (zip codes 97021, 97037, 97040, 97058, 97063);
Area 7 (ATAB 7) - Central Oregon	Crook County; Deschutes County; Grant County; Harney County; Jefferson County; Klamath County; Lake County; Wasco County (zip codes 97001 and 97057) and and Wheeler County; and
Area 9 (ATAB 9) - Eastern Oregon	Baker County, Malheur County, Morrow County; Umatilla County; Union County; and Wallowa County.

Figure 6 below graphically depicts the trauma system areas in Oregon.

Figure 6: Oregon Trauma System Area Mapii[ii]



To generate the maps below, we obtained an Administrative Boundaries Crosswalk map shapefile from Oregon Department of Human Services (ODHS)[x]. This file contains zip code, county, and ATAB identifiers along with geographic data for mapping each piece into its correct location. We matched the facility data to these identifiers by zip code and county and calculated the total number of facilities and beds by zip code and county. To calculate beds per 100,000 population, we added Zip Code Tabulation Area populations from the 2020 Census.[iii] We used the ggplot2 package in RStudio to generate the maps below. The facilities are mapped by zip code, so the locations indicated on the maps are not the exact locations of those facilities but are in the associated zip code. Facilities may also be counted twice if the facility has beds for more than one category.

CURRENT CAPACITY

Given the limitations identified above, this section offers a summary of each facility type encompassed in this project. Furthermore, tables and maps are employed to present the total bed counts for facilities in each trauma system area and the beds per 100,000 population rounded to the second decimal place. The population data comes from the 2020 US Census[iii] by zip code tabulation area.

Hospitals

State Hospitals

A State Psychiatric Hospital serves individuals statewide and provides the highest level of intensity of psychiatric care by limiting admissions to those most severely symptomatic individuals whose treatment and recovery needs cannot be met in a community treatment setting. State psychiatric hospitals are dedicated to the diagnosis and treatment of psychiatric and mental health conditions and operate twenty-four hours per day with a dedicated nursing staff and organized medical staff of psychiatrists and physicians. Additionally, State Psychiatric Hospitals care for a forensic population or may have a "forensic hospital" co-located with the State Psychiatric Hospital, serving individuals in the penal system. State Psychiatric Hospitals are generally considered a longer-term treatment option than acute care hospitals. Admissions to this level of care are deemed appropriate when:

(a) An individual's condition has not improved in an acute care setting despite receiving comprehensive psychiatric care and treatment for at least 7 days.

(b) An individual continues to require hospital level of care, as evidenced by failure to meet the state hospital's criteria for transition readiness.

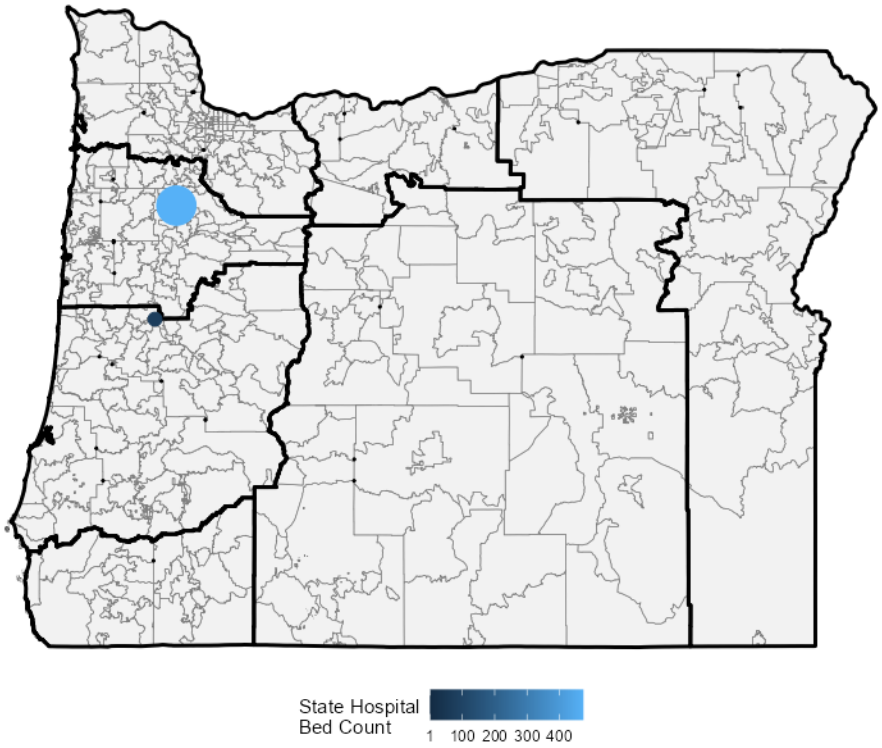
(c) Admissions are not based upon a primary diagnosis such as an acute or existing medical or surgical condition requiring placement in a medical setting, delirium, neurodevelopmental disorders, neurocognitive disorders, substance use or substance abuse disorders, or personality disorders, except Borderline and Schizotypal Personality Disorders, with psychotic symptoms.[xi]

Table 14. State Hospital Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	0	502	75	0	0	0	0	577

Beds per 100,000 population are not provided for State Hospitals as they serve individuals statewide.

Figure 7. State Hospital Facility Bed Count Map



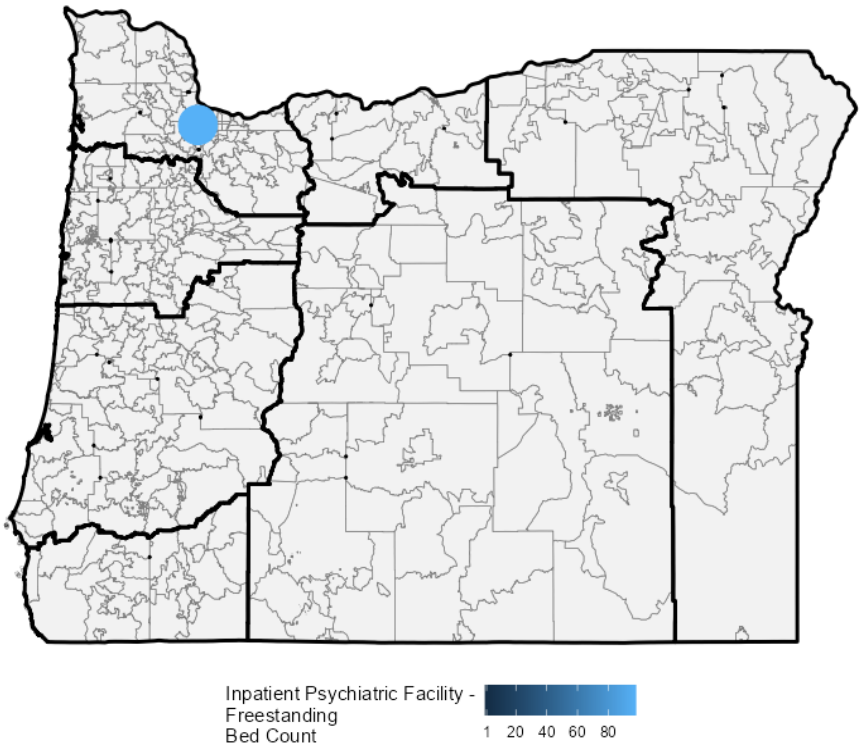
Inpatient Psychiatric Facility – Freestanding

A freestanding psychiatric hospital is a privately held hospital, dedicated to and specializing in the treatment of psychiatric disorders only. A facility with more than 16 beds is considered an Institution for Mental Disease (IMD) subject to Federal Medicaid IMD exclusion that prohibits Medicaid payments for inpatient stays for eligible recipients aged 22 through 64 years of age. A freestanding psychiatric hospital provides psychiatric service for the diagnosis and treatment of persons with mental illness by or under the supervision of a Doctor of Medicine or Osteopathy, satisfies requirements of the Social Security Act 1861(e)(3) through (e)(9), maintains clinical records to determine the degree and intensity of treatment provided, and meets staffing requirements to carry out active treatment for individuals receiving services.[xii]

Table 15. Inpatient Psychiatric Facility - Freestanding Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	98	0	0	0	0	0	0	98
Beds per 100,000 Population	4.91	0	0	0	0	0	0	2.31

Figure 8. Inpatient Psychiatric Facility - Freestanding Bed Count Map



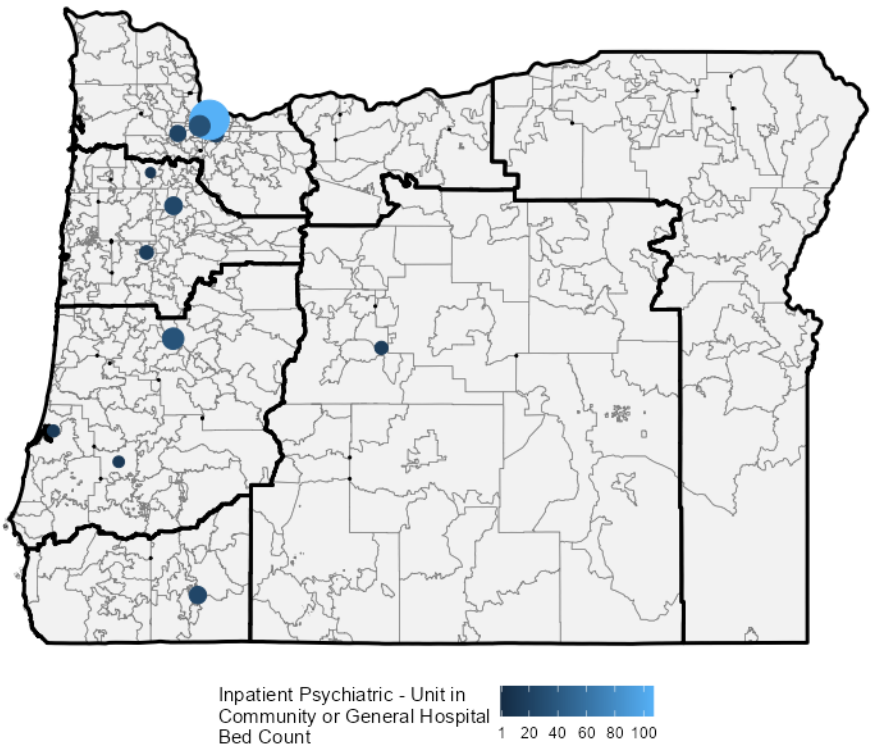
Inpatient Psychiatric - Unit in Community or General Hospital

Acute Care Hospitals (General or Low Occupancy) are a type of hospital which provides immediate and short-term treatment for acute medical conditions, injuries, and critical and life-threatening conditions. These hospitals have a governing body, an organized medical staff, 24-hour inpatient, outpatient services, and may perform surgical procedures. The primary focus is to diagnose, treat, and care for patients with short term or episodic medical conditions. Besides general medical conditions, Acute Care Hospitals may care for obstetrics or other specialties, such as mental health thus inpatient psychiatric unit in a community or general hospital. These facilities may have a distinct inpatient psychiatric unit, although not required, and treat psychiatric diagnoses in a dedicated inpatient psychiatric unit requiring hospitalization to manage and treat.[xiii]

Table 16. Inpatient Psychiatric - Unit in Community or General Hospital Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	213	51	60	24	0	15	0	363
Beds per 100,000 Population	10.67	6.69	10.39	7.24	0	4.38	0	8.57

Figure 9. Inpatient Psychiatric - Unit in Community or General Hospital Bed Count Map



Mental Health Residential Facilities

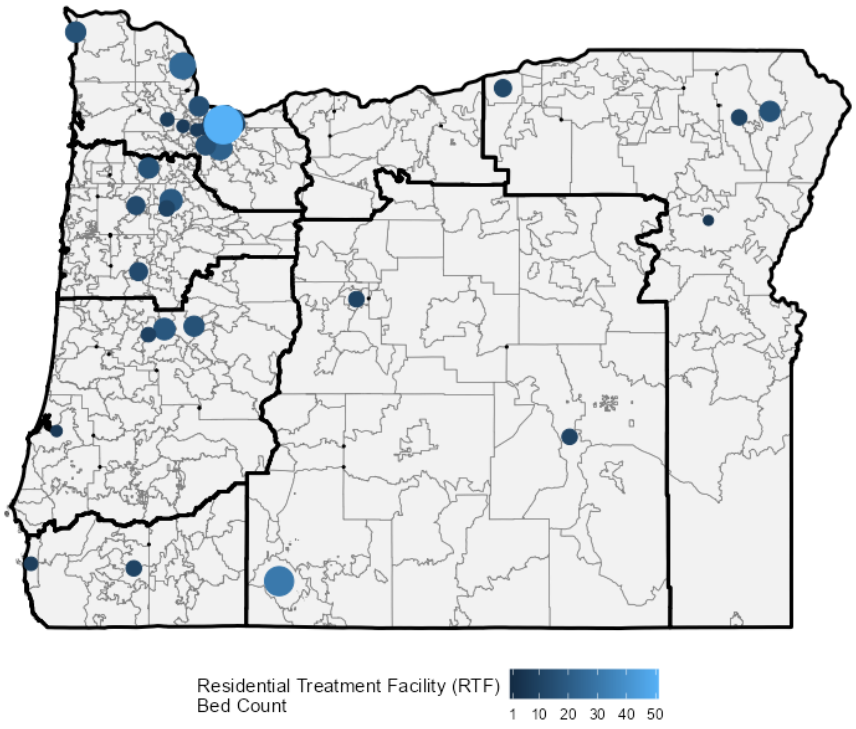
Residential Treatment Facilities (RTF)

RTF's are community-based specialized treatment programs providing twenty-four hours per day care for 6-16 residents in a homelike environment (though there are a few contracted RTFs with more than 16 residents in Oregon). RTFs are voluntary, unlocked and staffed twenty-four hours per day to provide supervision and care to individuals with mental or emotional disorders in a structured environment. These environments are the next level of care below hospitalization, providing a safe residential option with support staff, and are geared toward skill building, intervention, training, crisis intervention, medication monitoring, and daily living support to assist individuals to live in a residential setting. RTFs are for those 18 years or older who need supervision to live independently in a community setting to avoid higher levels of services or hospitalization, who are a danger to themselves or others, or who otherwise would not be able to remain in the community. Each RTF is licensed every two years by the Oregon Health Authority, Behavioral Health Division.[xiv]

Table 17. Residential Treatment Facility (RTF) Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	275	71	49	18	0	51	43	507
Beds per 100,000 Population	13.78	9.31	8.49	5.43	0	14.91	24.89	11.97

Figure 10. Residential Treatment Facility (RTF) Bed Count Map



Secure Residential Treatment Facilities (SRTF) – Class 1 & 2

SRTF's are community-based specialized treatment programs, providing twenty-four hour per day care for 1-16 individual residents in a homelike environment. SRTF's differ from Residential Treatment Homes and Facilities by requiring exits from the home, facility, or grounds of the home or facility to be restricted through the use of locking devices. These environments are the next level of care below hospitalization, providing a safe and secure residential option with support staff and geared toward skill building, intervention, training, crisis intervention, medication monitoring, and daily living support to assist individuals to live in a community residential setting.

A SRTF provides services for an individual who does not require hospital level of care and treatment but does require a highly structured secure environment with supports and supervision seven days a week, twenty-four hours per day in a habilitative and/or rehabilitative program. This community based residential environment and treatment is required for the individual to live in the community due to a clinically documented mental illness within the last 90 days or from an authority-approved and standardized risk assessment conducted within the past year, presenting a risk in one of the following areas: (A) Clear intention or specific acts of bodily harm to others; (B) Suicidal ideation with intent, or self-harm posing significant risk of serious injury; (C) Inability to care for basic needs that results in exacerbation or development of a significant health condition, or the individual's mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm; and/or (D) Due to the symptoms of a mental illness, there is significant risk that the individual will not remain in a place of service for the time needed to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's safety and well-being. SRTF's (as well as other facility types) can be classified into two categories in Oregon, which are described below:

Class 1

Class 1 facilities are approved to be locked to prevent a person from leaving the facility, use seclusion and restraints as needed and directed by a Licensed Independent Provider (LIP), and involuntarily administer psychiatric medications as needed as directed by an LIP. These facilities include hospitals, regional acute psychiatric care facilities or other nonhospital facilities approved under Oregon Administrative Rule (OAR) 309-033-0530, or a state hospital or a residential facility operated by a state hospital on a state hospital campus or a facility in which the Division deems to restrict the liberty of a person substantially the same degree as other facilities in this class.

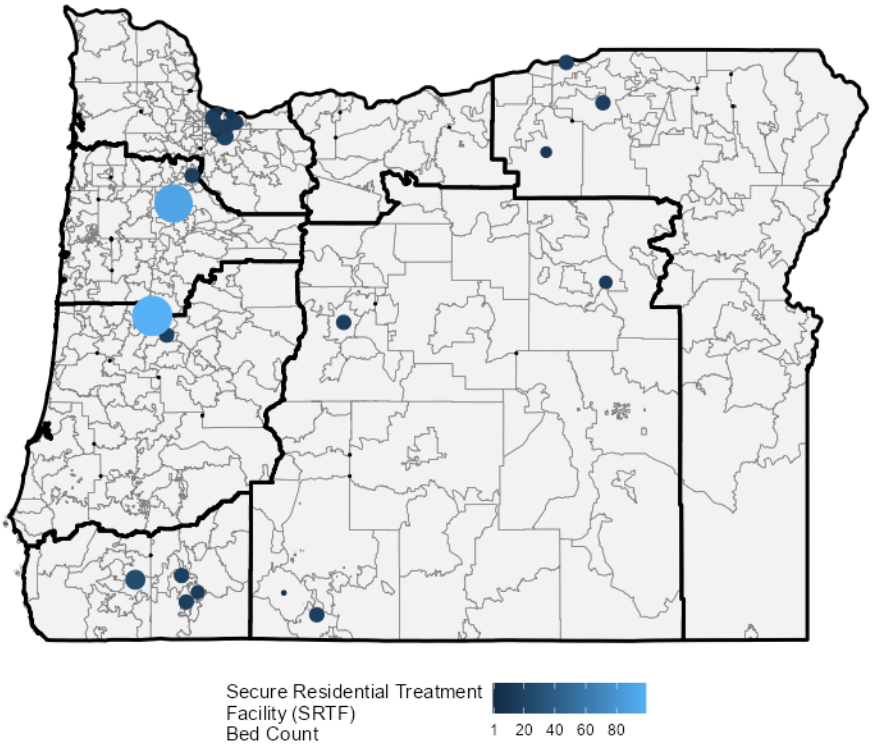
Class 2

Class 2 facilities are approved to be locked to prevent a person from leaving the facility. Class 2 facilities include a secure residential facility approved by the Division to be locked or a facility deemed to restrict the liberty of a person to the same degree as other facilities in this class by the Division. Class 2 facilities differentiate themselves from Class 1 by not allowing the use of seclusion and restraints or involuntary administration of psychiatric medications.[xv]

Table 18. Secure Residential Treatment Facility (SRTF) Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	127	106	115	72	0	48	42	510
Beds per 100,000 Population	6.36	13.90	19.92	21.71	0.00	14.03	24.31	12.04

Figure 11. Secure Residential Treatment Facility (SRTF) Bed Count Map



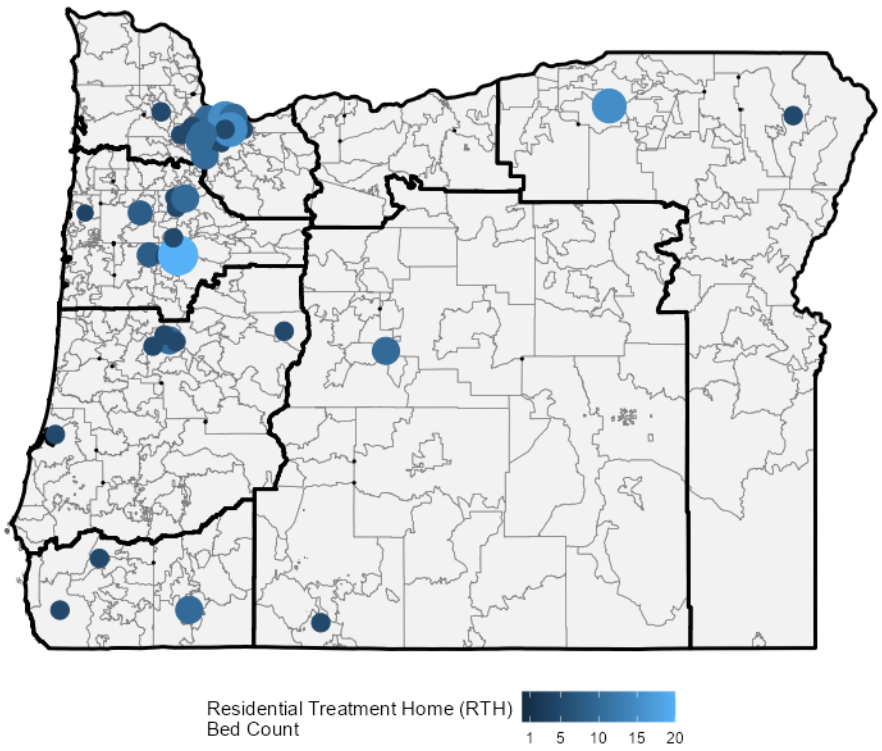
Residential Treatment Homes (RTH)

RTH's are community based, specialized treatment programs, providing 24-hour care for up to 5 individuals in a homelike environment. RTH's are unlocked facilities, staffed twenty-four hours per day to provide supervision and care to individuals with mental or emotional disorders in a structured environment and accept individuals on a voluntary basis. These environments are the next level of care below hospitalization, providing a safe residential option with support staff, geared toward skill building, intervention, training, crisis intervention, medication monitoring, and daily living support to assist individuals to live in a community residential setting. RTH's are for those 18 years or older who need supervision to live independently in a community setting, to avoid higher levels of services or hospitalization, who are a danger to themselves or others, or who otherwise would not be able to remain in the community. Each RTH is licensed every two years by the Oregon Health Authority, Behavioral Health Division.[xvi]

Table 19. Residential Treatment Home (RTH) Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	144	69	35	20	0	15	20	303
Beds per 100,000 Population	7.22	9.05	6.06	6.03	0.00	4.38	11.58	7.15

Figure 12. Residential Treatment Home (RTH) Bed Count Map



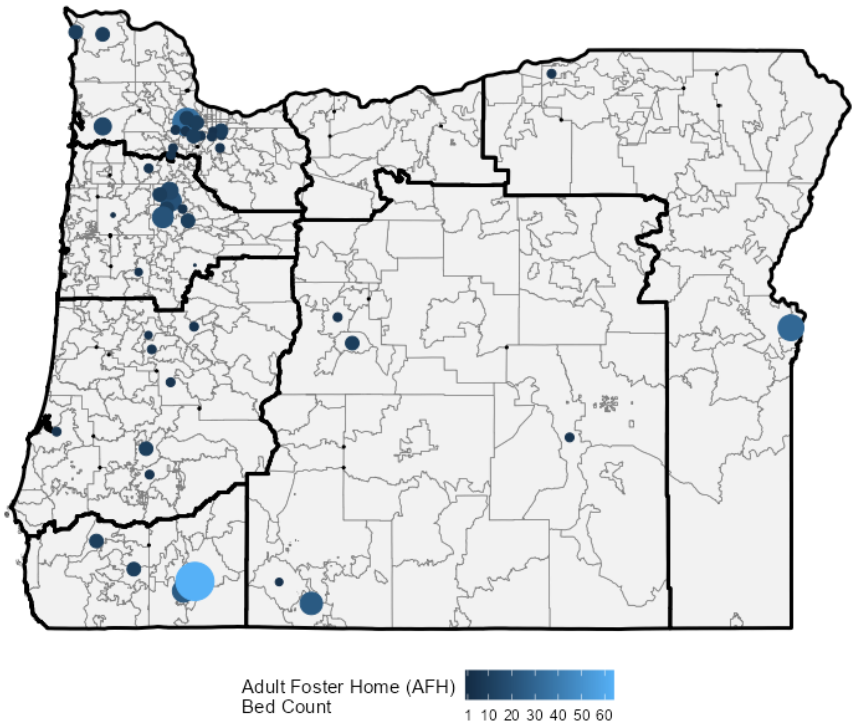
Adult Foster Homes (AFH)

AFH's, which are inspected and licensed by the Oregon Health Authority, Behavioral Health Division annually, are single family residences that offer care in a homelike setting for adults diagnosed with mental or emotional disorders and provide a different level of care than an RTF or RTH. The capacity of an AFH is up to 5 residents per home, requiring individuals to meet the qualifications listed in the AFH OAR's. AFH's provide supervision and care twenty-four hours per day, requiring providers or resident managers to live or remain on-site. Referrals for admission to an AFH are made through CMHP. AFHs are often utilized by individuals who need assistance with daily tasks because of mental or emotional disorders, and they commonly provide a supervised environment for adults who are unable to live independently. AFH's typically provide services such as: assistance with personal daily care; preparing meals; social interaction; transportation; and assistance with medical, recreational, vocational, and shopping activities. The care and services are designed to uphold individuals' rights to independence, choice, and decision-making. Moreover, providers are required to cater to individual needs in a manner that encourages the utmost level of independence while ensuring a safe environment.[xvii]

Table 20. Adult Foster Home (AFH) Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	159	103	39	108	0	48	36	493
Beds per 100,000 Population	7.97	13.51	6.75	32.57	0.00	14.03	20.84	11.64

Figure 13. Adult Foster Home (AFH) Bed Count Map



Substance Use Disorder Residential Facilities

Residential Substance Use Disorder Facilities

Residential substance use disorder treatment programs are publicly or privately operated programs, in a non-hospital setting, which provide assessment, treatment, rehabilitation, and 24-hour observation and monitoring for individuals with SUD's, consistent with Level 3 of the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition. ASAM Criteria is a standardized nomenclature scale used to determine levels of care and interventions to treat individuals with SUD's.

Residential SUD Treatment Programs provide services in a 24-hour structured environment for individuals who meet criteria, including diagnostic criteria for a moderate or severe substance use or addictive disorder, per Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Services provided include assessment, stabilization, development of treatment plan, group and individual counseling, case management and peer support, relapse prevention, medication monitoring and/or medication assisted treatment, education, and transitional care or support. Residential SUD Treatment Programs are licensed by Oregon Health Authority, Behavioral Health Division every 2 years.[xviii]

Residential SUD Facilities may also include Problem Gambling Treatment within a facility as described below:

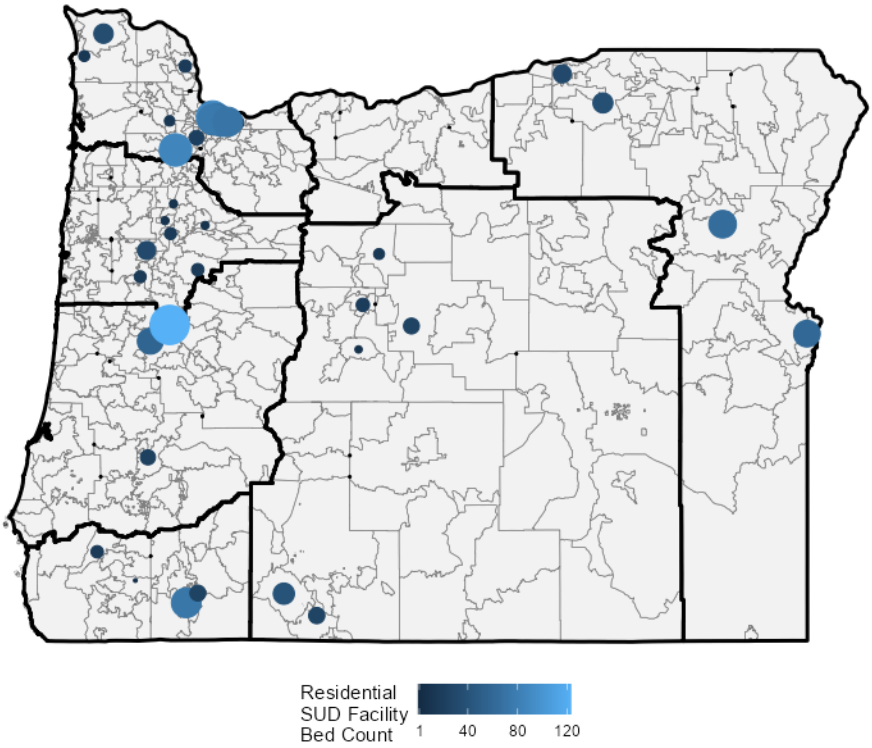
Substance Use Disorder and Problem Gambling Residential Treatment

Residential problem gambling treatment programs are publicly or privately operated programs, licensed in accordance with OAR 415-012-0000 through 415-012-0090 that provide assessment, treatment, rehabilitation, and 24-hour observation and monitoring for individuals with gambling disorders. Treatment includes services such as group, individual, and family treatment consistent with addressing the challenges of an individual as they relate, directly or indirectly, to problem gambling behavior. Residential treatment may also include co-occurring disorders such as alcoholism, substance use, or other addictions, in addition to gambling. These programs provide residential environments and treatment services for individuals, and they are licensed every 2 years by the Oregon Health Authority, Behavioral Health Division.[xix]

Table 21. Residential SUD Facility Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	639	100	202	116	0	127	190	1374
Beds per 100,000 Population	32.02	13.12	34.99	34.98	0.00	37.12	109.96	32.44

Figure 14. Residential SUD Bed Count Map



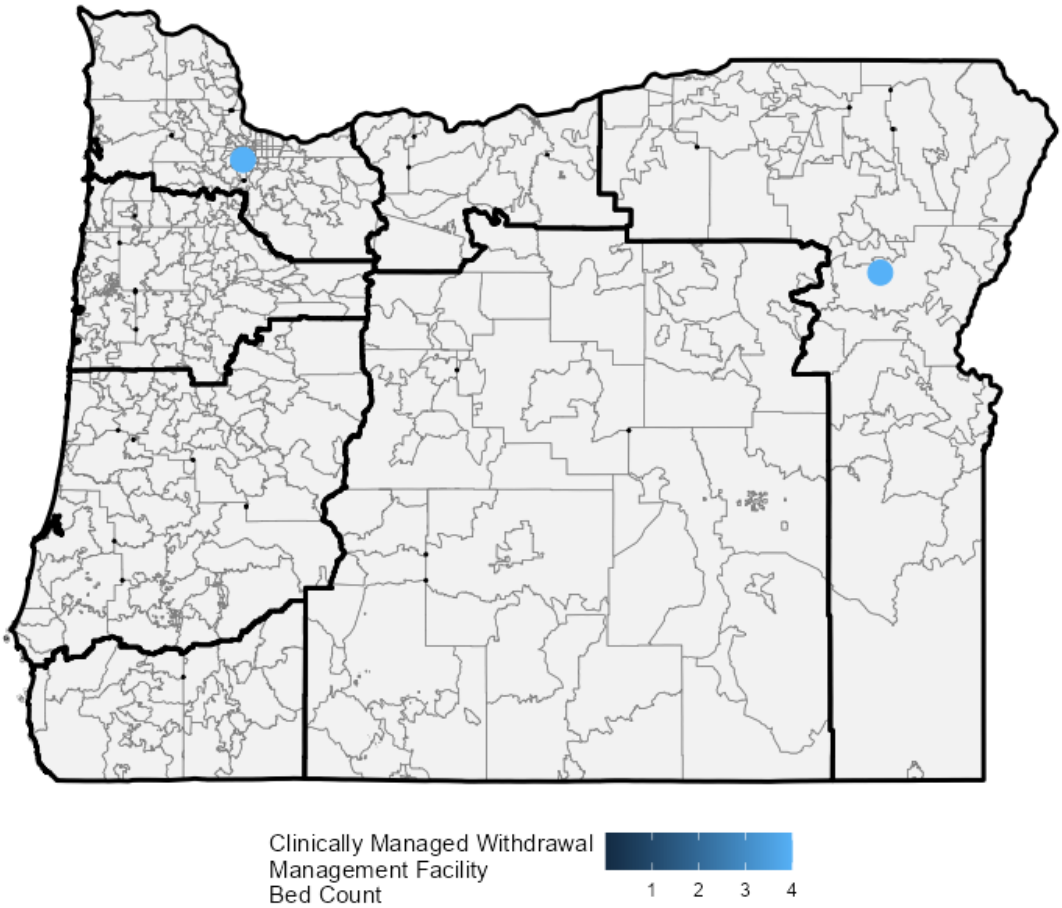
Clinically Managed Withdrawal Management Facilities

SUD withdrawal management clinically managed programs are SUD treatment programs that are publicly or privately operated programs in a non-hospital setting and provide assessment, treatment, rehabilitation and 24-hour observation and monitoring for individuals with substance use disorder. Clinically Managed Residential Withdrawal Management (ASAM Level 3.2- WM) means a setting in which clinically managed services are directed by non-physician addiction specialists rather than medical and nursing personnel.[xx]

Table 22. Clinically Managed Withdrawal Management Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	4	0	0	0	0	0	4	8
Beds per 100,000 Population	0.20	0	0	0	0	0	2.32	0.19

Figure 15. Clinically Managed Withdrawal Management Bed Count Map



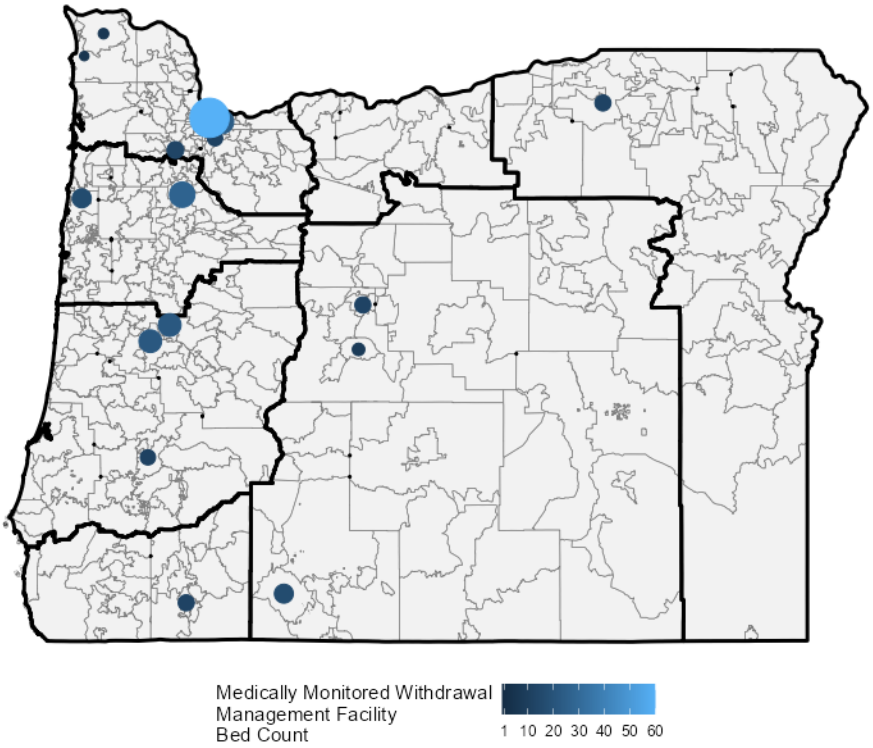
Medically Monitored Withdrawal Management Facilities

SUD withdrawal management medically monitored programs are SUD treatment programs that are publicly or privately operated programs in a non-hospital setting and provide assessment, treatment, rehabilitation, and 24-hour observation and monitoring for individuals with SUD's. Medically Monitored Withdrawal Management (ASAM Level 3.7-WM) means an inpatient setting which provides medically monitored intensive inpatient treatment services. Such settings are also automatically licensed for the provision of lower-level services.[xxi]

Table 23. Medically Monitored Withdrawal Management Bed Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Number of Beds	135	43	55	12	0	36	12	293
Beds per 100,000 Population	6.77	5.64	9.53	3.62	0.00	10.52	6.95	6.92

Figure 16. Medically Monitored Withdrawal Management Bed Count Map



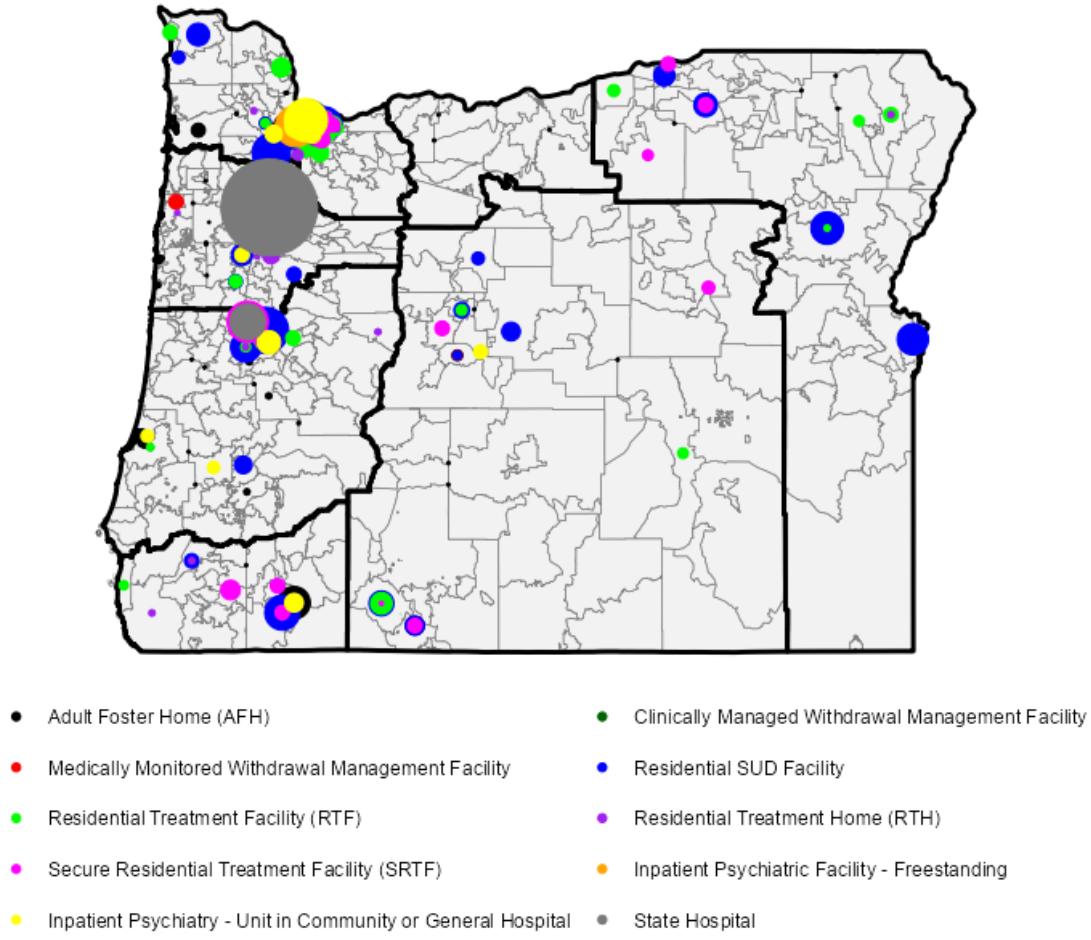
REGIONAL SUMMARY

The Regional Summary below shows all facility types and bed counts by trauma system area across Oregon:

Table 24. Regional Summary of Current Bed Capacity

Trauma System Area	ATAB 1 (Portland / N Coast)	ATAB 2 (Mid-Willamette Valley / N Central Coast)	ATAB 3 (S Willamette Valley / S Central Coast)	ATAB 5 (Southern Oregon / S Coast)	ATAB 6 (Columbia Gorge)	ATAB 7 (Central Oregon)	ATAB 9 (Eastern Oregon)	Total
State Hospitals	0	502	75	0	0	0	0	577
Inpatient Psychiatric Facility - Freestanding	98	0	0	0	0	0	0	98
Inpatient Psychiatric - Unit in Hospital	213	51	60	24	0	15	0	363
Residential Treatment Facility (RTF)	275	71	49	18	0	51	43	507
Secure Residential Treatment Facility (SRTF)	127	106	115	72	0	48	42	510
Residential Treatment Home (RTH)	144	69	35	20	0	15	20	303
Adult Foster Home (AFH)	159	103	39	108	0	48	36	493
Residential SUD Facility	639	100	202	116	0	127	190	1374
Clinically Managed Withdrawal Management Facility	4	0	0	0	0	0	4	8
Medically Monitored Withdrawal Management Facility	135	43	55	12	0	36	12	293
Total	**1,794**	**1,045**	**630**	**370**	**0**	**340**	**347**	**4,526**

Figure 17. Regional Bed Count Map



ADDITIONAL CAPACITY IN PROGRESS (PENDING FACILITIES)

In addition to the current capacity in Oregon, there are several new facilities in progress, which, upon completion, will contribute to the overall capacity in the State, supplementing the existing infrastructure. PCG was provided with grant data on projects supported with investments from HB 5202[iv] and HB 5024[v] to identify the facilities with funding to expand capacity in Oregon. We received grant documents to determine the pending facilities within the scope. The licensed residential facilities were identified and analyzed to determine project type, facility type, projected bed capacity, county, and cost. PCG cross-referenced the current capacity inventory to determine the facilities that are not currently open and operating.

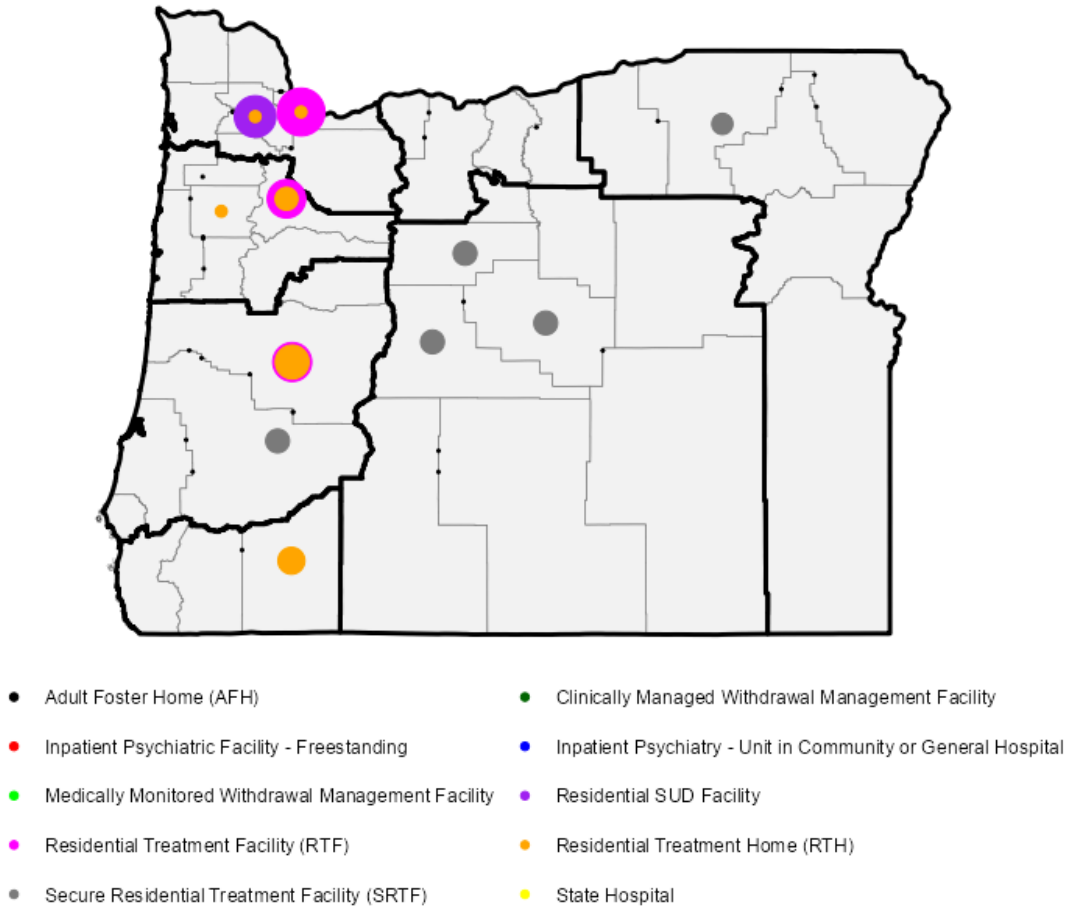
The table below shows the bed counts for the facilities in progress for the following types:

- New Construction
- Acquisition
- Renovation
- Purchase Remodel

Table 25. Facilities in Progress Bed Capacity

Trauma System Area	ATAB 1 (Portland / N Coast)	ATAB 2 (Mid-Willamette Valley / N Central Coast)	ATAB 3 (S Willamette Valley / S Central Coast)	ATAB 5 (Southern Oregon / S Coast)	ATAB 6 (Columbia Gorge)	ATAB 7 (Central Oregon)	ATAB 9 (Eastern Oregon)	Total
Residential Treatment Facility (RTF)	57	38	39	0	0	0	0	134
Secure Residential Treatment Facility (SRTF)	0	0	16	0	0	48	13	77
Residential Treatment Home (RTH)	10	25	30	20	0	0	0	85
Adult Foster Home (AFH)	0	0	5	0	0	0	0	5
Residential SUD Facility	44	0	0	0	0	0	0	44
Medically Monitored Withdrawal Management	16	0	0	0	0	0	0	16
Total	**127**	**63**	**90**	**20**	**0**	**48**	**13**	**361**

Figure 18. Facilities in Progress Bed Count Map



To note, PCG's analysis does not include 2024 legislative funded capacity from HB 4002[xxii] and HB 5204[xxiii]. OHA informed PCG that the funding from the 2024 legislative session provided $86.558 million to fund approximately 25 projects. These projects will provide a range of services from crisis stabilization to supportive housing to expanded treatment options for individuals in Oregon. The information below was provided by OHA directly to PCG to include in this report:

House Bill 5204: To address behavioral health facility capacity, this measure appropriates a total of $83,408,000 General Fund to the Department of Administrative Services to distribute as follows:

Table 26. HB 5204 Information Provided by OHA

Organization	Total Funding Allocated	Project Description
4D Recovery Center	$4,000,000	Multnomah County to support the acquisition of a facility to provide adolescent SUD residential and outpatient services
Adapt Integrated Health Care	$5,000,000	Douglas County to support the construction of the Adapt Recovery Campus

Addictions Recovery Center, Inc	$500,000	Jackson County for sobering center operations
Addictions Recovery Center, Inc	$1,000,000	Jackson County to support the Substance Use Disorder Withdrawal Management Expansion project
Benton County Health Department Behavioral Health Division	$5,000,000	Benton County to relocate Children and Family Services
BestCare Treatment Services, Inc	$525,000	Deschutes county to expand detox capacity in Central Oregon
BestCare Treatment Services, Inc	$1,500,000	Jackson County to develop culturally specific SUD residential treatment capacity
Bridgeway Recovery Services, Inc	$11,500,000	Marion County for the development of the Bridgeway Medical Center and SUD treatment residential facilities
Cascade AIDS Project	$4,000,000	Multnomah County to purchase the Prism Health facility located on North Morris Street, Portland, Oregon
Clackamas County	$4,000,000	Clackamas County for the construction of a crisis stabilization center
Clatsop County Behavioral Healthcare	$500,000	Clatsop County to acquire detox and SUD treatment residential beds
Coos Health and Wellness	$400,000	Coos County for the development of a sobering center
Deschutes County Community Mental Health Program	$1,500,000	Deschutes County to support the Deschutes County Stabilization Center
Klamath Basin Behavioral Health	$2,400,000	Klamath County to support the construction of a RTF with a crisis stabilization center
Lifeways, Inc	$5,750,000	Malheur County for the Ontario Medical Plaza project to convert
Lincoln County Health and Human Services Department	$3,500,000	Lincoln County to support the Lighthouse Village Apartments Mental Health Housing project
Multnomah County	$10,000,000	Multnomah County to support the construction of a behavioral health drop-off center
New Directions Northwest, Inc	$600,000	Baker County to build a crisis receiving center addition to the Recovery Village Crisis Stabilization and Detox Center
Transformations Wellness Center	$2,500,000	Klamath County for the construction of a residential, co-occurring, SUD treatment facility with detox beds
Wallowa Valley Center for Wellness	$333,000	Wallowa County to support phase 2 of the Park Street Transitional Housing project

Wasco County	$8,000,000	Wasco County to support the development of the Mid-Columbia Center for Living Campus
Washington County Behavioral Health Division	$8,900,000	Washington County to support the development of the Center for Addictions Triage and Treatment project
Willamette Family, Inc	$4,000,000	Lane County to support the construction of the Willamette Family Medical Detox and Resident Services facility
Total Allocated:	**$85,408,000**	

In addition, the measure appropriates $1,150,000 General Fund on a one-time basis to the Department of Administrative Services for the following purposes (not BH)

Provider	Total Funding Allocated	Project Description
Portland Opportunities Industrialization Center	$1,000,000	For a peer-to-peer mentoring outreach program
WomenFirst Transition and Referral Center	$150,000	To provide operational funding for detox services
Total Allocated:	**$1,150,000**	

CURRENT AND PENDING CAPACITY

For the remainder of this report, we assume the pending beds will be implemented and account for them in our bed counts for analysis. The table below shows the total number of current and pending bed counts in the State by the 3rd quarter 2025.

Table 27. Current and Pending Bed Capacity [iii]

Trauma System Area		ATAB 1 (Portland / N Coast)	ATAB 2 (Mid-Willamette Valley / N Central Coast)	ATAB 3 (S Willamette Valley / S Central Coast)	ATAB 5 (Southern Oregon / S Coast)	ATAB 6 (Columbia Gorge)	ATAB 7 (Central Oregon)	ATAB 9 (Eastern Oregon)	Total
State Hospitals	Beds	0	502	75	0	0	0	0	577
	Beds per 100k	0.00	65.84	12.99	0	0	0	0	13.62
Inpatient Psychiatric Facility - Freestanding	Beds	98	0	0	0	0	0	0	98
	Beds per 100k	4.91	0	0	0	0	0	0	2.31
Inpatient Psychiatric - Unit in Hospital	Beds	213	51	60	24	0	15	0	363
	Beds per 100k	10.67	6.69	10.39	7.24	0	4.38	0	8.57
Residential Treatment Facility (RTF)	Beds	332	109	88	18	0	51	43	641
	Beds per 100k	16.64	14.30	15.24	5.43	0	14.91	24.89	15.13
Secure Residential Treatment Facility (SRTF)	Beds	127	106	131	72	0	96	55	587
	Beds per 100k	6.36	13.90	22.69	21.71	0	28.06	31.83	13.86
Residential Treatment Home (RTH)	Beds	154	94	65	40	0	15	20	388
	Beds per 100k	7.72	12.33	11.26	12.06	0	4.38	11.58	9.16
Adult Foster Home (AFH)	Beds	159	103	44	108	0	48	36	498
	Beds per 100k	7.97	13.51	7.62	32.57	0	14.03	20.84	11.76
Residential SUD Facility	Beds	683	100	202	116	0	127	190	1,418
	Beds per 100k	34.23	13.12	34.99	34.98	0	37.12	109.96	33.48
Clinically Managed Withdrawal Management Facility	Beds	4	0	0	0	0	0	4	8
	Beds per 100k	0	0	0	0	0	0	2.32	0.19
Medically Monitored Withdrawal Management Facility	Beds	151	43	55	12	0	36	12	309
	Beds per 100k	7.57	5.64	9.53	3.62	0	10.52	6.95	7.30
Total	**Beds**	**1,921**	**1,108**	**720**	**390**	**0**	**388**	**360**	**4,887**

CRISIS FACILITY REVIEW

In addition to the licensed clinical facilities in-scope, PCG also reviewed the crisis facilities in Oregon. It is important to note that some of the crisis services or facilities in Oregon are not currently defined by State rules and do not have designated licensing and certification criteria at this time. The Behavioral Health Division is currently developing administrative rules for crisis stabilization centers which will provide certification requirements and minimum standards for services and care delivery. Therefore, PCG's report does not include an analysis on the current capacity of beds and recliners providing crisis services due to different facilities rendering crisis services in various ways while awaiting the defined rules and requirements from OHA. However, PCG has identified bed and recliner needs by county within this report based on the RI International Roadmap to Implementation of Oregon's 988 & Behavioral Health Crisis System report[xxxviii] and their analysis.

PCG has identified facility types and services provided within the crisis care continuum outlined in the chart below as provided by OHA. We recommend further assessments on crisis care once the State determines the appropriate rulemaking for providing and delivering crisis care throughout Oregon, analyzing facility capacity and subsequently analyzing against the RI International recommendations. The following information pertains to the crisis services and facilities in Oregon with information provided by the Oregon Health Authority.

Table 28. Crisis Services Review

Service or Facility Type	State Oversight	Services Provided
Psychiatric Emergency Services (PES)	Oregon Health Authority Behavioral Health Division: Behavioral Health Services – Chapter 309 Division 23 Oregon Secretary of State Administrative Rules[xxiv] Facilities providing PES must also meet standards for Regional Acute Care Psychiatric Facilities for Adults (OAR 309-032-0850 through 8070) and be approved as a hospital hold facility pursuant to OAR 309-033-0500 through 0550	Psychiatric Emergency Services are not distinct facilities – they are services provided in an emergency department of a hospital or satellite hospital for less than 23 hours. They may provide up to 23 hours of triage and assessment, observation and supervision, crisis stabilization, crisis intervention, crisis counseling, case management, medication management, safety planning, lethal means counseling, and mobilization of peer and family support and community resources. Oregon currently has only one PES unit – Unity Center for Behavioral Health in Portland.
Crisis Respite Services	Oregon Health Authority Behavioral Health Division: Behavioral Health Services – Chapter 309 Division 35 Oregon Secretary of State Administrative Rules[xxv]	Crisis Respite Services are not distinct facilities. Crisis Respite Services are Medicaid-reimbursable and are provided in RTH's, RTF's, or SRTF's for up to 30 days. According to an OHA memo[xxvi], Crisis Respite Services are short-term crisis and stabilization services that are provided in a residential setting to stabilize the individual in crisis, prevent further deterioration, and provide immediate treatment and intervention in a location best suited to the

Service or Facility Type	State Oversight	Services Provided
		needs of the individuals and the least restrictive environment possible.
Crisis Stabilization Centers	In Development – There is no facility type that is defined by rule.	Crisis Stabilization Centers are opening in Oregon, but they are not currently defined by rules. OHA is presently developing administrative rules for Crisis Stabilization Centers as directed by ORS 430.627(3). The rules are anticipated to go into effect by the end of 2024. Crisis Stabilization Centers utilize a recliner-based living room model and are designed to prevent or ameliorate a behavioral health crisis or reduce acute symptoms of mental illness or SUD's for individuals who do not require inpatient treatment by providing continuous observation and supervision for 23 hours or less. Crisis Stabilization Centers are staffed 24-hours per day, 7 days per week, 365 days per year by a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis and accepting walk-ins and first responder drop-offs.
Peer Respite Centers	Oregon Health Authority Behavioral Health Division: Behavioral Health Services – Chapter 309 Division 20 Oregon Secretary of State Administrative Rules[xxvii]	Peer Respite Centers are not licensed or certified and are not online in Oregon yet, but HB 2980 provided funding for four centers. Peer Respite Centers are peer-run, voluntary, short-term, overnight programs that provide community-based, non-clinical support for those experiencing or at-risk of experiencing an acute behavioral health crisis.
Crisis Walk-In Services	Crisis Walk-In Services are not defined by rules in Oregon.	Crisis Walk-In Services are offered in every county and typically have more limited business hours.

Given that the landscape of crisis services is under development with the rules being defined, PCG and OHA held nine interviews with CMHP's that that are currently operating crisis services and/or plan to open facilities in the future. PCG and OHA collaborated to create a survey that was discussed and reviewed during these conversations. The survey aimed to understand the services being offered, the delivery model, the number of people served, the challenges and barriers, the staffing models, and the plans for expanding crisis services in their county. Conversations were held with the following groups:

- Benton County CMHP
- Lane County CMHP
- Adapt Integrated Health Care (CMHP for Douglas County & Curry County)
- Polk County CMHP

- Deschutes County CMHP
- Marion County CMHP
- Clackamas County CMHP
- Washington County CMHP
- Multnomah County CMHP

PCG understands that the crisis services identified during these discussions may not represent the entirety of crisis offerings in the State. In addition to identifying the services provided, these discussions yielded important information about the barriers and challenges that are faced by the facilities that offer crisis services. Some key themes of the conversations with CMHPs are noted below:

- **Staffing:** Staffing was noted as a significant challenge for most of the programs that we spoke to. Hiring and retaining qualified staff has become increasingly difficult. Master's level clinician roles were noted as positions that have been the most challenging to fill with some facilities having several open positions that have been posted for long periods of time. These conversations also noted that retaining staff has been difficult due to alternative settings offering compensation that the crisis facilities cannot compete with. One of the CMHP's we spoke with noted that they often have limited hours on the weekend due to the staffing shortages and challenges that they face. Another facility noted that they have difficulty hiring and retaining staff for the night shift and have had to use staffing firms to bring in staff to fill these positions. The nature of crisis work also results in unpredictable schedules, which CMHP's said is a barrier to recruiting and retaining staff. The staffing shortages are leading to supervisors and staff from other teams having to step in to provide services in other positions. This is leading to staff burnout and strains in capacity in other parts of their programs. Additionally, some facilities indicated that they must limit bed availability due to staff shortages.
- **Unavailability of beds at the next level of care:** During our conversations, it was noted that there can be a significant challenge finding a bed available for someone at another level of care when transition is necessary. Some of the individuals we talked to noted that they had faced challenges discharging individuals from the crisis setting because there was a lack of available beds at another facility. Some individuals noted that residential is the most difficult facility to find with an open bed while others noted that withdrawal management is the most challenging to find for individuals who need it. Facilities noted that there are times when a bed is not available in a withdrawal management setting, so they refer the individuals to the emergency department. It was also identified that housing can be a barrier when discharging individuals from the crisis care setting – the facilities try to avoid sending someone back to the unhoused environment and have been working with community resources to prevent this.
- **Funding:** Funding was noted as a barrier for several of the facilities. It was mentioned that there is not adequate funding for some of the counties to provide mobile crisis services and to have mobile crisis teams that can cover the entire county. One facility noted that the cost to employ staff has risen substantially but there has been very limited State funding – they are relying on grant funding and, even with the grant funds, they are still operating with a funding gap. They also noted that unexpected changes in project costs, construction challenges, and other factors outside of their control are disrupting development plans for new programs and leading to pushing completion targets. It was noted that the costs needed to run and operate the facilities are increasing and causing all components to become more expensive. Additionally, a facility noted that the closure of a local Emergency Department unexpectedly shutting down affected the plans for the crisis facility.
- **Rule Requirements:** In addition to the conversation topics noted above, there was also concern about the potential administrative rule requirements for integration of physical health services in Crisis Stabilization Centers. They noted that many facilities do not have the capacity to add physical health services in their current space. This concern comes from ORS, but the rules are still under development. Facilities are currently awaiting the final OARs to know the full requirements and rules.

PROVIDER SURVEY

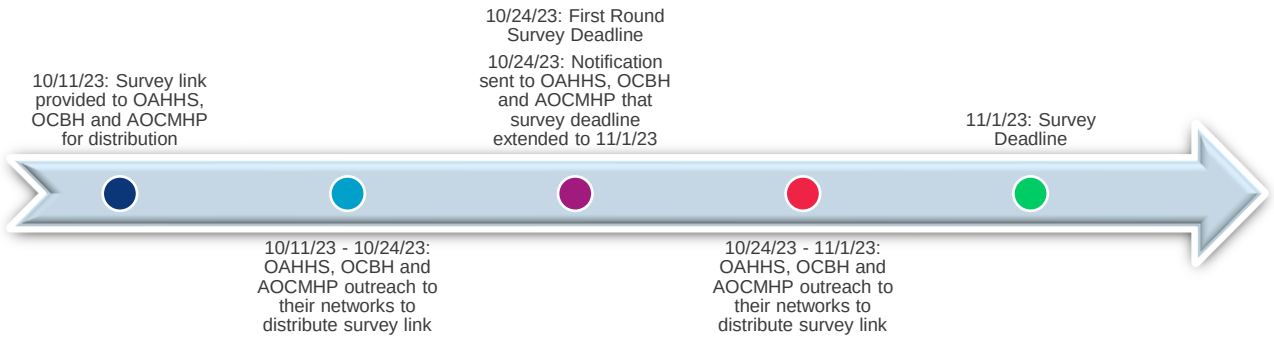
OVERVIEW

As noted previously in this report, PCG created a provider survey to collect original data for our analysis. The survey was reviewed by the OHA team, the Oregon Council for Behavioral Health, and the Hospital Association of Oregon. The questions in the survey aimed to gather the following information about behavioral health facilities in Oregon:

- Name and location
- Licensure type
- Level of care provided
- Populations served
- Licensed capacity
- Fully operational capacity (operational capacity is defined as the number of beds a facility intends to make available, assuming no staff or resource constraints.)
- Average staffed capacity (staffed capacity is defined as the maximum number of beds a facility is able to operate based on available staff and resources.)
- Staffing data and challenges
- Admission and discharge information
- Additional information on facility challenges or needs

The survey was distributed through the Hospital Association of Oregon, the OCBH, and the AOCMHP. The survey was distributed with the following timeline:

Figure 19. Survey Distribution Timeline



SURVEY HIGHLIGHTS

Following the close of the survey, PCG reviewed 220 responses and analyzed the results. Some notable survey highlights are included below:

Figure 20. Survey Highlights

Survey Response Details

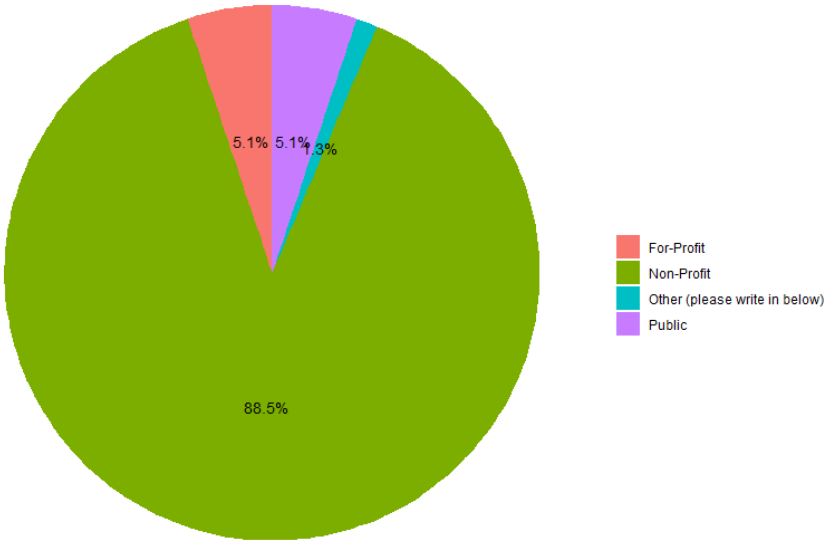
PCG has highlighted some of the survey responses of note for our analysis. The details of those responses are included below:

Facility Details and Structure

Survey Question: Please select the correct Facility Type below.

156 individuals responded to this question and 138 (88%) respondents represented non-profit facilities.

Figure 21. Survey Response Highlight

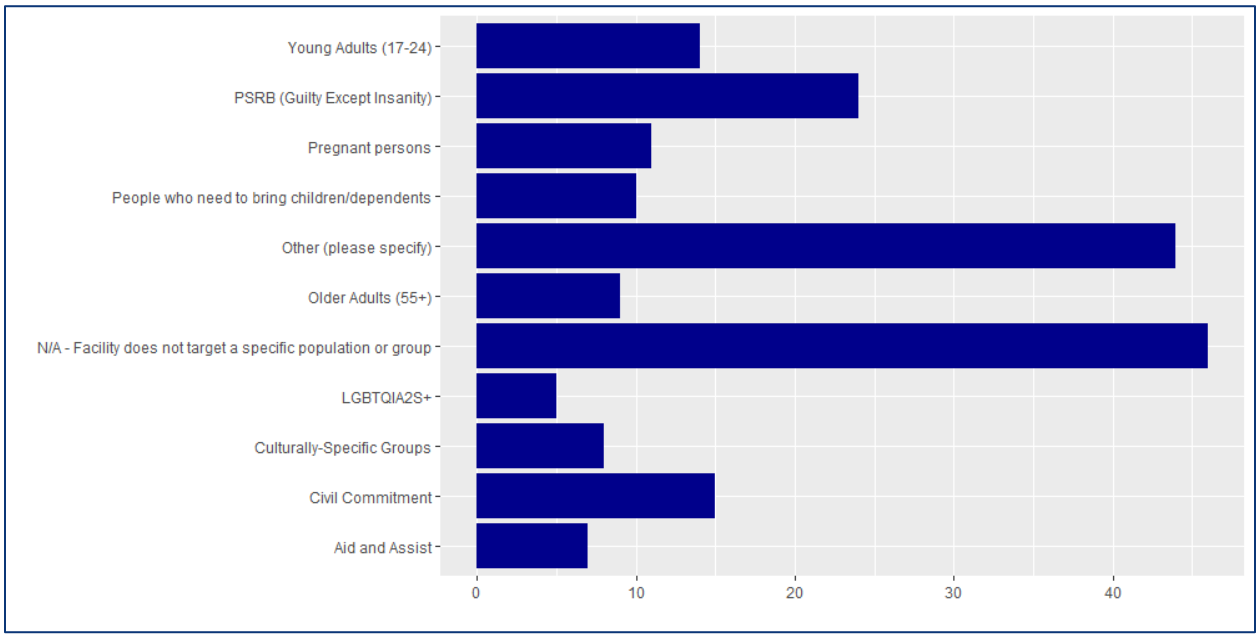


Survey Question: What are the types of admissions/legal statuses accepted at your Facility? (select all that apply)

Of the 134 responses for this question, 46 respondents selected that the Facility does not target a specific population or group. Another large portion, 44 respondents, selected "other" and wrote in the following items:

- Young Adults (17-24)
- Older Adults (55+)
- Culturally Specific Groups
- Pregnant Persons
- People who need to bring children/dependents
- Psychiatric Security Review Board (PSRB)
- Aid and Assist
- Civil Commitment

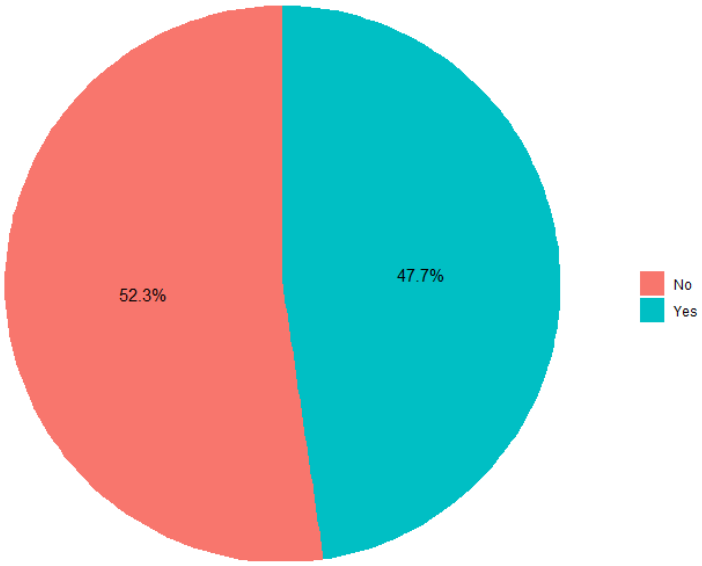
Figure 22. Survey Response Highlight



Survey Question: Does the Facility accept individuals with co-occurring conditions i.e.... the coexistence of both a mental health and substance use disorder?

Of the 128 responses for this question, 61 respondents (48%) selected yes and do accept individuals with co-occurring conditions and 67 respondents (52%) selected no and do not accept individuals with co-occurring conditions.

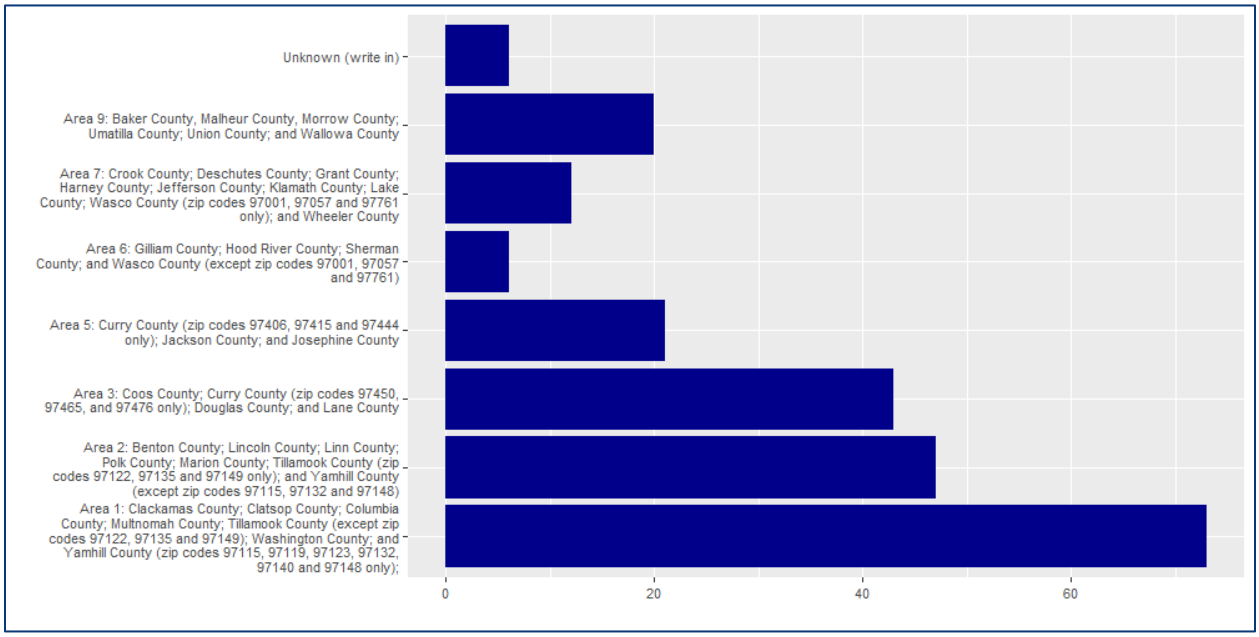
Figure 23. Survey Response Highlight



Survey Question: What trauma system area do most of your patients come from?

The survey yielded 145 responses for this question with half of the responses (50%, 73 people) indicating that most of the patients come from trauma system area 1. Trauma system area 6 yielded the smallest number of responses with six survey selections.

Figure 24. Survey Response Highlight



Capacity & Occupancy

Survey Question: Other than staffing, are there reasons why your facility cannot operate at licensed capacity?

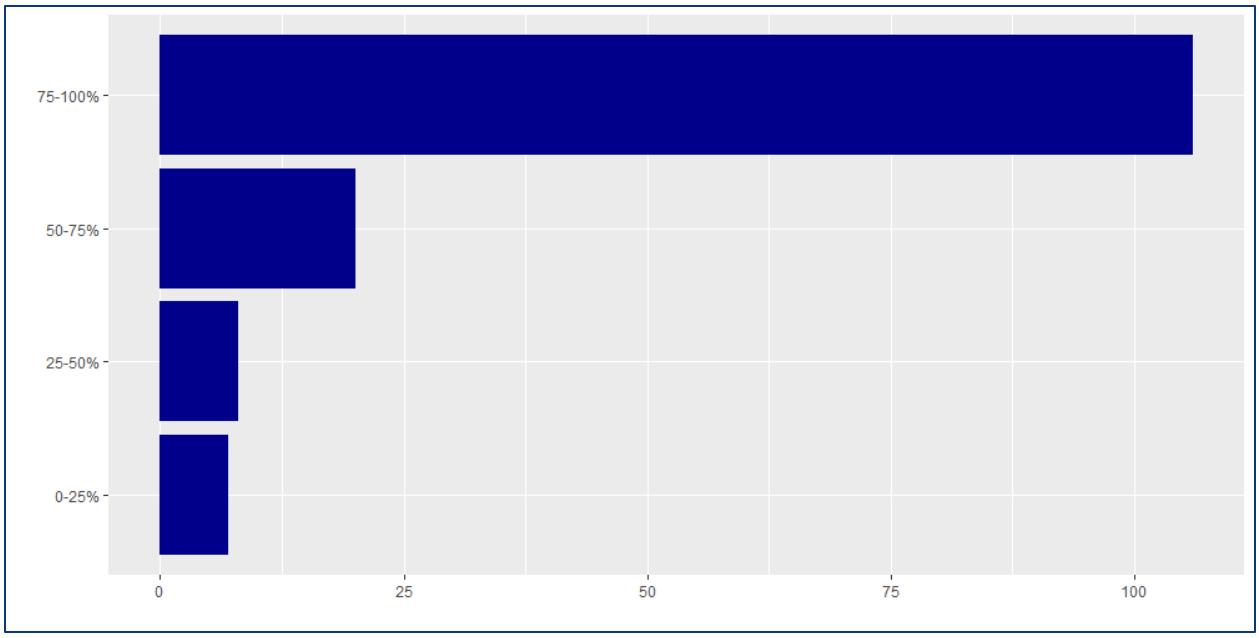
116 individuals responded to this question. 82 individuals noted that they operate at full capacity and this question did not apply to them. 34 people noted that there were additional reasons other than staffing for why the facility cannot operate at licensed capacity. Some of those reasons are noted below:

- Rooms are not available due to needing maintenance
- Building falling down
- Physical space
- Capability due to acuity of patients
- Facility limitations
- Challenges around sharing rooms

Survey Question: What is the average estimated monthly occupancy rate of available beds?

141 individuals responded to this question with 106 of them selecting that the monthly occupancy rate of available beds is between 75% and 100%. Only seven respondents noted that their monthly occupancy rate is below 25%.

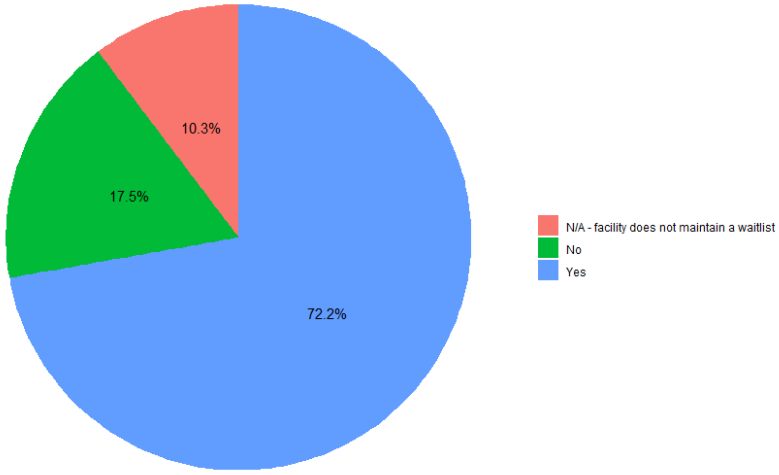
Figure 25. Survey Response Highlight



Survey Question: Does the Facility have people waiting to get into the Facility or a "waitlist" currently?

Of the 133 responses, 91 individuals noted their facility has people waiting to receive services, 22 people noted their facility does not have a waitlist, and 13 individuals said their facility does not maintain a waitlist.

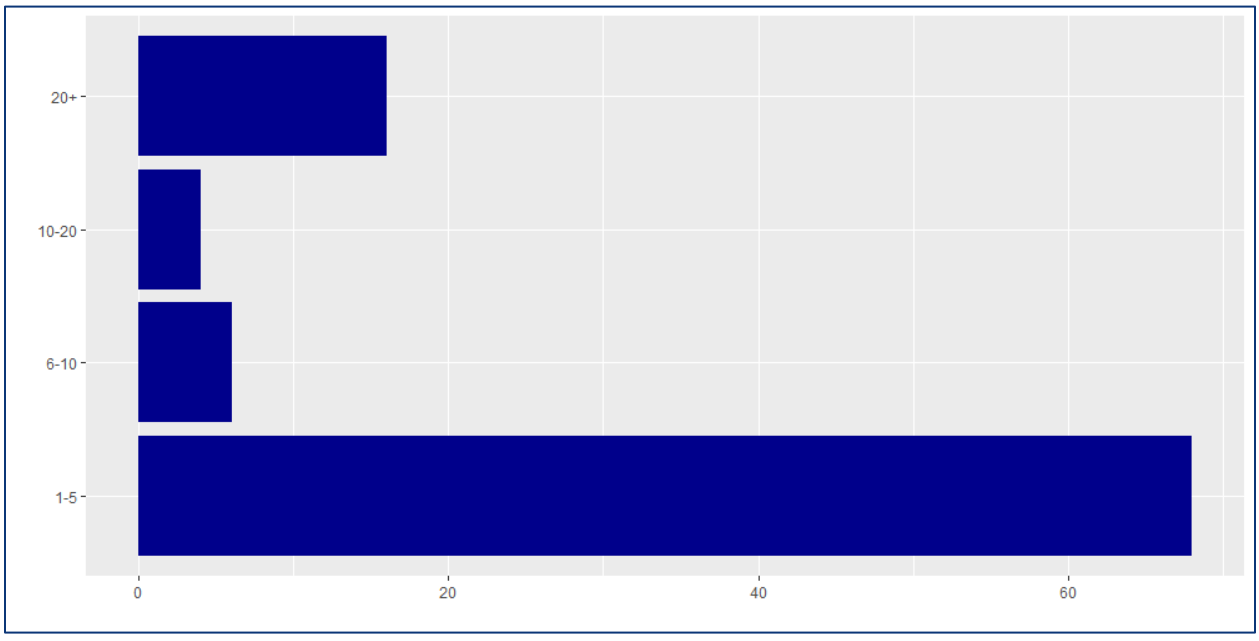
Figure 26. Survey Response Highlight



Survey Question: If yes, how many people are on the "waitlist"?

94 respondents answered this question and 68 (72%) noted that the waitlist has between one and five people with 16 respondents (17%) noting that there are over 20 people on the waist list.

Figure 27. Survey Response Highlight



Staffing

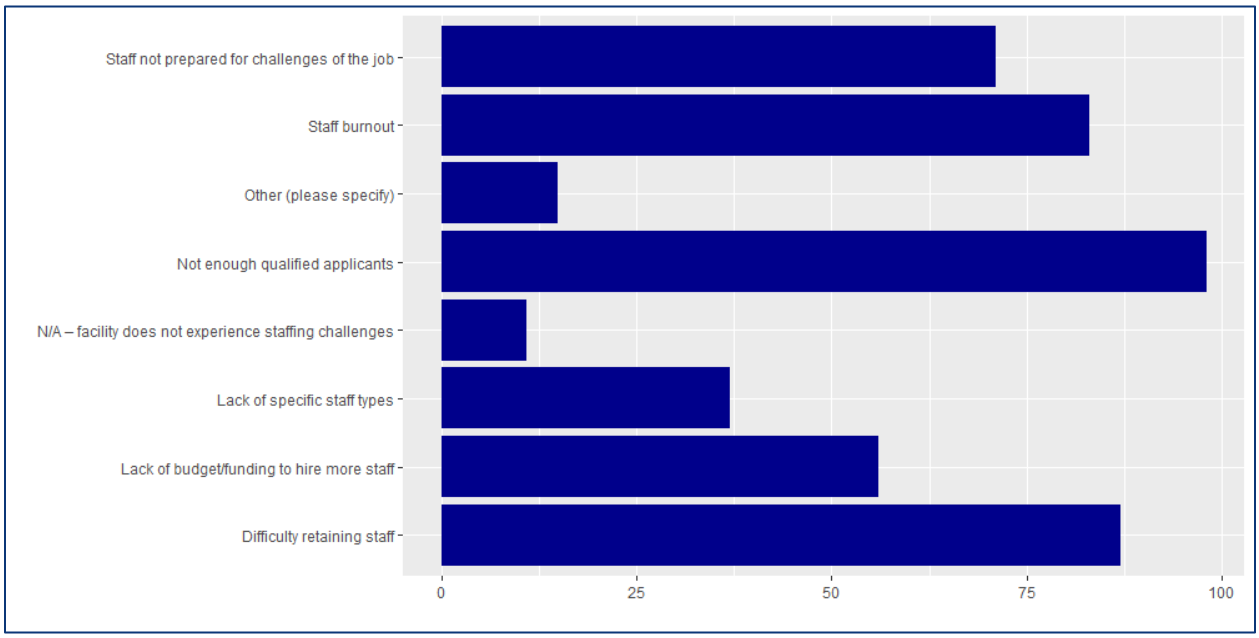
Survey Question: Thinking over the past year, what has been the Facility's average staffed capacity? Staffed capacity is defined as the maximum number of beds a facility is able to operate based on available staff and resources.

30 respondents noted for this question that their staffed capacity was lower than their operational capacity. The average difference in staffed capacity and operational capacity for these 30 responses was just over 10 beds.

Survey Question: Does the Facility experience any staffing challenges? If yes, please select the applicable staffing challenges noted below.

There were 135 responses for this survey question. The most selected option for the staffing challenges was that there were not enough applicants (98 responses). Additionally, the facilities noted that they have difficulty retaining staff (87 responses) and that staff experience burnout (83 responses).

Figure 28. Survey Response Highlight



Survey Question: Thinking over the past year, how often did the Facility have to limit bed availability due to staff shortages?

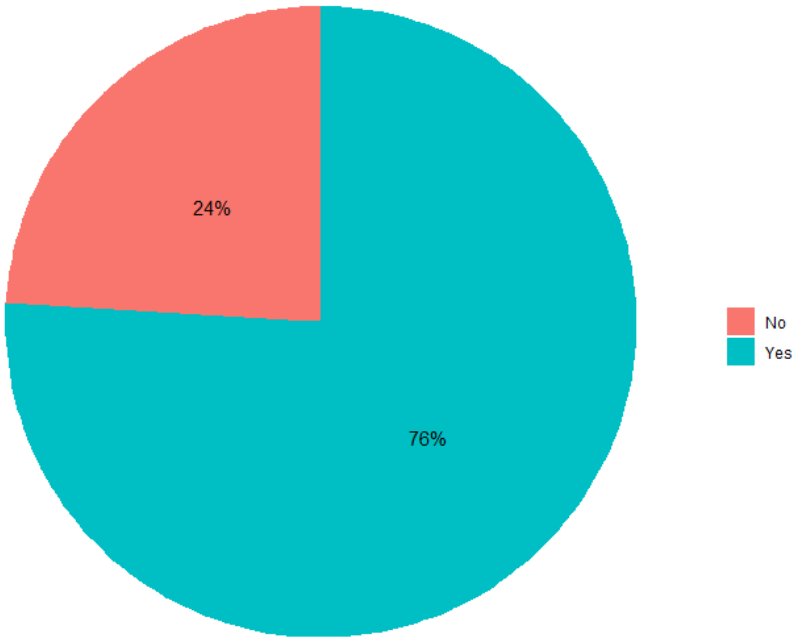
3 respondents selected "Always (all – or nearly all – days/months)". 13 respondents selected "Often – many days each month and/or many months in the year)". 21 respondents selected "Sometimes (some days each month and/or some months in the year)". 16 respondents selected "Rarely (occasional days or weeks)". 37 respondents selected "Never/do not experience staff shortages".

Additional Challenges

Survey Question: Does the Facility ever experience barriers and/or challenges discharging patients to other settings or facilities which results in prolonged patient stay?

133 individuals responded to this question and 101 (76%) noted that their facility experiences barriers and challenges discharging patients to other settings or facilities which results in a prolonged patient stay.

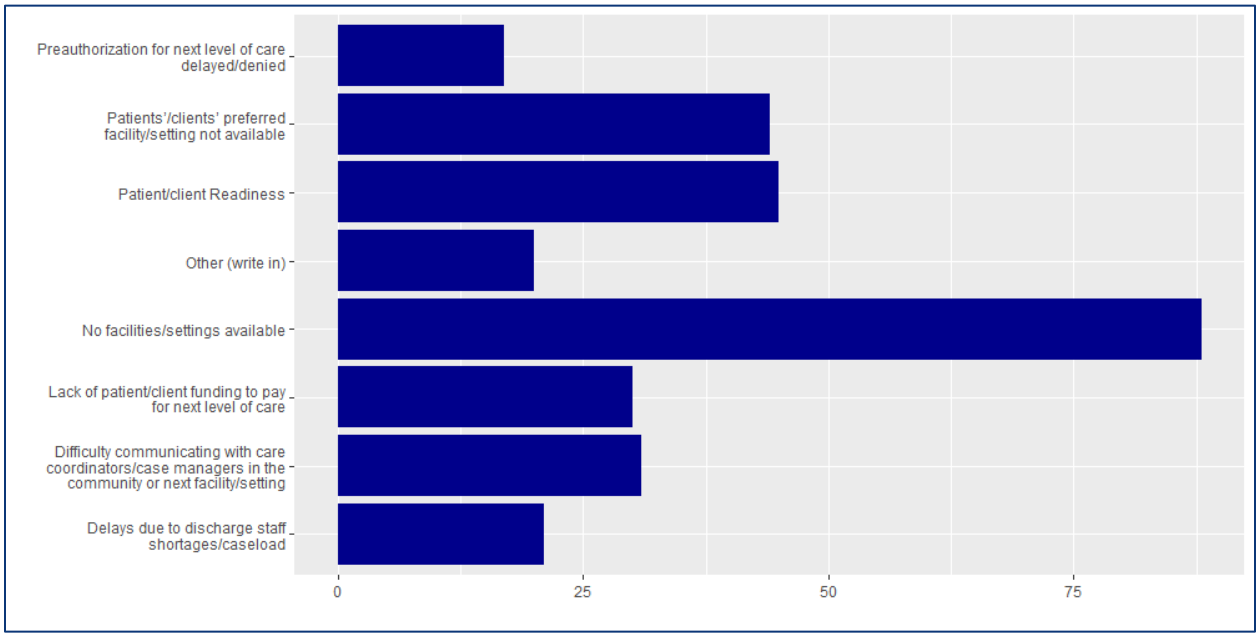
Figure 29. Survey Response Highlight



Survey Question: If yes, please identify the top three barriers and challenges discharging a patient to another facility or setting.

98 individuals responded to this question and were able to select all options that apply to their facility. The most selected option (88 responses) for the barrier or challenge in discharging a patient in that no facilities or settings are available. Additionally, patient readiness (45 responses) and the patient's preferred setting not being available (44 responses) were also top barriers and challenges to discharge.

Figure 30. Survey Response Highlight



Survey Question: Is there anything else you would like to share about your Facility's challenges and needs?

Respondents were given the opportunity to share any additional feedback and information about their facility's challenges and needs. Some of those responses are noted below:

- Additional Facility Themes
    - More outpatient treatment is needed
    - Safe and supportive housing continues to be the main barrier to early recovery after a residential transition
    - Residential facilities at every level are needed so the transition from other programs is easier
    - More short term acute psychiatric beds are needed
    - Access to long-term or residential care placements
    - More rehabilitative services for substance use (inpatient) are needed
    - More community resources to support individuals are needed
    - More low-income housing is needed
- Financial and Funding Themes
    - An increase in reimbursement rates is needed
    - More funding for operations and staff is needed
    - No capital investment funding has yet been made available to build or remodel a facility for its intended purpose
- Population Themes

    - Another challenge that is becoming an equally difficult barrier is our aging resident population
    - Referrals with complex medical issues that cannot be supported by facilities is a challenge
    - A rural location has benefits and challenges due to the location, for instance, family visits are more infrequent due to the location. Women often have less opportunities to engage in the community prior to graduation since the program is in a rural setting.
    - We often have power outages and evacuations due to weather that can impact treatment
    - Committed patients who are violent are a huge challenge to discharge and there has not been any ability to transfer to the State hospital
    - More programs for fathers with children are needed
- Operational Themes
    - Receiving incomplete referrals is a challenge as it adds significant time to the referral processing workflow and can delay beds being filled
    - A primary barrier is being a PSRB program. The PSRB evaluation and referral process is extensive and time consuming. Additionally, these residents need to have a court hearing prior to moving into the facility, which can be a delay of months while that bed sits open. Additionally, not all referrals are ready for placement, then that bed ends up being held until the resident is ready to move. The lack of control the facility has over filling their beds is cumbersome, costly, and frustrating.
    - Medical transport, dental care accessibility and proper housing are barriers
    - More clear guidelines on guardianship laws are needed
    - Additional trainings are needed for an understanding of ASAM

COMMUNITY ENGAGEMENT

INTRODUCTION & METHODOLOGY

To provide context for the quantitative data collected in this report, a critical aspect of this project is engaging with a diverse group of community members. Gathering information and hearing stories from Oregonians that have lived experience with the behavioral health system across the State must be a driving force behind our analysis and recommendations. This section will detail our community engagement goals and emerging themes from the community engagement period, and how these key themes and takeaways will inform recommendations.

The following section outlines each step of the community engagement Process. Each of the following steps critically influenced who was included in community engagement, how the sessions were approached, and what emerged as the key themes and areas of focus for this aspect of the project.

Review of Previous Community Engagement Initiatives

At the start of the community engagement process, we initiated a thorough review of previous community engagement conducted by the State. With this review, we sought to understand what questions had been asked of community partners previously to ensure our community engagement process was not repetitive or exhausting for participants, as such repetition can result in frustration and burnout for participants. We evaluated previous reports put forth by the State to understand what community outreach and themes had already been conducted and to what groups/populations/individuals.

Identification of Community Partners

PCG and OHA collaborated closely to identify community partners that reflect a wide spectrum of perspectives and experiences within the behavioral health continuum. Jointly, we developed a comprehensive list of key community partner groups. We worked closely with external associations and advisory groups to identify participants, and OHA played a crucial role in establishing individual contacts within the identified categories, ensuring a holistic representation of diverse viewpoints. Recognizing the regional variations in available services across Oregon, PCG and OHA prioritized the identification of community partners in both rural and urban areas. This approach aimed to capture the full range of perspectives and challenges present in the State's diverse communities, contributing to a more inclusive and comprehensive understanding of behavioral health needs.

In addition to capturing both rural and urban perspectives, PCG and OHA prioritized engaging culturally specific providers and people with lived experience, in alignment with OHA's 2030 goal to eliminate health inequities. Members of culturally and linguistically diverse populations face unique and disproportionate challenges accessing, engaging in, and following through with behavioral health care. By engaging with culturally specific providers, the study aimed to gain an understanding of these unique barriers, particularly within the context of behavioral health facility capacity in Oregon. OHA's Office of Behavioral Health Equity and Community Partnerships assisted in identifying culturally specific providers that would cover a wide range of perspectives, including, but not limited to Native American, African American, Asian American, Latino/a American, immigrants and refugees from countries in Eastern Europe, Africa, and the Middle East, and LGBTQIA2S+ individuals. Capturing the behavioral health experience of these populations is integral to developing facility capacity and infrastructure that benefits all Oregonians.

A priority was also placed on engaging with people with lived experience (PWLE), which included members of the peer workforce. Individuals with lived experience have firsthand knowledge of the challenges, nuances, and complexities associated with engaging with behavioral health services. Their insights can provide a deep understanding that may be difficult to capture through purely quantitative perspectives. When PWLE are involved in developing program recommendations, there is a potential for reduced stigma and more successful engagement and outcomes. As part of continuing engagement with PWLE who contributed their perspectives to the study, PCG shared a copy of the preliminary report, published in

January, with these participants. Participants then had the opportunity to provide feedback on the report and additional insights and recommendations, which have been synthesized and included in the final report.

Development of Community Partner Engagement Matrix

The Community Engagement Matrix was developed in partnership with OHA and populated with ideas of people/groups to reach out to begin solidifying the Community Engagement strategy and list. The Community Engagement Matrix included the following information regarding potential participants:

- Source
- Group
- Name
- Title
- Organization
- Email
- County
- City
- Zip Code
- Trauma System Area
- Community Engagement Method
- Meeting Date & Time
- Status
- Notes

Review of Community Partner Engagement Matrix

The Community Partner Engagement Matrix underwent extensive review from individuals at OHA, external community partners, and members of the PCG team to solidify the list of potential participants. A Community Engagement Snapshot was created to condense information and track specific outreach to individuals, email communication, and follow-up. This document was utilized to provide weekly updates to OHA on the status and progression of the Community Engagement process. Attendance and stipend distribution were also noted in the Community Engagement Snapshot.

Stipend Distribution

A $160 stipend was distributed to all participants with lived experience who engaged in a key informant interview or a focus group. Eight stipends were distributed to key informant interview participants in the Peers or PWLE groups, four stipends were distributed to participants in the Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC) focus group, and six stipends were distributed to the participants in the Caregivers with Lived Experience focus group. All stipends were sent within a few days following the Community Engagement activity via email using Tremendous in the form of a digital gift card.

Focus Groups/Discussions

PCG developed a focus group guide to inform the structure and substance of the two focus groups that were conducted. The questions were designed to initiate meaningful discussion among a group of diverse participants, and to encourage them to share their stories and insight, as all focus group participants held unique experiences with the behavioral health continuum in Oregon.

Once the focus group guide was created and reviewed by the PCG team, it underwent review from members of the OHA team. While the focus group guide was being reviewed and finalized, the PCG team conducted identification and outreach to potential focus group participants. When identifying participants for the focus groups and listening sessions, PCG partnered with OHA, including OHA's Office of Recovery and Resilience and Director of Tribal Affairs, Julie Johnson. PCG also collaborated with the leaders of the Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC). The Office of Recovery and Resilience at OHA facilitated the distribution of focus group invitations to the Oregon Consumer Advisory Council. Council members were encouraged to share the invitation within their respective networks, and the participants for

the caregivers with lived experience focus group were subsequently identified from this distributed invitation.

Focus group outreach was conducted by email. Additionally, the details of the focus groups were confirmed during this period: the focus groups were held virtually on Microsoft Teams, stipends would be available for participants, and members of OHA or the PCG team would facilitate.

It was important to emphasize an open line of communication between focus group organizers and participants, so participants felt comfortable continuing the conversation and sharing follow-up thoughts, and for the organizers to emphasize the participants' centrality to the project and the ability to keep in touch if more opportunities for community input arose in the future. Contact information was collected from each participant for stipend distribution and further communication, and the contact information of focus group organizers was also made available to participants.

Tribal Discussion

PCG was invited to participate in a discussion with the nine federally recognized tribes of Oregon and OHA about the Behavioral Health Residential+ Facility Study. The discussion was held on December 7, 2023, with both virtual and in-person participants. Ebony Clarke, the Behavioral Health Director for OHA, facilitated the discussion and PCG was present to listen and take notes. The following questions were asked during the discussion session:

1. What are the greatest behavioral health challenges and needs your tribal communities are facing?
2. What existing models of care should the State expand upon to better serve American Indian and Alaska Natives in Oregon?
3. Where do you believe State funding for behavioral health services should be prioritized or invested to address unmet need and improve the overall system?

Focus Group #1: OBBIAC

The first focus group was held on October 13, 2023, via Microsoft Teams. The focus group was planned in collaboration with leaders of the Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC). The focus group was scheduled for 90 minutes. Four members of OBBIAC participated in the focus group. It was co-facilitated by Larry Turner and Jose Luis Garcia of OBBIAC and Samantha DuPont of OHA and supported by members of the PCG team. Stipends were sent to all participants on October 18, 2023. During the focus group, members of the PCG team took detailed notes, tracking the direction of the conversation and aggregating feedback, so all key takeaways were documented.

Focus Group #2: Caregivers with Lived Experience

The second focus group was held on October 24, 2023, via Microsoft Teams. This focus group included Caregivers with Lived Experience, and all six participants were parents of children with interaction with the behavioral or mental health systems within the State. The focus group was scheduled for two hours. This focus group was led by members of the PCG team; Phoebe Kelleher facilitated the conversation, and Kaitlyn Crone and Rhea Lieber supported note taking and monitoring of the meeting platform and the chat. Stipends were sent to all participants on October 24, 2023. With a slightly larger group all sharing the identity of parents, the conversation flowed and there was a meaningful exchange of stories and ideas for improving Oregon's systems and resources.

Key Informant Interviews

PCG also conducted community engagement through key informant interviews to learn more about the behavioral health care continuum from those who have diverse experiences, knowledge, and involvement in behavioral health across the State. Some of the key informant interviews were conducted in-person, but most were conducted virtually via Microsoft Teams. The key informant interviews encompassed the following groups:

- Rural & Urban CCO

- Rural & Urban Hospital
- Tribal
- Public Safety
- Rural & Urban CMHP
- Housing
- Residential/LGBTQIA2S+
- Person with Lived Experience (PWLE)
- Peers
- Inpatient and Outpatient Providers

An interview guide was also developed for the key informant interviews. The interview guide consisted of five general questions, and sections with questions specifically tailored to each group. The key informant interview guide was reviewed and revised extensively by the PCG team and members of OHA.

Outreach was conducted via email for all key informant interview participants. Once a mutually convenient time was chosen for the interview, PCG sent a calendar invitation with a link to join the meeting through Microsoft Teams, or a location to meet in-person, if applicable. The interviews were scheduled for one hour in duration.

Due to the sensitive nature of the interviews, particularly when participants shared their personal experiences with behavioral health services, community engagement encounters were not recorded to ensure a safe space for open discussion. Identifiable information about participants was carefully omitted. Participants were briefed on this confidentiality measure at the outset of the interview, and a PCG staff member attended to take notes and identify key themes. The semi-structured interviews, guided by prepared questions, also provided flexibility for participants to explore important topics beyond the interview guide.

Twenty-three key information interviews were conducted during the community engagement period. Fourteen were conducted virtually via Microsoft Teams, and three were conducted in-person. The key informant interviews were led by members of the PCG team: Phoebe Kelleher facilitated the conversations, and Kaitlyn Crone and Rhea Lieber supported note taking.

Table 29. Community Engagement Meetings

#	Type	Meeting Date & Time (PT)
1	Residential/LGBTQIA2S+	9/13/2023, 12-1pm
2	PWLE #1	9/19/2023, 11-12pm
3	PWLE/Peer #1	9/25/2023, 1-2pm
4	PWLE #2	10/2/2023, 1-2pm
5	PWLE/Peer #2*	10/5/2023, 9-10am
6	Housing*	10/5/2023, 11-12pm
7	Rural Hospital/Public Safety	10/5/2023, 1-2pm
8	Public Safety	10/5/2023, 3-4pm
9	Urban CCO	10/11/2023, 3-4pm
10	Housing	10/12/2023, 11-12pm
11	PWLE/Peer #3	10/18/2023, 12-1pm

#	Type	Meeting Date & Time (PT)
12	Rural CCO	10/19/2023, 10-11am
13	PWLE #3	10/23/2023, 12-1pm
14	Urban Hospital	10/23/2023, 12-1pm
15	PWLE/Peer #4	10/26/2023, 1-2pm
16	PWLE/Peer #5	10/30/2023, 10-11am
17	Urban CCO	11/16/2023, 2-3pm
18	Tribal Interview #1	2/29/2024, 2-3pm
19	Tribal Interview #2	4/4/2024, 10-11am
20	Tribal Interview #3	4/5/2024, 10-11am
21	Outpatient Services	4/11/2024, 12-1pm
22	Court System	4/12/2024, 1-2pm
23	Residential Services	4/23/2024, 12-1pm

*Conducted in-person

Like the focus groups, it was also important to emphasize an open line of communication after the key informant interview concluded. Participants were encouraged to save the email addresses for Ms. Kelleher and Ms. Lieber, who oversaw interview outreach and the sessions themselves. Multiple key informant interview participants followed up with PCG staff with additional feedback and insights, so offering space to share more ideas or follow-up questions was important. Furthermore, stipends were distributed to Peer and PWLE interview participants.

Facility Visits

The PCG team traveled to Oregon from October 3rd to October 5th, 2023, and had the opportunity to visit facilities that spanned the care continuum. These facilities were identified either through referrals from OHA or by extending invitations to the PCG team to visit. During these site visits, PCG met with key personnel at the facilities to learn more about their work, goals, and challenges in delivering care. PCG visited the following facilities:

- Project Network – Lifeworks NW, Portland
- Native American Rehabilitation Association of the Northwest, Inc. – Residential Treatment Center, Portland
- Willamette Family Inc. – Buckley Center, Eugene
- Willamette Family Inc. – Women's Residential Program, Eugene

In addition to having the opportunity to tour the facilities' grounds, PCG spent ample time learning about the inner workings and day-to-day operations from the staff. The PCG team asked questions, heard personal stories and experiences, and learned about the challenges of operating post-pandemic that included staffing shortages and a greater need for services with a higher acuity population.

FEEDBACK ANALYSIS

The data compilation process involved inputting notes from each interview into an Excel spreadsheet, with individual columns allocated to each question. Each entry included columns for coding, participant ID number, and responses. Responses were entered with their corresponding participant ID number.

During the feedback analysis, multiple PCG staff members reviewed the data to identify common categories or themes across entries for each question. Once consensus was reached, numerical or alphabetical labels were assigned to the categories and the team applied these labels to each entry. The team utilized the Excel 'Sort' function to group entries by the assigned categories, and in instances where inconsistencies arose, re-categorized entries or introduced new categories. This process was repeated for each interview, resulting in an organized arrangement of categories based on the frequency of entries. From this process, we were able to identify key themes and recommendations.

KEY INFORMANT INTERVIEW KEY THEMES

Common themes quickly emerged among the interview data collected, and similar themes arose across all respondent types. Although our study primarily focuses on identifying the capacity of residential behavioral health facilities, participants frequently addressed additional needs in behavioral health resources and how various points of care impact residential facilities. As a result, key themes not only centered on residential facilities but also extended across the entire behavioral health continuum. While many of these key themes fall outside the immediate scope of this study, their inclusion was integral to capture to inform further analysis of behavioral health needs across the continuum and to provide essential context to the behavioral health access experience. The first part of this subsection provides a narrative review of those common themes organized by interview topic. This is followed by a table outlining specific insights noted by each community partner category.

Perspectives of People with Lived Experience (PWLE)

As PWLE constituted nearly half of our key informant interviews, their insights and recommendations are integrated into the emerging key themes. Notably, PWLE respondents also offered unique perspectives and recommendations, highlighting key areas for improvement:

- **Trauma-Informed Care:** PWLE emphasized the need for staff training in trauma-informed communication and evidence-based practices to enhance the quality of services.
- **Community Supports and Supportive Housing:** Community partners stressed the importance of robust community-based supports to address gaps in follow-up care upon discharge. Recommendations included expanding supportive housing, outpatient treatment centers, day programs, group therapy, and street outreach services.
- **Prevention:** PWLE advocated for increased funding in prevention services, emphasizing basic needs like housing and food security, addiction psychoeducation, and street outreach.
- **Criminal Justice Experience:** Individuals with lived experience in the criminal justice system highlighted unique challenges accessing behavioral health services and community supports. Criminal records often hindered access to programs, leaving individuals without essential resources.

Staffing

Community partners report that the current operational challenges within various facilities stem from staffing shortages and difficulties in retaining qualified personnel. These issues have hindered the ability of these facilities to operate at full capacity and have led to negative experiences for individuals accessing behavioral health facility services. Many express reluctance to expand capacity without a proportional increase in the workforce. This sentiment is echoed across Oregon and the wider United States. Addressing these pressing workforce challenges is imperative for any meaningful expansion of residential capacity. Community partners identified multiple factors that contribute to persistent staffing challenges. Some of these factors included:

- **Burnout and Safety:** Provider burnout has been a large contributor to staff turnover in recent years, especially following the COVID-19 Public Health Emergency (PHE). According to respondents, one of the main causes of this burnout is lack of safety and support in the work environment. The acuity of individuals accessing behavioral health and substance use services has

sharply increased in recent years. Current facility capacity does not align with this level of acuity, causing individuals to be placed in facilities that are unable to meet their level of need. Some participants also indicated that newly graduated providers entering the workforce are not properly trained in the increased acuity or complex needs of the populations served. Staff who operate in these facilities feel unprepared to serve the population and are overwhelmed by the workload.

- **Administrative Burden:** Participants report that administrative reporting and lack of proper training creates increased and unmanageable workloads.
- **Pay and Compensation:** Low pay and lack of benefits were referenced multiple times as drivers for increased staff turnover. Behavioral health facilities also compete with a rapidly growing number of telehealth and private practice services, which offer higher pay and more job flexibility. While rate increases and stay bonuses have provided some increase in pay in recent years, it has not been enough to meet the competitive salaries offered outside of facility-based settings.
- **Peer Expansion and Peer Experience:** Participants expressed that Peers and peer services are integral to the success of behavioral health services and should be expanded in many settings, including in behavioral health residential facilities. However, Peers face unique challenges in their scope of work. Peer respondents often express feelings of being "othered" within their respective settings, facing perceptions that can marginalize their unique contributions. Many peer workers report being assigned tasks beyond their defined scope of work, potentially undermining the effectiveness of their roles. To address this, there is a growing consensus among peer workers and advocates for clearer delineation of responsibilities and the promotion of supportive work environments. Additionally, these professionals advocate for structured opportunities for career growth within the Peer workforce, emphasizing the importance of recognizing and fostering the valuable expertise they bring to behavioral health settings.

Facility Access, Availability, and Experience

- **Wait Times:** Wait times were reported as an issue when accessing all levels of care across the behavioral health continuum, but particularly when accessing residential services. Multiple community partners described a “bottle neck,” situation, where street outreach engagement can connect with individuals who are seeking treatment services, but there is a significant wait to access withdrawal management or detox care. Then, once individuals can access withdrawal management services, after discharge they are unable to access timely residential care. Extended wait times were also a notable issue when individuals sought access to residential care from hospital emergency departments. This often led to individuals spending multiple days or weeks in the emergency department while waiting for available placements.
- **Exclusionary Criteria:** Community partners have raised significant concerns regarding the exclusions imposed by residential facilities on who can access their services, particularly noting the heightened barriers faced by some of the most vulnerable populations. Exclusions based on legal history, medical conditions, insurance, and co-occurring disorders were consistently cited as problematic, exacerbating disparities in access to care. As Oregon contemplates expanding residential facility capacity, it is imperative to consider who will benefit from these expansions. Community partners stress that even with increased capacity, many vulnerable populations may remain underserved due to these exclusions. To address this issue, suggestions were made for the establishment of "no refusal" facilities, ensuring that critical mental health care services are accessible to all who need them, regardless of their circumstances or background.
- **SUD Level of Care Mismatch and Rising Acuity:** Community partners advised that there is a general lack of preparedness for the levels of care needed to meet the high acuity needs of patients in Oregon today. This mismatch between available levels of care for SUD and the actual required level of care carries significant consequences throughout the healthcare continuum. It is imperative to build out the correct levels of care for SUD that are in line with the acuity of the patient population with a specific focus on the effects of new drug use trends, a growth in co-occurring diagnoses and conditions, and the traumas associated with houselessness. A mismatch in levels of care also has trickle down effects that can lead to no one receiving adequate care at any level of the medical or

mental health system. One such effect is workforce burnout. Staff are being asked to treat at the wrong level of care just so patients can receive some form of treatment, however inadequate or inappropriate the treatment given the patient's unique needs. Staff are being asked to address increasingly complex and intense situations that are outside their training or available resources, which can lead to burnout, or even unsafe situations.

- **State Hospital Accessibility Issues:** Oregon's public psychiatric hospitals have dedicated most of their capacity to individuals in the legal system, causing these facilities to greatly reduce admissions for civilly committed individuals. Community partners shared concerns that with this reduced capacity, there is nowhere to place individuals experiencing a mental health crisis. Often, these individuals must stay in facilities' emergency departments, putting a strain on available resources.
- **Residential Experience:** Many of the people with lived experiences that the PCG team met during the community engagement period reflected on negative experiences in a residential treatment setting. Participants discussed how providers and staff are not trained to adequately serve patients with sensitivity, compassion, respect, and empathy, especially high acuity patients and those with serious mental illness (SMI), due to a lack of understanding or education, or fatigue and burnout. This led to patients feeling unsafe and feeling as though they had nowhere to turn to access services after being discharged from a facility in which they experienced distress, trauma, or stigma. Compounded upon an existing shortage of residential treatment options, patients feeling further isolated from potential spaces to access care is a critical issue with both personal and systemic effects.

Funding and Facility Expansion Priorities

During the community engagement process, we sought the perspectives of each respondent regarding their funding priorities for behavioral health and the expansion of residential facilities. The identified themes below underscore the key areas emphasized by community partners, shedding light on where those community partners believe funding should be prioritized. Although many of these priorities extend beyond the immediate scope of this study, they offer crucial insights for understanding the behavioral health continuum. These themes not only contribute to a comprehensive understanding but also point towards areas for further exploration and in-depth analysis.

A holistic approach to the behavioral health continuum in Oregon is crucial. While expanding residential facility capacity is vital, it's just one facet of a broader spectrum that demands attention. Community partners emphasize the significance of strengthening community-based supports and health-related social needs, particularly in housing. By bolstering these aspects, we can potentially reduce the demand for residential capacity. This approach can pave the way for robust community-based paths to care, reduce acuity among individuals seeking services, and shorten their length of stay. When contemplating expansion of residential capacity, it is imperative to recognize that strengthening other components of the behavioral health continuum can mitigate the need for increased capacity.

- **SUD Continuum of Care:** To meet the rising acuity and complex needs of individuals accessing SUD services, community partners emphasized that the SUD continuum needs to be strengthened at all points of care, not just within residential facility and withdrawal management capacity. Additionally, the participants pointed to the absence of residential facilities that can provide an intermediate level of care, such as partial hospitalization (PHP) and intensive outpatient programs (IOP). Such facilities play a critical role in the care continuum, supporting safe discharge from inpatient and acute care settings as well as preventing decompensation that leads to inpatient utilization. Priority facilities to be invested in and expanded according to participants include withdrawal management, sobering centers, day centers, strong step-down programs, Medication-Assisted Treatment (MAT), harm reduction and street outreach services, and community housing facilities.

- **Culturally Specific Services:** There is a need to expand culturally specific services and providers across the behavioral health continuum in Oregon. Challenges related to culture, language, and identities frequently amplify the symptoms of both mental and physical illnesses. Recent and historical encounters with oppression, discrimination, and severe trauma pose significant hurdles to involvement in behavioral healthcare systems. Participants with lived experience report feeling safer when providers share their identities. Community partners identified that culturally specific services should be expanded to meet the needs of populations, including but not limited to: Black, Asian, Hispanic, Native American, immigrants and refugees, and members of the LGBTQIA2S+ community, particularly transgender and gender nonconforming individuals.
- **Meeting Complex Needs:** In addition to culturally specific services, community partners identified populations that experience disproportionate unmet needs within the behavioral health system in Oregon, and services to target these populations should be expanded. This includes youth and families, individuals requiring gambling use treatment, individuals accessing services during pregnancy, individuals with physical disabilities, veterans, co-occurring disorders, and individuals experiencing homelessness.
- **Peer Workforce Expansion:** In addition to the above workforce considerations, community partners emphasized the crucial need to expand Peer services in residential behavioral health and substance use disorder treatment settings. According to their feedback, having individuals with lived experiences in recovery as Peers creates trust, understanding, and hope in individual's experiences. Integrating Peer services was seen not only as an enhancement to overall care quality but also as a key component of a more inclusive and holistic treatment approach. Further considerations for the Peer workforce are also mentioned above in the Staffing themes.
- **Models for Rural Communities:** The diverse geographic landscape and unique social needs of rural areas require a tailored approach to treatment design and residential facility options. Oregon's rural communities often face distinct challenges, such as limited access to mental health resources, long travel distances, and a scarcity of specialized and culturally specific facilities. Recognizing and addressing these specific hurdles is essential to creating effective and accessible behavioral health care.

Table 30. Community Engagement Feedback

Community Partner Category	Facility Capacity Expansion Priorities	Barriers to Accessing Care	Recommendations	Additional Information
PWLE	• Increase psychiatric walk-in services • Increase availability of services for the uninsured, Medicaid, and Medicare populations • Expand capacity of inpatient units • Increase availability of sobering centers • Facilities without exclusions for forensic individuals • Facilities for co-occurring disorders • Facilities that specialize in gambling use services	• Wait times for accessing services • Lack of helpful services • Transportation • Inaccessible treatment options based on location, particularly in rural areas • Negative clinician interactions, lack of sensitivity at the point of care • Lack of resources for individuals in crisis • Cost of treatment • Low capacity and staff shortages • Lack of treatment options, especially for Medicaid/Medicare pop. • Lack of care coordination • Stigma surrounding MAT/MOUD	• Expansion of inpatient gambling addiction services • Integrating more PWLE and peers into treatment • Increase in telehealth availability for rural areas • Establish workshops, practice groups, support groups, and peer support to address homelessness and violence • Engage OHA leadership to initiate change regarding the criminal justice system • Provide more affordable treatment options • Increase street outreach • Improve provider trauma-informed training for supportive and compassionate care • Implement education to reduce stigma around MAT/MOUD • Increase housing/rental assistance • Provide funding for a peer workforce in residential facilities	• Discharges are frequently unsafe and/or to homelessness • Naloxone and Good Samaritan Law education is necessary • Drug-related crime convictions often exclude individuals from accessing housing or employment
Rural Coordinated Care Organizations	• Provide funding for tribal facilities and residential treatment centers in rural areas • Increase in the number of facilities that can provide care for patients with children	• Lack of funding for facilities in rural areas • Lack of tribal engagement • Individuals “slipping through the cracks” after discharging due to a lack of peer expansion	• Increase funding for rural areas • Inclusion of tribal engagement • Address workforce retention for rural areas	

Community Partner Category	Facility Capacity Expansion Priorities	Barriers to Accessing Care	Recommendations	Additional Information
Housing	• SUD residential facilities • Increase community-based PHP and IOP Services • Increase funding for community organizations delivering services aside from SMI	• Lack of coordination among leadership county, city, and State leadership • Racism and bias • Ineffective distribution of funding • Workforce turnover, often due to safety concerns	• Improve coordination between county and city departments delivering behavioral health services • Increase training opportunities so that people from community organizations might move into leadership roles	• There is a call for an increase in licensing opportunities for providers to do behavioral health supportive housing
Urban Hospital	• Residential treatment services for co-occurring disorders • SUD residential facilities, particularly with long-term stay availability • Community-based hospital alternatives when it is an inappropriate setting to meet the needs of the individual. • Increase crisis services • Increase housing with intensive treatment and vocational training	• Workforce recruitment and retention • Staff often feel unsafe and unprepared for the level of patient acuity • Stigma surrounding SMI population • Homelessness exacerbates SUD/MH crisis and acuity	• OHA should establish workgroups to address workforce, reimbursement, and access issues • Strengthen jail diversion programs • Increase education around Mink Ruling and serving the aid & assist population • Reorganize staffing and reimbursement for residential programs • Increase peer street outreach	
Provider	• Increase acute inpatient capacity • Increase funding for all levels of residential care (acute inpatient, co-occurring high security residential, SUD residential, brick and mortar outpatient) • Need for SUD treatment tailored to the needs of 60+ age group • Some providers estimate there is a need for up to 30,000 affordable housing units in the tri counties, 15,000 need to be supportive housing • Implement and expand culturally specific services, including for BIPOC, LGBTQIA+, and T/GNC individuals	• Higher acuity needs than the services available due to workforce burnout • High price of indemnity insurance • Policy barriers: need behavioral health to be an integrated benefit and collected investment • Barrier with civil commitment process change, short term inpatient psych units can't handle long term patients, so beds quickly become full	• Reduce reliance on high level credentials for providers • Establish a workgroup to address administrative burden • Implement education incentives for MSWs and certifications • Improve the funding model for adult BH system • Elevating people with lived experience and BIPOC • Build out workforce to reduce burnout • Need to invest in providers so new beds can staffed	• Wage impact and burnout have resulted from providers feeling like they're "helping people to nowhere" • Discharges occur without giving people a place to go • Withdrawal management currently meets a fraction of the need • Pipeline issue with workforce: biggest staffing gaps are with medical providers and licensed clinicians

Community Partner Category	Facility Capacity Expansion Priorities	Barriers to Accessing Care	Recommendations	Additional Information
			• Increase coordination between facilities to avoid lag between withdrawal management to facility treatment	
Rural Hospital	• 20 acute psychiatric beds need to be built • Expanding capacity like in more urban counties is needed	• Acuity barriers keep people out of treatment facilities • Inadequacy of supportive housing and treatment • All 36 counties have different resources and systems • Individuals have an easier time accessing services through the criminal justice system then they do on their own • People with dual diagnoses (SUD with MH) have challenges in accessing services	• Behavioral healthcare could be triaged like the physical health system	• People are routinely being discharged to homelessness • Outdated medical model doesn't allow people to work at the top level of their licensure and level of care • Administrative burden across the board
Public Safety/LE	• Community-based services • Low to no threshold supportive housing • Long-stay residential treatment programs	• Lack of early interception before an issue worsens	• Regionalization of models that can meet direct and unique needs of each region • Incorporation of a better balance between voluntary and involuntary commitment • Community partnerships and diversion should be implemented more around the State	• Duplication in the system is causing closures and problems with distribution • There needs to be communication to OHA that this is not a "turf war" and biases must be overcome to make progress
Tribal	• 8 bed psychiatric lock down facility in the local community would be beneficial • Need for a mental health facility • Only one tribe in OR has an inpatient facility, there is a need for more	• Workforce challenges • Telehealth has led to a recruitment nightmare, elders do not want to do telehealth • Historical and generational trauma	• Mental health education is needed to break the stigma • There needs to be more suicide prevention • More education to parents and caregivers is needed	• Opioid use disorder is the biggest need • There is nowhere for people to land when they return from treatment, the need for handoff and support

Community Partner Category	Facility Capacity Expansion Priorities	Barriers to Accessing Care	Recommendations	Additional Information
	• More support services and housing	• Any mental health therapist is hard to find • Cultural barrier: shame	• Funding for training for culturally relevant care when facilities are established	• Reservation lands are federal, not State • Administrative burden of paperwork
Judicial/Courts	• More capacity for those who are justice-involved, particularly for after their court case has ended • Need for no refusal beds • SRTF level beds needed	• Stigma around people with MH, SUD, and criminal background • Charge based exclusions	• More beds need to be built, but they also need to let marginalized justice involved people into those beds.	• High risk people are ending up on the street, people reach the end of their stay in the State hospital, and they become a public safety concern
Urban Coordinated Care Organization	• Increase capacity for withdrawal management • Need more beds in long-term psychiatric • More sobering, respite, withdrawal management, long-term, and short-term psychiatric beds are needed (places where people can be safe)	• Workforce capacity has been exceeded • Capacity reached on outpatient programming due to staffing shortages • Poor care coordination system between levels of care and programs • Inability for those who have been released from incarceration to access long-term psychiatric care	• More culturally specific services are needed	• State leaders don't understand the severity of the civil commitment issue and its impact on capacity • Many regulations have become burdensome for providers

FOCUS GROUP KEY THEMES

Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC)

There were four participants in the OBBIAC focus group, which was held on October 13, 2023. The key themes that emerged from participants in this focus group are as follows:

- **"One Size Fits All" Approach:** Most facility treatment and care delivery models are not created for Black, Brown or Indigenous people. They have a "one size fits all" approach, but differences in cultures and backgrounds need to be recognized. Programs need to diversify their approach, services, and staff to better care for these groups.
- **Diverse Providers:** There is a severe lack of Black, Brown, and Indigenous providers in treatment programs and across the care continuum. Black, Brown, and Indigenous people are affected differently by treatment and can be triggered by verbal language, body language, specific settings, and provider actions, so it is important to have providers that understand the unique needs and experiences of these communities. For white providers, it is imperative to offer training programs that focus on culturally specific care delivery, interaction, and engagement. Providers must also "unlearn" practices that are rooted in white supremacy.
- **Leadership:** There is a need for more Black, Brown, and Indigenous folks in leadership roles. Currently, leaders from these communities are unrecognized, dismissed, or undermined. Voices from these communities need to be heard through more representation from these groups at the table. And for white leadership, there needs to be training to ensure culturally specific and aware care delivery starting from leadership down through the entirety of the medical and mental health systems.
- **Racism and Stigma:** Due to a lack of cultural awareness or appropriateness of treatment options Black, Brown, and Indigenous patients face racism and stigma when attempting to access treatment. There is racism in admission to and treatment at facilities – patients from these communities have experienced harassment and mistreatment from providers when trying to access care. This leads to negative health outcomes and high dropout rates from treatment. As a result, these groups are further isolated and disincentivized to seek future treatment.
- **Funding:** Participants reported that program models that are created to facilitate culturally appropriate care and receive funding may lose their funding as improvements are witnessed, which puts these critical programs in jeopardy. Moreover, when agreed upon collaborations with organizations or providers for culturally-specific programs or beds are made available for these groups, often funding for these collaborations does not come to fruition, causing frustration and further disillusionment with the system and treatment offerings.
- **Workforce Challenges:** Many positions in the behavioral and mental health field require degrees, which is a deterrent for many applicants and does not allow for a diverse workforce to be sufficiently built up. And among the existing workforce, there is a need for workforce development that is culturally specific, including leadership.
- **Support for Smaller Organizations:** Smaller organizations and programs serve an important purpose within the behavioral and mental health system and need support to bolster their foundational structure. They should receive flexibility and technical support as they work to build out processes and programs to offer culturally-specific services that better serve diverse patient populations. Reporting requirements can be especially challenging, and often do not take precedence for smaller organizations, so flexibility would be appreciated for these types of organizations. Larger, established organizations often have advantages over smaller, newer providers in winning and managing grants, which creates an unlevel playing field.
- **Grants for Culturally-Specific Groups:** In order to bring culturally-specific groups and patients to the table, the State should offer grant opportunities that are targeted and limited in order to increase cultural diversity and expand funding opportunities for organizations that will offer culturally-specific services.

Caregivers with Lived Experience

There were six participants in the Caregivers with Lived Experience focus group, which was held on October 24, 2023. The key themes that emerged from participants in this focus group are as follows:

- **Waiting Periods:** There are often long waiting periods to receive treatment, especially for residential treatment settings and the emergency department. This is especially detrimental for people who are in crisis, and frustrating for parents when a child is in desperate need of care and unable to access treatment within the level of care that is appropriate for their needs.
- **Capacity:** There are severe limitations in available services due to distance/travel constraints, staffing, resource constraints, and other issues. These capacity issues have an impact on receiving timely and appropriate care. Due to capacity issues, the system is not able to provide the services needed to the amount of people requiring services.
- **Staffing:** Given staffing shortages and workforce burnout, there is a lack of access to providers, especially for psychiatric/mental health services and therapy. Veterans are acutely affected by this issue. This issue could be partially addressed by launching tuition reimbursement or training programs that attract providers to the field and incentivize them to practice in Oregon.
- **High Barrier to Entry:** Participants in this focus group expressed that the definition of "a danger to yourself or others" is too high a bar for entry into a secure treatment facility. More specifically, only extremely high-need patients are able to access psychiatric inpatient treatment. Participants explained that this high barrier to entry encourages a negative cycle, as people are either excluded from these treatment options or encouraged to allow their conditions to worsen in order to qualify for admission. There is a need to expand access to partial and residential treatment options at different acuity levels and points of intervention, so that individuals' conditions do not have to worsen to access treatment, and the behavioral health continuum is able to meet people where they are.
- **Access to Appropriate Providers:** A major barrier to accessing appropriate providers is the need to go through a primary care provider for a referral to behavioral or mental health treatment when many of these providers are not trained in mental health and SUD. And, if there is a form about mental health and drug use at a primary care provider's office, often these forms are ignored and the need for mental health or SUD treatment is overlooked. It would be helpful for patients to have the ability to establish a primary care provider in mental health too, to ensure the coordination of care, an adherence to treatment, and that all needs are being sufficiently addressed.
- **Administrative Barriers:** Many forms are required to access doctors and programs, especially inpatient treatment. It can be retriggering for patients and families to do enormous amounts of paperwork for each interaction with the system.
- **Communication with Families:** There is inadequate communication with families and caregivers from facilities, especially if the patient is an adult. For caregivers of adults, it is difficult to not be able to access certain aspects of their care while still being fully responsible for their treatment and safety. Family and parental involvement is crucial to the care of a patient and building a strong family unit in the midst of a crisis situation.
- **Care Coordination:** Participants reported significant issues that result from poor care coordination. First, trauma is created by repetitive forms that are ignored or describing struggles time and time again to different providers with no resulting action or access to support. Second, patients get passed between doctors with no emphasis on trust or relationship building with providers. Though there are high turnover rates and staffing shortages within the industry, placing patients and families with doctors with whom they have an existing relationship should be a priority. The focus group participants offered a few key ways the State could address issues of care coordination, such as: embed care coordination into every clinic, improve access to services outside of crisis situations, marry mental and physical health care and encourage these providers to collaborate, work with law enforcement and State agencies to track individuals in mental health crisis, and offer early intervention and wraparound services.

- **Quality of Care:** Throughout our community engagement period, people expressed their dissatisfaction with the quality of care across the mental and behavioral health systems in the State. The participants in this focus group echoed this sentiment, that the quality of care is neither good nor adequate and has led to repeated failures and hopelessness. When it is challenging to access programs and services that fit a patient's needs, especially in crisis, it is unacceptable that once they gain access, the care serves no purpose or is of poor quality.
- **Hopelessness:** In this focus group, participants posed this question: how can you have hope in the system when it continues to fail at every juncture? For many caregivers with lived experience who have navigated extremely challenging situations within the behavioral and mental health systems, it feels as though no one sees or hears you even when you are in the utmost need. They shared that the system is truly broken and reiterated that these are humans and loved ones the system is continuously failing. These sentiments breed hopelessness that can affect every interaction and touchpoint.

Tribal Leadership Discussion

The key themes that emerged during the tribal leadership discussion included:

- **Cultural Approaches to Care:** Participants indicated that there are currently not enough culturally-specific treatment facilities, and those that are in operation currently face severe waitlists and staffing challenges. In addition, there needs to be more openness for traditional treatment considerations, particularly tribe-specific practices. Providers have seen success in treating individuals when integrating each tribe's unique cultural approach. There were many suggestions for how to strengthen culturally-specific services, including creating tribal-based practice models, encouraging a culturally-specific peer workforce, and creating clear and affordable paths for tribal descendants to access education and training for behavioral health clinical positions. Additionally, capacity to care, especially retaining workforce, is particularly difficult in rural areas. Encouraging the workforce development of tribal members with close ties to the area could help address this issue.
- **Housing and Community-Based Services:** There is a great need for housing and supportive housing programs that can support individuals with behavioral health and substance use diagnoses, especially low and no barrier options. Without these programs, residential facilities and hospitals cannot safely discharge individuals. In addition to housing, lack of long-term support serves as a large hurdle in care management and low-term success of individuals seeking treatment for behavioral health or substance use disorders.
- **Assessing Leading Practice:** While policy recommendations are necessary and important, the State of the behavioral health system and the way it impacts tribes needs to be urgently addressed. Participants recommended looking at leading practices in other states and tribal communities, particularly Alaska and Idaho, to seek immediate answers on improving workforce and access to services.
- **OHA and Program Building:** Participants emphasized that the tribes are incredibly diverse, with a range of traditions and practices that are essential to consider when building interventions, including residential facilities. As the State continues to work closely with the tribes, they must remember that implementing a wide-sweeping approach to care will likely not be successful. Consistent relationship building from OHA will help to develop culturally specific programming that is rooted in the communities it seeks to impact.

APAC DATA REVIEW

INTRODUCTION

PCG collaborated with the OHA Office of Health Analytics to acquire the All Payer All Claims (APAC) data files spanning from 2019, 2021 and 2022. Recognizing the volatility caused by the COVID-19 pandemic, PCG decided to procure data from this three-year period to account for changes in financial reimbursement, admissions, closures, and staffing issues which would impact claims patterns during this time period, noting 2022 and 2023 are not complete data sets because the Medicare data was not uploaded at the time of our data retrieval. Upon obtaining the data, we conducted a high-level review to assess patterns and trends in services, focusing solely on facilities within the defined scope. The following outlines our methodology and key findings from the APAC review, as related to this study.

ANALYSIS METHODOLOGY

PCG received extensive claims data comprising millions of lines, necessitating the use of the "R" programming language for iterative importation and aggregation of the data. This involved breaking down the data into manageable pieces, conducting seven iterations in total. During each iteration, we assigned appropriate column names, loaded and aligned the corresponding data pieces with the relevant column headings. Subsequently, we filtered each data element to retain only rows featuring mental health or substance use diagnosis codes in the primary diagnosis field, as well as taxonomy codes associated with inpatient psychiatric units (distinct part units or freestanding hospitals), mental health residential, or substance use disorder residential facilities and withdrawal management facilities. We then aggregated various metrics such as the number of claims, claim lines, patients, providers, and total expenditure based on combinations of taxonomy codes, diagnosis codes, zip codes, payer type, facility type, and ATAB region. After processing each segment of the data file, we recombined the pieces and aggregated them using the same variables to allow further analysis.

After this data preparation was complete, PCG conducted an analysis of APAC data to assess utilization variables affecting facility requirements, bed capacity, and programming needs. This included examining average length of stay, total claims paid, and diagnosis characteristics across all payer types to juxtapose with the capacity needs outlined in this report. The data was aggregated by categorizing all diagnoses into their respective categories to identify the top five diagnosis categories across all payer types. For instance, the category of Schizophrenia Spectrum and Other Psychotic Disorders encompassed diagnoses such as Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Delusional Disorder, and similar conditions. Furthermore, we segmented all claims by payer type and classified all facilities by taxonomy codes to assess bed utilization. PCG also conducted an analysis measuring Episode Length of Stay (ELOS) for the facility types of interest. SQL Server Management Studio (SSMS) was used to query the APAC data to aggregate the claims into defined episodes. The SQL script to measure episodes of care and calculate ELOS was written by the client and adapted to run in SSMS. The output allowed PCG to assess trends in ELOS, reimbursement and utilization by facility type of interest. It is important to note that the APAC data was missing information in the bill type code, admit date and discharge date fields in a number of claims, which are pertinent in identifying facilities and calculating ELOS. Due to a significant number of missing bill type codes (28,769,235 out of 31 million rows), PCG used taxonomy codes to identify facility types without filters on bill type code. Claims with missing admission or discharge dates were also excluded from the analysis. While the APAC data obtained from the Office of Analytics was comprehensive from 2019, 2021 and 2022 it should be noted that the data for 2022 and 2023 may lack complete Medicare data at the time of the data run and could differ from other reported data sources. Hence, the analysis should be regarded as a snapshot, acknowledging these limitations. Additionally, the analysis of APAC data did not encompass utilization of inpatient psychiatric services at State hospitals, due to focusing solely on community treatment alternatives.

KEY FINDINGS

PCG's analysis of the APAC data identified the following key findings:

- The total amount paid for all behavioral health and substance use disorders treated in each facility within the scope of the study, totaled $437,797,660 in 2021 and 2022. However, the data contained gaps, specifically missing payment totals for 17,870 combined episodes, therefore the total cost spent on services is projected to be significantly higher than the total sum identified.
- The combined claim episodes decreased in all facility types except for Psychiatric Hospitalization from 2021 to 2022, which could be explained by a couple of factors. The first is an incomplete data set for 2022, with missing Medicare data, followed by incomplete data due to missing fields such as admission or discharge dates, in addition there could be some decreases in specific facility types due to closure or staffing challenges.
- The combined total number of days utilized decreased from 2021 to 2022, which could be explained by an incomplete data set for 2022, with missing Medicare data, followed by incomplete data due to missing fields such as admission and discharge dates.
- The combined average length of stay for inpatient psychiatric admissions between both inpatient psychiatric – freestanding and inpatient psychiatric – hospital unit for 2021 is 23.03 days.
- The combined average length of stay for inpatient psychiatric admissions between both inpatient psychiatric – freestanding and inpatient psychiatric – hospital unit for 2022 is 12.66 days.
- The combined average length of stay for Mental Health Residential for 2021 is 33.65 days.
- The combined average length of stay for Mental Health Residential for 2022 is 15.99 days.

When analyzing the data, 2021 appears to be the most consistent data to identify Oregon's utilization trends, although limitations exist within the data with gaps in Medicare data and missing or incomplete data fields. When further comparing the length of stay, the 2021 combined inpatient psychiatric hospital length of stay of 23.03 days and withdrawal management findings of 8.55 days seem in line, even though higher than other reviewed reports. One source reports the average length of stay in a hospital is between 3 to 10 days; Oregon's would appear higher, although trending down in 2022; however, additional data would be needed to confirm. Additionally Lifeline Connections[xxviii] reports Withdrawal Management treatment is on average 3 to 5 days, with Oregon's average length of stay just slightly above.

However, when reviewing the residential treatment length of stay, both mental health and SUD residential average length of stay appear to be on the lower end of reported norms. Oregon's combined Mental Health residential length of stay during 2021, is 33.65 days and SUD residential is 16.66 days. The Anxiety and Depression Association of America[xxix] cite the average residential stay is 30 to 60 days and The American Addiction Centers[xxx] reports the average SUD residential program is 3 months to 6 months.

The variances in the reported data are significant enough to warrant additional analysis or studies to ensure the Medicare data is accounted for, gaps in data are filled in and a thorough analysis is conducted to make further assessments and decisions on bed utilization and capacity at a local level. This crucial step will further develop conversations and ensure capacity and clinical needs are being met in a timely manner to meet the needs of all Oregonians.

Table 31. 2021 APAC Data Table

Year	Taxonomy Code	Taxonomy Description	Combined Claim Episodes	Total Number of Days	Average Length of Stay	Claims Paid Per Year by Facility Type
2021	283Q0000X	Psychiatric Hospital	2,897	51,411	17.75	$16,394,490
	273R0000X	Inpatient Unit	3,848	108,922	28.31	$45,740,616
	32080000X	Psychiatric Residential	6,144	256,461	41.75	$98,241,812
	323P0000X	Psychiatric Residential	3,559	90,904	25.55	$30,212,305
	32450000X	SUD Residential	55,984	932,414	16.66	$56,228,209
	27640000X	Withdrawal Management Medically Monitored	804	6,869	8.55	$3,033,508
	Totals		**73,236**	**1,446,981**		**$249,850,940**

Table 32. 2022 APAC Data Table

Year	Taxonomy Code	Taxonomy Description	Combined Claim Episodes	Total Number of Days	Average Length of Stay	Claims Paid Per Year by Facility Type
2022	283Q0000X	Psychiatric Hospital	3,104	33,215	10.7	$15,296,362
	273R0000X	Inpatient Unit	3,643	53,223	14.61	$47,199,926
	32080000X	Psychiatric Residential	4,499	74,052	16.46	$40,529,960
	323P0000X	Psychiatric Residential	3,311	51,410	15.53	$22,009,458
	32450000X	SUD Residential	53,380	569,229	10.66	$60,043,293
	27640000X	Withdrawal Management Medically Monitored	785	4,518	5.76	$2,867,721
	Totals		**68,722**	**785,647**		**$187,946,720**

Table 33. Total Combined Claim Episodes

Taxonomy Code	Taxonomy Description	2021 Combined Claim Episodes	2022 Combined Claim Episodes	Difference
283Q0000X	Psychiatric Hospital	2,897	3,104	207
273R0000X	Inpatient Unit	3,848	3,643	(205)
32080000X	Psychiatric Residential	6,144	4,499	(1,645)
323P0000X	Psychiatric Residential	3,559	3,311	(248)
32450000X	SUD Residential	55,984	53,380	(2,604)
27640000X	Withdrawal Management Medically Monitored	804	785	(19)
Totals		**73,236**	**68,722**	(4,514)

Table 34. Total Number of Days by Facility Type

Taxonomy Code	Taxonomy Description	2021 Total Number of Days	2022 Total Number of Days	Difference
283Q0000X	Psychiatric Hospital	51,411	33,215	(18,196)
273R0000X	Inpatient Unit	108,922	53,223	(55,699)
32080000X	Psychiatric Residential	256,461	74,052	(182,409)
323P0000X	Psychiatric Residential	90,904	51,410	(39,494)
32450000X	SUD Residential	932,414	569,229	(363,185)
27640000X	Withdrawal Management Medically Monitored	6,869	4,518	(2,351)
Totals		**1,446,981**	**785,647**	**(661,334)**

FORECASTED BEHAVIORAL HEALTH CAPACITY NEEDS

INTRODUCTION

Like other states around the U.S., Oregon has sought to assess shortages in mental health and SUD treatment beds to improve access and treatment options for Oregonians. Although there is no perfect methodology for determining the appropriate number of residential and inpatient beds in a given behavioral health system, PCG used an array of State and National data sets, findings from literature research, as well as surveys of treatment facilities to estimate mental health and SUD treatment bed capacity and needs within the continuum of care. The measurement described below relies on a longstanding ratio standard, which considers the number of beds required to meet treatment needs per 100,000 people in a given population, to establish and determine capacity needs. The table below further describes PCG's workstreams to analyze data and develop capacity projections.

Table 35. Work Streams for Capacity Data Analysis

Work Stream	Process

Quantitative Data Analysis	• Confirmed the data points required with OHA to accurately describe current adult behavioral health and SUD facilities and bed types by region.
	• Reviewed data points from State and community partners.
	• Processed data received and conducted follow-up with identified sources as needed.
	• Completed Provider Survey
	• Incorporated additional data from the cited sources in the report, in addition to the following sources into the analysis:
	  ○ National Association of State Mental Health Program Directors, Trends in Inpatient Capacity[xxxi]
	  ○ Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS) 2020[xxxii]
	  ○ Substance Abuse and Mental Health Services Administration (SAMHSA), 2020 National Mental Health Services Survey (N-MHSS)[xxxiii]

Peer State Analysis	• Identified and confirmed five states for inclusion: Colorado, Kentucky, Massachusetts, Utah, and Washington.
	  ○ Colorado, Utah, and Washington represent similar geographies
	  ○ Kentucky represents a similar population
	  ○ Massachusetts is a highly ranked state nationally for access to general mental health care with the most providers per capita
	  ○ Utah is similar statistically with prevalence of mental health and overdose statistics, as well as similar geographies and populations
	• These states were used as benchmarks for community bed capacity based on data obtained from:
	  ○ The National Association of State Mental Health Directors Trends in Inpatient Capacity[xxxi].
	  ○ Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS) 2020[xxxii]
	  ○ Substance Abuse and Mental Health Services Administration (SAMHSA), 2020 National Mental Health Services Survey (N-MHSS)[xxxiii]

CURRENT & PENDING CAPACITY

As noted earlier in this report, PCG gathered and analyzed available Oregon bed source data to estimate current behavioral health capacity for the facilities within our scope. In addition to the current capacity, PCG reviewed the Behavioral Health Investment Team data to determine the facilities that are currently under construction, expanding their capacity and contributing to the overall bed capacity within the State. There may be facilities currently in development which are not State funded, however this report includes data on the facilities that are only receiving State funds. PCG determined a timeline of third quarter 2025 for beds to be online and accessible, by reviewing anticipated completion dates listed in grants that are supported with State funding through HB5202 and HB5024. Table 36 below details the current capacity, pending capacity, total beds projected by the third quarter of 2025, and the current and pending beds per 100,000 people.

Table 36. Current Facility Capacity

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Beds Per 100k population
State Psychiatric Hospital	577	0	577	13.62
Inpatient Psychiatric Beds	461	0	461	10.88
Mental Health Residential (RTF & RTH only)	810	219	1029	24.29
Mental Health Residential (AFH only)	493	5	498	11.76
Secure Residential Treatment Facility (SRTF only)	510	77	587	13.86
SUD Residential	1,374	44	1418	33.48
Withdrawal Management	301	16	317	7.48
Total	**4,526**	**361**	**4,887**	**115.38**

METHODOLOGY FOR DEFINING CAPACITY NEEDS

PCG used a variety of methodologies to determine the capacity needs for each facility type within scope – PCG's methodologies are detailed in Table 37 below. Due to recent data from the Census.gov indicating the population in Oregon is decreasing, PCG did not include any percentages of increase to capacity need based on population changes.

Table 37. Methodology for Defining Capacity Needs

Facility Type	Methodology for Calculating Capacity Needed
State Psychiatric Hospital	OHA did not designate State Psychiatric Hospital beds as a prioritized requirement for this study. Consequently, PCG did not compute the needed capacity for State Psychiatric Hospitals.
Inpatient Psychiatric Beds (Freestanding & Unit)	PCG conducted an analysis and formulated peer state comparisons using data sourced from "Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model,"[xxxiv] and "Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process"[xxxv]. Additionally, PCG examined Oregon's inpatient hospital bed needs from data sourced from *Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model."*
Residential Treatment Facility & Residential Treatment Home (RTF & RTH)	PCG conducted an analysis and formulated peer state comparisons using data sourced from The National Association of State Mental Health Directors Report titled "Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022."[xxxvi] Additionally, PCG examined a decade's worth of data from this report, focusing particularly on Oregon, to assess historical trends in Residential Treatment Facilities.
Secure Residential Treatment Facility (SRTF)	PCG conducted an analysis and formulated peer state comparisons using data sourced from "The National Association of State Mental Health Directors Report titled "Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022."[xxxvi] Additionally, PCG examined a decade's worth of data from this report, focusing particularly on Oregon, to assess historical trends in Secure Residential Treatment Facilities.
Adult Foster Home (AFH)	OHA did not designate Adult Foster Home beds as a prioritized requirement for this study. Consequently, PCG did not compute the needed capacity for Adult Foster Homes.
Residential SUD Facility	PCG derived projections for the bed needs of Residential SUD facilities using data and forecasts obtained from Substance Abuse and Mental Health Services Administration's Calculating for an Adequate System Tool (CAST) model, as reported in the 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis[vi] as of January 2, 2024.
Withdrawal Management Facility	PCG derived projections for the bed needs of Residential SUD facilities using data and forecasts obtained from Substance Abuse and Mental Health Services Administration's Calculating for an Adequate System Tool (CAST) model, as reported in the 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis.[vi], as of January 2, 2024.
Crisis Facility	RI International RTI Report with Recliners and Bed Needs in Appendix C[xxxviii]

PEER STATE COMPARISON

To establish a benchmark for the targeted number of residential beds needed in Oregon per capita, we completed a peer state comparison using data from Colorado, Kentucky, Massachusetts, Utah, and Washington. Bed data was extracted from the Substance Abuse and Mental Health Services Administration (SAMHSA), 2020 National Mental Health Services Survey (N-MHSS)[xxxiii]. Although various factors may have evolved since then, including the repercussions of the COVID-19 pandemic, PCG utilized this report as a reference point for data calculations. The report includes the number of beds per state for 24-hour residential facilities and we used population data from the United States Census Bureau from 2020. For comparison purposes, we calculated the number of beds per 100,000 population and then averaged the peer state ratios to calculate our target beds per 100,000 population as shown in Table 38.

The peer state comparison tables do not represent the most residential beds per capita; however, for the sake of consistency, PCG utilized the same states to determine an average between all five peer states for the reasons outlined in our methodology. The states themselves may have different care models, staffing, bed types or utilization when compared to Oregon and the actual state residential beds per 100,000 population may not be the highest in the U.S; however, aggregating each state's residential beds gave a framework for comparison between all five states.

Table 38. **Calculating the Peer State Average for Residential Beds**
Source SAMHSA report Table 4.9

State	# Residential Beds	Population	Residential Beds per 100k
Colorado	412	5,773,714	7.14
Kentucky	878	4,505,836	19.49
Massachusetts	1,307	7,029,917	18.59
Utah	1,285	3,271,616	39.28
Washington	634	7,705,281	8.23
Average	**903.2**	**5,657,272**	**18.54**

CAPACITY NEEDS ANALYSIS

Inpatient Psychiatric Beds

Through PCG's analysis of all data sources, we have estimated 461 (10.88 beds per 100,000 population) inpatient psychiatric beds are currently available in Oregon. This includes Inpatient Psychiatric Facility – Freestanding, Inpatient Psychiatric – Unit in Hospital in a General or Acute Care Hospitals; however, this does not include "scatter beds", which are beds in a general medical unit of a hospital used to place psychiatric inpatients. In addition, the total does not include State psychiatric hospital beds that have a total of 577 beds (13.62 per 100,000 population).

Inpatient psychiatric beds are usually for those who need intensive psychiatric inpatient level of care to manage an illness in an emergency or acute situation, but not requiring the highest level of intensity services provided by a State psychiatric hospital. According to a report published in the International Journal of Environmental Research and Public Health titled *"Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model,"*[xxxiv] the overall rate of psychiatric beds needed per 100,000 population, was 34.9. Additionally, this report identifies Oregon should have 35.98 beds per 100,000 people, and after reviewing with OHA, the direction was determined to utilize Oregon specific numbers as much as possible for this report. These figures are validated by another report entitled, *"Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process,"*[xxxv] citing 30 to 60 beds per 100,000. To conduct a brief analysis of current capacity and needs within Oregon, PCG used 35.98 beds per 100,000 to estimate 1,524 inpatient psychiatric beds are needed in the State of Oregon. Consequently,

employing this methodology suggests that Oregon's capacity in inpatient psychiatric beds could increase by an additional 486 beds.

To further analyze the gap between the State of Oregon's inpatient psychiatric beds and the above needed projection, PCG combined the 461 existing psychiatric inpatient beds with the 577 current State psychiatric hospital beds, resulting in a total of 1038 inpatient psychiatric beds, equivalent to 24.51 beds per 100,000 population. With both bed capacity numbers combined, Oregon's beds per 100,000 population is below the 35.98 beds per 100,000 population Oregon specific benchmark by 11.47 beds per 100,000 population or 486 beds. Table 39 shows peer state beds per 100,000 population according to a 2021 report titled *"Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model."*[xxxiv] When reviewing peer states, utilizing the lowest beds per 100,000 from Utah and Washington, the average is 26.59 beds per 100,000 population, which is higher than Oregon's 24.51, by 2.08 or 88 beds.

Table 39. Peer State Population and Inpatient Psychiatric Beds Per 100,000 Population

State	Population	Psychiatric Hospital Beds per 100,000
Colorado	5,773,714	114.30
Kentucky	4,505,836	29.61
Massachusetts	7,029,917	32.62
Utah	3,271,616	28.45
Washington	7,705,281	24.73
Oregon	**4,280,804**	**22.54**

Although the Behavioral Health Residential+ Study did not encompass a comprehensive analysis of inpatient psychiatric freestanding, inpatient psychiatric - hospital unit beds, or State psychiatric hospital beds for that matter, PCG recognizes the necessity for a full continuum of care within a geographic region to facilitate psychiatric treatment and enhance accessibility, thereby mitigating challenges and bottlenecks to access care throughout the continuum. PCG would recommend further comprehensive analysis of inpatient psychiatric beds and investigation into how the State could support non-profit or for-profit hospitals in developing additional capacity for a minimum of 122 beds, a median of 243 beds, and up to a maximum of 486 beds. Furthermore, the inclusion of crisis facilities, supportive or transitional housing or additional outpatient programs, may potentially mitigate some of the required inpatient beds. In addition, the RI International Report, *Roadmap to Implementation of Oregon's 988 & Behavioral Health Crisis System*[xxxviii], utilized the Crisis Now Calculator and identifies the short-term bed needs of 238 inpatient psychiatric beds with additional crisis beds and/or recliners to support behavioral health needs. These services could have a notable effect on the overall demand for hospital beds in the State, thanks to the supplementary support available within the community. Additionally, PCG has not outlined which type of community inpatient psychiatric hospital bed is needed, i.e. inpatient psychiatric- freestanding or inpatient psychiatric – hospital unit, as that would be best determined by the State, region and organization developing inpatient psychiatric bed capacity. Furthermore, the impact of State rules related to Certificate of Need, will need to be evaluated and considered when deciding to expand inpatient psychiatric bed capacity, as that could pose significant barriers, challenges, costs and time constraints, which could deter some organizations from entering the State or market as providers of inpatient psychiatric - freestanding hospitals.

Mental Health Residential Treatment Facilities and Residential Treatment Homes

Residential Treatment Facilities (RTF) and Residential Treatment Homes (RTH) are unlocked and provide community residential treatment for longer term care of adults with a mental health diagnosis. Of note, Adult Foster Homes could be discussed in this section; however, they were not included in the capacity needs assessment as high priority facilities in discussions with OHA, therefore only RTF and RTH facilities are discussed here.

As shown in Table 40, Oregon has 810 mental health residential beds in the State, of which 507 (11.97 beds per 100,000 population) are classified as RTFs and 303 (7.15 beds per 100,000 populations) as RTHs. Mental Health Residential Beds of this type, equating to 19.12 beds per 100,000 population.

Table 40. Combined Residential Treatment Facilities and Homes Bed Current Capacity

Trauma System Area	**ATAB 1** (Portland / N Coast)	**ATAB 2** (Mid-Willamette Valley / N Central Coast)	**ATAB 3** (S Willamette Valley / S Central Coast)	**ATAB 5** (Southern Oregon / S Coast)	**ATAB 6** (Columbia Gorge)	**ATAB 7** (Central Oregon)	**ATAB 9** (Eastern Oregon)	Total
Combined Number of Beds	419	140	84	38	0	66	63	810
Combined Beds per 100,000 Population	21	18.36	14.55	11.46	0	19.29	36.47	19.12

PCG analyzed data from grants supported with funding from HB 5202 and HB 5024 to determine the number of new mental health Residential Treatment Facility (RTF) and Residential Treatment Home (RTH) beds coming online. Through our analysis, PCG determined 219 new mental health RTF and RTH beds are coming online by the third quarter of 2025. With the current bed capacity of 810 plus the addition of 219 beds, we are projecting a total of 1,029 beds by the third quarter of 2025.

Utilizing peer states' average of 18.54 beds per 100,000, Oregon would need 785 beds to support this type of service and care. Currently, Oregon has a capacity of 810 beds or 19.12 beds per 100,000 population statewide. When combining additional capacity of 219 new beds by the third quarter 2025, Oregon will have a projection of 1,029 beds or 24.29 beds per 100,000 population. When comparing Oregon to peer states average, Oregon's beds per 100,000 projection of 24.29 exceeds beds per 100,000 population of the comparison states by 5.75, thereby indicating residential beds for Mental Health Facilities and Residential Homes meet or exceed needed capacity by this method.

To further analyze if the above-described method determined if bed capacity was met or exceeded, PCG analyzed Oregon's historical data from The National Association of State Mental Health Directors Report, "*Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022,*"[xxxvi] for the number of patients per 100,000 in a 24-Hour Residential Treatment Facility of each reporting year from 2010 through 2020 in the State of Oregon. On April 30th for each year reported, PCG can determine that the projected bed capacity of 1,029 or 24.29 beds per 100,000 does support the number of individuals in residential care treatment for the State in 2018 (22.36 per 100,000 population) and 2020 (17.31 per 100,000 population). Of note, in 2020, there is a decline in the number of patients per 100,000 reported; however, this would reflect the impact of the COVID-19 pandemic on health care.

However, if you average each year together for Oregon, the average number of patients in a 24-hour residential facility over the ten-year reporting period is 26.71 residents per 100,000 on a given date, indicating that 2.42 additional beds per 100,000 or 102 additional beds would be needed to support residential treatment services. If you remove the high and low variables reporting individuals per 100,000 in a 24-hour residential setting on that given date, the average is 24.43 per 100,000, placing Oregon within capacity of the projected beds within the State by the end of 2025. The current recommendation of meeting or slightly exceeding capacity needs by the end of 2025 with new additional capacity would be validated by

this methodology; however, incorporating an additional 102 beds into the care continuum would enhance capacity to address the complex and specialty population needs of residents in Oregon.

Table 41. Average Patients in RTF or RTH Facility

State	2010	2014	2018	2020	Average
Oregon	26.5	40.66	22.36	17.31	26.71

However, PCG would be remiss if we did not acknowledge an opportunity in the 24-hour residential space, in which a clear need was identified during our data collection and interviews. During PCG's interviews with providers and government subject matter experts, the difficulty of placing individuals with complex needs in 24-hour residential facilities emerged as a key theme. For example, we were told that mental health residential providers licensed by OHA's Behavioral Health Division may lack capacity to care for people who are aging, have significant physical needs or have co-occurring intellectual and developmental disabilities. Conversely, residential facilities licensed by the Oregon Department of Human Services—which covers the aging and people with disabilities (APD) population and intellectual and developmental disabilities (IDD) population—may not be equipped to care for people with serious mental health conditions. The net effect is that these populations are not being served adequately in any setting. Additionally, PCG also heard of difficulties in placing individuals into mental health residential facilities or homes for those with a forensic background, further creating hardship on those who would be a high risk for recidivism or exacerbating mental health or substance abuse diagnosis without care and treatment.

While the present study does not account for different types of care needs within adult residential beds, the State of Oregon would benefit from completing an additional study focusing on older adults, individuals with physical disabilities and co-occurring mental health or substance abuse diagnosis, individuals with co-occurring intellectual and developmental disabilities and individuals with a forensic history who require mental health treatment and continuum of care services, further defining if there is a need for increasing services and funding for these specialized population. In the event that the State of Oregon would like to add beds to the 24-hour residential facility continuum, PCG would recommend adding beds dedicated to these specialty population or other populations like those requiring intensive services or those who have more complex needs. Specifically, placing individuals within this population subset can be challenging due to the unique needs of the patients and the shortage of residential treatment homes and facilities capable of addressing both mental and physical requirements. Consequently, there is an increased likelihood of patients being "boarded" in facilities or emergency rooms until suitable placement becomes available, or potentially being homeless further exacerbating potential issues for individuals and the behavioral health care continuum.

Secure Residential Treatment Facilities (SRTF)

PCG decided to complete the analysis of SRTFs separately due to a slightly higher level of care provided and different treatment environment structures, compared to Mental Health Residential Treatment Facilities or Homes. However, PCG utilized the same methodology to complete the analysis, capacity and needs assessment for Secure Residential Treatment Facilities as described above with Residential Treatment Facilities and Homes.

Secure Residential Mental Health Treatment Facilities are locked facilities, providing longer term care for individuals with a mental health diagnosis and usually for those with a criminal history or ordered to a locked community facility. The current estimate suggests that Oregon has 510 beds in SRTFs, equivalent to 12.04 beds per 100,000 population in the State, including 165 SRTF beds in the Oregon State Hospital (OSH) system. Of note, the 165 beds in the Oregon State Hospital system are not readily accessible to those in a community setting, therefore this limits the total number of SRTF beds available within the State to 345, which strains the care continuum for this type of bed.

PCG analyzed data from projects supported with funding from HB 5202 and HB 5024 to determine the number of new Secure Residential Treatment Facility (SRTF) beds coming online. Through our analysis, PCG determined 77 new SRTF beds are coming online by the third quarter of 2025. With the current bed capacity of 510 (inclusive of OSH SRTF beds) plus the addition of 77 beds, we are projecting 587 beds to support Secure Residential Treatment Facility needs by the third quarter of 2025, with the limitations described above.

Utilizing the peer states average of 18.54 beds per 100,000, Oregon would need 785 secure residential beds to support this type of service and care. Currently, Oregon has a capacity of 510 beds with an additional capacity of 77 new beds coming online by the third quarter 2025. At that time, Oregon will have a projection of 587 beds or 13.86 beds per 100,000 population, thereby requiring an additional 198 SRTF beds to meet or exceed needed capacity by this method.

To further analyze if the above-described method did determine if bed capacity was not met, PCG analyzed data from The National Association of State Mental Health Directors Report, "*Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022,*"[xxxvi] for the number of patients per 100,000 in a 24-Hour Residential Treatment Facility of each reporting year from 2010 through 2020 within the State of Oregon. On April 30th for each year reported, PCG can determine that the projected bed capacity of 587 or 13.86 beds per 100,000 does not support the number of individuals in secure residential care treatment for 2018 (22.36 per 100,000 population) and 2020 (17.31 per 100,000 population), thus indicating the capacity need is not met. Of note, in 2020, there is a decline in the number of patients per 100,000 reported; however, this would reflect the impact of the COVID-19 pandemic on health care.

However, with Secure Residential Treatment Facilities more exclusively providing care and treatment to individuals requiring a locked community facility, such as forensic status individuals, the trends according to The National Association of State Mental Health Directors report indicates a decline of 9% in forensic population in State psychiatric hospitals. While the report does not specifically account for different levels of care within community residential treatment options, PCG would recommend convening an advisory group to determine the most appropriate use of the additional 198 residential beds identified through the capacity analysis for Secure Residential Treatment Facilities. This is especially important to consider in light of the 165 SRTF beds on OSH campus, accounted for in the total SRTF bed capacity, which limits the availability of this type of bed in general throughout Oregon.

Substance Use Disorder Residential Facilities

Residential Substance Use Disorder treatment provides assessment, treatment, rehabilitation, and 24-hour observation and monitoring for individuals with substance use disorder, consistent with Level III of ASAM. Through our analysis, we identified Oregon has 1,374 SUD Residential Treatment Beds (32.44 per 100,000 population).

To determine SUD Residential capacity needs, PCG analyzed data from projects supported with funding from HB 5202 and HB 5024 to determine the number of new SUD Treatment Facility beds currently pending in the State. Through our analysis, PCG determined 44 new SUD residential beds will be available by the third quarter of 2025. With the current bed capacity of 1,374 beds plus the addition of 44 beds in progress, we are projecting a total of 1,418 beds (33.48 per 100,000 population) to support SUD Residential needs by mid-year 2025.

To evaluate SUD residential capacity needs, PCG utilized two resources to further evaluate the capacity needs for the State. First, a report from the Rand Corporation titled "*Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California*,"[xxxvii] which cited that a reference benchmark for adult SUD treatment beds needed were about 42.7 to 46.2 beds per 100,000 adults after literature research. Using the average of the quoted beds per 100,000 population of 44.45, PCG estimated that the State of Oregon would need 1883 beds with this method, which is 465 beds short to

support the needs in the State with projected capacity by the 3rd quarter of 2025, when all beds should be operational.

The second source within our analysis, and the model OHA determined to be the most be the most precise for estimation of SUD residential capacity need, is the 2022 Oregon Substance Use Disorder Services Inventory and Gap Analysis report, which applied the SAMSHA-developed Calculating for an Adequate System Tool (CAST) model.[vi] This model includes predictions based on the Calculating for and Adequate System Tool (CAST)—from September of 2022 with support from JG Research & Evaluation reevaluating the prediction as of January 2, 2024. While the initial evaluation and numbers were completed and reported a little more than one year ago, a request was made to re-analyze data from PCG's current data assessment due to more precise data being made available so fewer assumptions would be made to predict CAST model estimates of SUD residential capacity need. JG Research & Evaluation staff updated estimates of capacity/need for withdrawal management facilities and SUD residential treatment facilities, providing a summary and new estimate with more refined data elements. During the re-evaluation, JG Research noted variations, which are two fundamental differences, in the approach taken to produce estimates for each facility type. These must be pointed out between the initial CAST estimates from the September 2022 report and the December 2023 evaluation, as they cause a shift in the numbers reported between the two points of reference. Those two fundamental differences are explained below:

1. The primary source of variation in the estimates is a transition from estimated capacity/need at the facility level to estimating it at the bed level. In doing so, there is an increased precision to the estimates as there are fewer assumptions built into the model about organization level bed capacity. The assessment methodology utilized for this assessment is called CAST and the base equations use national averages of organizational capacity to produce quantifiable estimates of need in the absence of complete organization specific information. This decision was made by the creator of CAST because of the broad challenges with states having access to precise and complete inventories of substance use care system intervention capacity. Due to work on a separate project, OHA was able to provide updated data that included bed totals by county, and these totals were utilized to produce new estimates.
2. The second source of variation is in the precision of the organization-level data. During the initial assessment, a set of assumptions were made about the existence of specific types of treatment services across organizational settings. With the updated dataset, this assumption has been removed from the models. Based upon conversations between JG staff and OHSU staff, the assumptions in the initial models were intentionally conservative to avoid overestimating the need in the absence of limited or incomplete data. In being able to have full information, the assumptions could be removed and replaced with a more precise understanding of bed capacity by county/region/State. The additional shift was in using data that was self-reported from organizations in assessment 1 to more reliable information via State licensing data in assessment.

The method of estimating the population who may need services as well as the components to the CAST estimation equations remained the same, minus the adjustment needed to estimate by bed rather than facility. All estimates have been completed by region, and region is defined by the boundaries used in SAMHSA's National Survey on Drug Use and Health (NSDUH). These boundaries are necessary, as there are no other reliable methods for estimating the populations of need. Use of these regional boundaries also ensures alignment of this assessment with the geography of the initial report.

Table 42 defines the NSDUH boundaries used to define regions for the CAST model, initial assessment, and re-assessment, which do not line up exactly with the ATAB regions.

Table 42. NSDUH Boundaries for CAST Model

Regions	Counties
Region 1	Multnomah
Region 2	Clackamas, Washington
Region 3	Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill
Region 4	Coos, Curry, Douglas, Jackson, Josephine, Klamath
Region 5	Crook, Deschutes, Jefferson
Region 6	Baker, Gilliam, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler

The updated equation of the CAST model included the following assumptions to build capacity needs for each region and the State of Oregon by facility type:

- Assumed the average length of stay is 25 days
- Assumed on average, across the population of likely users, that the re-use of a bed will occur 1.2 times per year

Considering the outlined variables, assumptions, and detailed data inputs, the projections for SUD residential treatment bed requirements for the entire State indicated a need for 3,775 beds in the updated forecast. Therefore, with the projected capacity, by 3rd quarter 2025 of 1,418 beds, with the addition of 44 beds, Oregon will still need 2,357 additional beds to develop capacity to the CAST bed projections needed. With the projected bed capacity, Oregon will have 33.48 beds per 100,000 population and if the State would increase the SUD residential treatment beds by 2,357 over a period of time, this would inflate Oregon's bed per 100,000 population to 89.13, thus increasing by 55.65 beds per 100,000 population.

While the CAST model was identified to be the most precise in reflecting the additional bed capacity need within the State due to utilizing more specific Oregon data, PCG also understand that a significant capital investment within the infrastructure would be needed to increase the SUD residential bed totals across the State. Therefore, the recommendation would be to create a five-year plan, thereby increasing the State's SUD residential treatment bed capacity by a minimum of 1,179 and a maximum of 2,357 beds to meet the anticipated demand as an ideal state based on State, regional, county and city input for further need of these beds.

Table 43 identifies the projected bed needs to support the demand for SUD residential treatment by region.

Table 43. Capacity and Demand

Region	Calculated Bed Demand
Region 1	745
Region 2	896
Region 3	1,175
Region 4	519
Region 5	222
Region 6	217
Statewide	3,775

Withdrawal Management Facilities

Through our analysis, we identified that Oregon has a total of 301 Withdrawal Management Beds (7.11 beds per 100,000 population), currently, with 293 beds (6.82 per 100,000 population) designated as Medically Monitored Withdrawal treatment beds and 8 (0.28 per 100,000 population) beds are classified as Clinically Managed Withdrawal treatment beds. Medically Monitored and Clinically Managed treatment differ by the setting, management, and monitoring of individuals going through withdrawal or detoxification treatment and under the type of treatment guidance provided by medically or clinically trained personnel. Medically monitored is an inpatient setting that provides medically managed intensive inpatient treatment services requiring 24-hour nursing care and under the guidance of a physician and classified as ASAM Level 3.7. Clinically Managed Withdrawal Management is provided in a setting which is residential in nature, delivering clinically managed services directed by non-physician addiction specialist rather than medical or nursing personnel and classified as ASAM Level 3.2. Medically Monitored is considered the higher level of care of the two care delivery models, therefore allowing either Clinically Managed or Medically Monitored treatment to occur in this setting versus Clinical Management which can only provide Clinically Managed treatment or lower.

To determine Withdrawal Management capacity needs, PCG analyzed data from projects supported with funding from HB 5202 and HB 5024 to determine the number of new Withdrawal Management beds in development currently within the State. Through our analysis, PCG determined that 16 new Medically Monitored Withdrawal Management beds will be available by the third quarter of 2025. With the current bed capacity of 301 plus the addition of 16 beds in progress, we are projecting a total of 317 beds (7.48 beds per 100,000 population) to support Withdrawal Management needs by mid-year 2025.

As for Substance Abuse Disorder Residential Treatment beds, at the direction of OHA, PCG utilized CAST estimate[vi] predictions from JG Research & Evaluation. While the initial evaluation and numbers were completed and reported a little more than one year ago, a request was made to re-analyze data from PCG's current data assessment due to more precise data being made available and therefore fewer assumptions were made to predict CAST model estimates of Withdrawal Management capacity need. JG Research & Evaluation staff updated estimates of capacity/need for withdrawal management facilities, providing a summary and new estimate with more refined data elements. During the re-evaluation, JG Research noted variations, which are two fundamental differences, in the approach taken to produce estimates for each facility type. These must be pointed out between the initial CAST estimates from the September 2022 report and the December 2023 evaluation, as they cause a shift in the numbers reported between the two points of reference. Those two fundamental differences are explained below:

1. The primary source of variation in the estimates is a transition from estimated capacity/need at the facility level to estimating it at the bed level. In doing so, there is an increased precision to the estimates as there are fewer assumptions built into the model about organization level bed capacity. The assessment methodology utilized for this assessment is called CAST and the base equations use national averages of organizational capacity to be able to produce quantifiable estimates of need in the absence of complete organization specific information. This decision was made by the creator of CAST because of the broad challenges with states having access to precise and complete inventories of substance use care system intervention capacity. Due to work on a separate project, OHA was able to provide updated data that included bed totals by county, and these totals were utilized to produce new estimates.
2. The second source of variation is in the precision of the organization-level data. During the initial assessment, a set of assumptions were made about the existence of specific types of treatment services across organizational settings. With the updated dataset, this assumption has been removed from the models. Based upon conversations between JG staff and OHSU staff, the assumptions in the initial models were intentionally conservative to avoid overestimating the need in the absence of limited or incomplete data. In being able to have full information, the assumptions were able to be removed and replaced with a precise understanding of bed capacity by county/region/State. The additional shift was in using data that was self-reported from organizations in assessment 1 to more reliable information via State licensing data in assessment.

The method of estimating the population who may need services as well as the components to the CAST estimation equations remained the same, minus the adjustment needed to estimate by bed rather than facility. All estimates have been completed by region and region is defined by the NSDUH boundaries. These boundaries are necessary, as there are no other reliable methods for estimating the populations of need. Use of these regional boundaries also ensures alignment of this assessment with the geography of the initial report.

Table 44 defines the NSDUH boundaries used to define regions for the CAST model re-assessment, which do not line up exactly with the ATAB regions.

Table 44. NSDUH Regions for CAST Reassessment

Regions	Counties
Region 1	Multnomah
Region 2	Clackamas, Washington
Region 3	Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill
Region 4	Coos, Curry, Douglas, Jackson, Josephine, Klamath
Region 5	Crook, Deschutes, Jefferson
Region 6	Baker, Gilliam, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler

The updated equation of the CAST model included the following assumptions for Withdrawal Management facilities for each region.

- Assumed that the average length of stay is 5 days
- Assumed that on average, across the population of likely users, re-use of a bed will occur 2.2 times per year

With the variables, assumptions, and detailed data inputs described above, the projections for Withdrawal Management bed needs for the State indicated that 888 beds (20.74 beds per 100,000 population) were needed in the updated forecast. Therefore, with the projected bed capacity of 317, the State of Oregon would need an additional 571 (13.34 beds per 100,000 population) Withdrawal Management beds to support this service and demand. As with other service types, the type of bed (Medical vs Clinical management) which is needed in this treatment capacity is not determined by this study; however, left up to the State, regions, counties or cities to determine which bed type would best serve the need.

Table 45 identifies the projected bed needs to support the demand for withdrawal treatment beds by region.

Table 45. Calculated Bed Demand Based on Cast Scores

Region	Calculated Bed Demand
Region 1	175
Region 2	211
Region 3	276
Region 4	122
Region 5	52
Region 6	51
Statewide	888

Summary of Capacity Needs

After analysis of current, pending, and projected forecasted needs, PCG has identified areas and bed capacity needs by service and facility type for community based behavioral health care which includes mental health residential, secure residential treatment facilities, SUD residential treatment, and withdrawal management services. Adult foster homes are not included in the table below. In addition, the summary of inpatient psychiatric facility capacity needs is outlined as well to close the gap on the high-level analysis completed on this service area. While the projection for additional capacity varies by the methodology utilized, below are the projected needs and total percentage increases by facility and service to increase capacity within Oregon.

Table 46. Needed Capacity Analysis

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Future Bed Capacity (Current + Pending + Needed Beds)	% Increase
Inpatient Psychiatric Facility *(Includes State & Community Hospital Beds)*	1,038	0	1,038	486	1,524	46.81%
Mental Health Residential Facility *(RTF & RTH only)*	810	219	1,029	102	1,131	9.91%
Secure Residential Treatment Facility *(Current Capacity Includes 165 SRTF beds which are part of Oregon State Hospital)*	510	77	587	198	785	33.77%
SUD Residential Facility	1,374	44	1,418	2,357	3,775	166.22%
Withdrawal Management Facility *(Clinical & Medical)*	301	16	317	571	888	180.13%
Totals	4,033	356	4,389	3714	8,103	84.63%

Crisis Facilities

As previously mentioned in this report, certain crisis services or facilities in Oregon currently lack defined State rules and do not possess designated licensing and certification criteria. The Behavioral Health Division is actively formulating licensing criteria for crisis facilities, which will offer clarity regarding the types of crisis services and care delivery at each facility. Consequently, PCG's report does not encompass an analysis of the current capacity of beds and recliners providing crisis services. This omission arises from the diverse ways in which different facilities render crisis services while awaiting the stipulated rules and requirements from the Oregon Health Authority.

However, in January 2022, RI International completed a report for OHA titled "Roadmap to Implementation of Oregon's 988 & Behavioral Health Crisis System."[xxxviii] This report meticulously outlined the projected crisis capacity needs for Oregon, taking into account the 2021 population and anticipated crisis episodes in each county. When assessing the crisis capacity requirements in Oregon, OHA should consider both the projected crisis episodes and how to effectively address the unique needs of each community across the State.

It's important to acknowledge that this report by RI International was completed over three years ago, and the data may have been influenced by post-pandemic factors. For further details, please refer to Appendix C from the RI International Report which is included below.

Table 47. RI International Report Appendix C

Name	2021 Population	Episodes	Recliner Need/Bed Need
Multnomah County	820,421	6,301	39/33
Washington County	610,968	4,692	29/25
Clackamas County	423,729	3,254	29/17
Lane County	389,103	2,988	19/16
Marion County	352,630	2,780	12/14
Jackson County	224,010	1,720	11/9
Deschutes County	209,266	1,670	10/9
Linn County	134,345	1,032	6/5
Douglas County	112,712	866	5/5
Yamhill County	108,566	834	5/4
Benton County	94,275	724	5/4
Polk County	88,271	678	4/4
Josephine County	88,161	677	4/4
Umatilla County	79,008	607	4/3
Klamath County	69,340	533	3/3
Coos County	64,917	499	3/3
Columbia County	52,572	404	3/2
Lincoln County	51,438	395	2/2
Clatsop County	41,250	317	2/2
Malheur County	30,607	235	1/1
Tillamook County	27,688	213	1/1
Wasco County	27,182	209	1/1
Union County	27,103	208	1/1
Jefferson County	25,674	197	1/1
Crook County	25,562	196	1/1
Hood River County	23,612	181	1/1

Curry County	23,185	178	1/1
Baker County	16,304	125	1/1
Morrow County	12,089	93	1/0
Lake County	7,937	61	0/0
Harney County	7,595	58	0/0
Wallowa County	7,508	58	0/0
Grant County	7,227	56	0/0
Gilliam County	1,950	15	0/0
Sherman County	1,940	15	0/0
Wheeler County	1,294	10	0/0

FORECASTED BEHAVIORAL HEALTH FUNDING NEEDS

PCG has determined an average cost per bed to build facilities based on available grant data provided by the OHA Behavioral Health Investment Team, Request for Information data, national research as well as estimates from RS Means Data Online. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operations.

PCG used a variety of methodologies to determine the forecasted costs for each facility type within scope – PCG's methodologies are detailed in Table 48 below.

Table 48. Methodology for Forecasted Behavioral Health Funding Needs

Facility Type	Methodology for Calculating Capacity Needed
State Psychiatric Hospital	Given this was not a priority area for this Study, PCG did not compute the necessary funding for State psychiatric hospitals.
Inpatient Psychiatric Facility *(Freestanding & Unit)*	PCG conducted research on national examples to determine new building cost per bed and renovation cost per bed for inpatient psychiatric beds. 10 examples were chosen across the US and used for this analysis[xxxix].
Mental Health Residential Facility *(RTF & RTH)*	Development cost data from the Behavioral Health Investment Team was used to derive an average cost per bed. PCG then found some example square footages through our research to calculate an average square footage of an RTF and RTH to utilize in RS Means.[xl] This produced a cost per bed based on the average number of beds across all current capacity data. The two data points (Behavioral Health Investment Team data and RS Means data) were averaged together to get an average capital cost per bed.
Secure Residential Treatment Facility	Development cost data from the Behavioral Health Investment Team was used to derive an average cost per bed. PCG then found some example square footage through our research to calculate an average square footage of an SRTF to utilize in RS Means.[xli] This produced a cost per bed based on the average number of beds across all current capacity data. The two data points (Behavioral Health Investment Team data and RS Means data) was averaged together to get an average capital cost per bed.
Adult Foster Home (AFH)	Given this was not a priority area for this Study, PCG did not compute the necessary funding for Adult Foster Homes.
Residential SUD Facility	2 RFIs were provided by OHA and those costs were used to determine an average cost per bed. PCG then found some example square footage through our research as well as from providers to calculate an average square footage of a Residential SUD facility to enter into RS Means.[xlii] (Executive Director, Personal Communication, March 13, 2024)(Facility Program Director, Personal Communication, March 13, 2024) This produced a cost per bed based on the average number of beds across all current capacity data. The two data points (RFI data and RS Means data) was averaged together to get an average capital cost per bed.
Withdrawal Management Facility	2 RFIs were provided by OHA and those costs were used to determine an average cost per bed. PCG then found some examples of square footage through our research to calculate an average square footage of a Withdrawal Management facility to enter into RS Means.[xliii] This produced a cost per bed based on the average # of beds across all current capacity data. The two data points (RFI data and RS Means data) was averaged together to get an average capital cost per bed.
Crisis Facility	While Crisis Facilities are a priority for OHA, PCG is only during a review of the landscape of crisis services while the rules are being formally developed and implemented. Consequently, PCG did not compute the necessary funding for Crisis.

RESEARCH ON INPATIENT COST ESTIMATIONS

PCG conducted research to determine national standards for inpatient capital cost estimates. Through our research, PCG identified ten examples of states opening new inpatient behavioral health beds and the associated capital costs. However, some of the examples were for construction of new facilities while other examples are for renovation of existing facilities. The capital cost estimate range, average development cost, and the average cost per bed are detailed below.

Table 49. Inpatient Estimated Capital Costs

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Facility Development Cost	Average Cost per Bed
New Build	$60,000,000.00	$234,000,000.00	$132,600,000.00	$1,272,520.20
Renovation	$1,975,000.00	$9,700,000.00	$5,335,000.00	$214,873.38

BEHAVIORAL HEALTH INVESTMENT TEAM DATA FOR COST ESTIMATIONS

Mental Health Residential Facilities Capital Costs

PCG received preliminary estimates of new facility construction costs provided by the OHA Behavioral Health Investment Team. The dataset from the Behavioral Health Investment Team included sixteen records categorized with the following facility categories:

- 8 Residential Treatment Facilities
- 1 Residential Treatment Home
- 7 Secure Residential Treatment Facilities

The cost of the one Residential Treatment Home is $652,500 for the five-bed facility, or $130,500 per bed. For Residential Treatment Facilities, the costs range from $1,789,000 to $6,155,500 with an average cost of $3,466,137.50 per facility. The per-bed cost of these facilities ranges from $121,869 to $384,718.80 with an average of $249,558.38 per bed. For Secure Residential Treatment Facilities, the total cost range is $515,658 to $12,494,000 with an average cost of $5,761,802 per facility. The per-bed cost of SRTFs ranges from $85,943 to $780,875 with an average cost of $415,982.54 per bed in these facilities.

There are limited data points included in this analysis and substantial ranges in the estimates, particularly for Secure Residential Treatment Facilities. The table below summarizes the average total facility development cost and average cost per bed for each facility type.

Table 50. Behavioral Health Investment Team Data for Mental Health Residential Estimated Capital Costs

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Facility Development Cost	Average Cost per Bed
Residential Treatment Home	N/A	N/A	$652,500.00	$130,500.00
Residential Treatment Facility	$1,789,000.00	$6,155,500.00	$3,466,137.50	$249,558.38
Secure Residential Treatment Facility	$515,658.00	$12,494,000.00	$5,761,802.00	$415,982.54

Residential SUD Facilties and Withdrawal Management Facilities Capital Costs

PCG received copies of proposals, specs, and costs submitted to OHA for expanding capacity by building new facilities in Residential Substance Use Disorder and Withdrawal Management Treatment Facilities. The dataset from OHA included two records for these facilities which are categorized as Residential Substance Use Disorder and Withdrawal Management Facilities to determine cost per bed. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operations.

Based on this data, construction development costs for new residential substance use disorder and withdrawal management facilities range from $5,000,000 to $6,100,000 with an average cost of $5,550,000 per facility. On a per-bed basis, this comes out to a cost range of $174,285 to $500,000 with an average cost of $246,667 per bed for residential SUD and withdrawal management facilities.

Table 51. Behavioral Health Investment Team Data for Residential SUD and Withdrawal Management Facility Estimated Capital Costs

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
SUD Residential & Withdrawal Management Facility	$5,000,000	$6,100,000	$5,550,000.00	$246,667

RS MEANS DATA FOR COST ESTIMATIONS

PCG used RS Means Data Online, an internet-based software package, as an additional source for determining capital construction costs for building new behavioral health facilities across the State. RS Means offers the following:

- **Construction Cost Data:** RS Means collects and compiles national construction cost data for various building types.
- **Cost Per Square Foot Estimates:** RS Means provides up-to-date cost per square foot estimates that consider design, materials, and labor costs which are specific for the building type and size.
- **City Cost Indexes:** RS Means publishes a set of city cost indexes which allow for adjustments to the base cost estimates based on local-specific factors. The system incorporates the different city options, so the cost estimates reflect a cost for each region compared to a statewide average. The cities included for the State of Oregon along with their corresponding trauma system area are as follows: Bend, Eugene, Klamath Falls, Medford, Pendleton, Portland, Salem, and Vale.

The primary factor in estimating construction costs using RS Means is the square footage required for the structure. PCG conducted an analysis of existing facilities to project the square footage needed for new construction costs. When creating the construction cost estimate for each facility type, PCG examined property listings and real estate results for three existing facilities in each category to determine their square footage. It is important to note that square footage data is not maintained by OHA, so the data utilized by PCG was limited.

PCG obtained square footage data for each facility type where available. For these facilities, we calculated the square feet per bed using the licensed bed count. Next, we averaged the square feet per bed across the sample facilities in our analysis to determine an average square footage estimate per bed for each facility type. To arrive at the square footage for the RS Means cost analysis, we multiplied this average square footage per bed for each facility by the current capacity average number of beds per facility type. It

is important to recognize that facility sizes can vary significantly due to various factors. Given the wide range of facility types and sizes, our approach provides an estimate for the size to use in each facility type.

PCG used the 2024 – Quarter 1 dataset in RS Means which is the most current and updated data set in the system.

While RS Means provides the ability to estimate capital construction costs for different regions throughout the State, there are a few limitations to the estimations that are noted below:

- One significant unknown is the exact location and cost of land for any new facility. This represents a cost that can vary tremendously and is not included in our analysis due to the extreme variation. Thus, land will be an additional cost for Oregon to consider when building these facilities.
- Secondly, RS Means does not account for the cost of anti-ligature construction in new facilities. This is an important consideration, as it represents an additional expense for the State. Anti-ligature construction is crucial for individual safety, ensuring that no parts of the facility can be used for self-harm.
- The RS Means costs are modeled on the "hospital" and "assisted senior living" setting in the software. The hospital settings are brick veneer/wood frame and are 2 stories without a basement. The assisted senior living settings are brick veneer/wood frame and are 1 story without a basement. These settings represented the most comparable facility setting to a new behavioral health facility. Given the limited selection of available building types in RS Means, these settings may include costs for equipment, labor, materials, and space that may not be relevant to behavioral health facilities. Selecting this facility type may represent additional costs, however, these may be offset by the behavioral health specific costs that are not included (i.e., anti-ligature construction, safety requirements).
- In addition to the already noted limitations, these estimates do not encompass several other crucial factors: site utilities, parking, landscaping, sales tax, and other variables. Furthermore, costs specific to additional costs resulting from additional design requirements, prevailing wage regulations, and agency project management fees are not included in these estimates.

From our analysis, capital costs for residential treatment facilities range from $1,330,493 to $1,582,637 with an average total cost of $1,474,090 and cost per bed of $147,409. For residential treatment homes, the minimum construction estimate is $1,011,009 with a maximum estimate of $1,197,732. This provides an average total development cost of $1,118,194 and an average cost per bed of $233,639. The capital costs for secure residential facilties ranges from $4,541,818 to $5,209,272 with an average total development cost of $4,920,784 and an average cost per bed of $289,458. The development costs for an SUD residential facility range from $6,791,737 to $7,771,059 with an average total development cost of $7,343,864 and an average cost per bed of $253,237. Lastly, the capital costs for withdrawal management facilities range from $3,930,764 to $4,511,211 with an average total development cost of $4,262,916 and an average cost per bed of $304,494.

Table 52 below summarizes the cost estimations for each facility type within scope.

Table 52. RS Means Data for Estimated Capital Costs

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
Residential Treatment Facility	$1,330,493	$1,582,637	$1,474,090	$147,409
Residential Treatment Home	$1,011,009	$1,197,732	$1,118,194	$223,639
Secure Residential Treatment Facility	$4,541,818	$5,209,272	$4,920,784	$289,458
SUD Residential Facility	$6,791,737	$7,771,059	$7,343,864	$253,237
Withdrawal Management Facility (Clinical & Medical)	$3,930,764	$4,511,211	$4,262,916	$304,494

CAPITAL COST ESTIMATE COMPARISONS

PCG's analysis of the inpatient costs from our research, the Behavioral Health Investment Team capital cost data. RFI cost data, and the RS Means cost data provided four sources of estimates for our capital cost comparison. Table 53 below shows the comparison of the four data sources and the average cost per bed for each facility type across all data points.

Table 53. Capital Cost Comparisons

Facility Type	Inpatient Estimates per Bed (New Build)	Inpatient Estimated per Bed (Renovation)	Behavioral Health Investment Team Cost Estimates per Bed	RFI Cost Estimates per Bed	RS Means Estimates per Bed	Average Cost per Bed
Inpatient Psychiatric Facility *(Freestanding & Unit)*	$1,272,520	$214,873	N/A	N/A	N/A	$743,697
Residential Treatment Facility	N/A	N/A	$249,558	N/A	$147,409	$198,484
Residential Treatment Home	N/A	N/A	$130,500	N/A	$223,639	$177,069
Secure Residential Treatment Facility	N/A	N/A	$415,983	N/A	$289,458	$352,720
SUD Residential Facility	N/A	N/A	N/A	$246,667	$253,237	$249,952
Withdrawal Management *(Clinical & Medical)*	N/A	N/A	N/A	$246,667	$304,494	$275,580

FORECASTED CAPACITY NEED INVESTMENT COSTS

The below table represents the average number of beds per facility type from the Licensing and Certification Data current capacity data. The cost per bed numbers below are reflected as whole numbers in this analysis. This table provides a high-level projection of the average costs associated with building new facilities based on average bed size to meet the demands of Oregonians.

Table 54. Average Capital Cost per Facility

Facility Type	Average Capital Cost per bed	Average Number of Beds	Average Capital Cost Per Facility
Inpatient Psychiatric Facility *(Freestanding & Unit)*	$743,697	33	$24,542,001
Residential Treatment Facility	$198,484	10	$1,984,840
Residential Treatment Home	$177,069	5	$885,345
Secure Residential Treatment Facility	$352,720	17	$5,996,240
SUD Residential Facility	$249,952	29	$7,248,608
Withdrawal Management Facility *(Clinical & Medical)*	$275,580	14	$3,858,120

To calculate the total projected investment costs for the capacity needs in Oregon, PCG utilized the projected capacity needs and the cost per bed derived from our above analysis. This resulted in a total projected investment cost for capital funds for each of the facility types in the analysis. In our analysis of projected capacity need, the total capacity needs for Mental Health Residential (RTF & RTH only) yielded a need of 102 beds. For the Cost Estimation, we averaged the cost per bed for RTF and RTH which yielded an average cost per bed of $187,777.

In our analysis, we excluded projected capital investment costs for inpatient beds. Typically, these costs are covered by for-profit or non-profit entities, hospitals, or organizations looking to expand their inpatient capacity. Such endeavors often receive support from the State in the form of subsidies, tax credits, incentives, and assistance in securing funding.

Table 55 below provides the Total Projected Capital Costs for each facility type based on the capacity needed in Oregon. To increase capacity in residential facilities across residential treatment homes, residential treatment facilities, secure residential treatment facilities, SUD residential facilities, and withdrawal management facilities, the total projected capital costs are estimated to be $835,484,858.

Table 55. Forecasted Need and Capital Costs

Facility Type	Projected Capacity Needed	Average Capital Cost per bed	Total Projected Capital Investment Costs
Mental Health Residential *(RTF & RTH)*	102	$187,777	$19,153,254.00
Secure Residential Treatment Facility	198	$352,720	$69,838,560.00
SUD Residential Facility	2,357	$249,952	$589,136,864.00
Withdrawal Management Facility *(Clinical & Medical)*	571	$275,580	$157,356,180.00
Total	3,228		$835,484,858.00

PCG recognizes that this figure surpasses our initial estimate from the January 2024 Draft Report. The upward revision stems from two key reasons. First, a more recent data set and a precise assessment of existing and anticipated capacity throughout the State resulted in an elevated requirement for beds needed in Oregon. Second, at the direction of the OHA, PCG utilized CAST scores solely for the SUD residential facility and withdrawal management bed needs, which increased the total number of beds needed in the State. Furthermore, our conclusive analysis incorporates supplementary data points related to capital expenses, offering a more comprehensive perspective for evaluating the projected capital costs. It is essential to note that these forecasted costs are estimations based on the data provided, with the acknowledged limitations outlined in this report.

CAPACITY PLANNING RECOMMENDATIONS FOR FIVE YEAR PLAN

INTRODUCTION & METHODOLOGY

At the direction of OHA, PCG devised a five-year plan based on the analysis of State and national benchmarks used in this report. The plan identifies capacity goals for each assessed bed type within scope. Our roadmap for capacity planning outlines essential yearly milestones by bed type and trauma system area based on proportional distribution of State population defined by trauma system area. These milestones serve as the foundation for developing capacity to meet the needs of Oregonians, considering various factors.

The five-year plan serves several purposes:

1. Situational Awareness: It provides an understanding of the current state and future trajectory.
2. Solution Development: It aids in formulating potential solutions.
3. Implications and Funding Strategies: It identifies implications and funding approaches for each geographical region and facility type.

The five-year plan strategically organizes capacity-building efforts between Calendar Year 25 to Calendar Year 29. This comprehensive plan serves as a guiding framework for critical decisions related to capacity expansion, shaping the trajectory of behavioral health facility capacity in Oregon. By establishing target bed capacity increases in each trauma system area, the plan aims to address gaps in the State's behavioral health infrastructure. It specifically focuses on bridging disparities in access to specific bed types across different trauma system areas.

PCG conducted intraregional analyses to ascertain the required capacity for each facility type within each trauma system area of the State. The process involved identifying the total population for each trauma system area, assessing the current and pending bed capacity across various facility types within each area, and proportionally allocating the statewide capacity need based on the trauma system area population relative to the overall State population. As a result, we determined the total capacity needed for each facility type within each trauma system area, prioritizing care continuum bed types accordingly. The map and table below illustrate the bed needed per trauma system area.

Figure 31. Total Capacity Needed for Each Trauma System Area

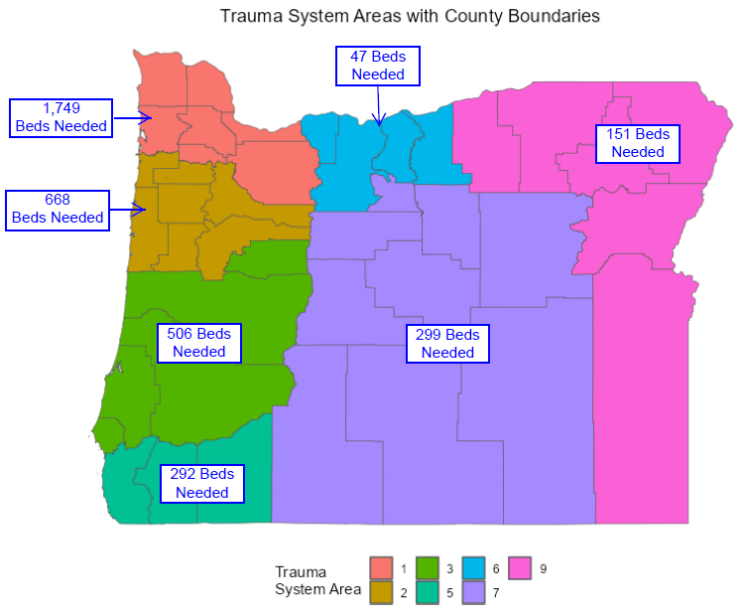


Table 56. Total Capacity Needed for Each Trauma System Area

Bed Capacity Needed for Each Trauma System Area								
Facility Type	ATAB 1 (Portland / N Coast)	ATAB 2 (Mid-Willamette Valley / N Central Coast)	ATAB 3 (S Willamette Valley / S Central Coast)	ATAB 5 (Southern Oregon / S Coast)	ATAB 6 (Columbia Gorge)	ATAB 7 (Central Oregon)	ATAB 9 (Eastern Oregon)	Bed Capacity Needed Statewide
Inpatient Psychiatric Facility *(Freestanding & Unit)*	229	87	66	38	6	39	20	485*
Mental Health Residential Facility *(RTF & RTH)*	48	18	14	8	1	8	4	101*
Secure Residential Treatment Facility	93	36	27	16	3	16	8	199*
Residential SUD Facility	1,110	424	321	185	30	190	96	2,356*
Withdrawal Management Facility *(Clinical & Medical)*	269	103	78	45	7	46	23	571
Total	1,749	668	506	292	47	299	151	3712*

**Slight variations from statewide capacity need totals are due to rounding in the calculations*

To allocate the bed capacity needed for each of the trauma system areas in the five-year plan, PCG evenly distributed the total. This was chosen to allow for a manageable but effective way to increase mental health and substance use disorder facilities in the State in each of the regions. This is additionally supported by the following items:

- SUD Residential and psychiatric residential have the highest amount of bed days utilized in 2021 and 2022 per the APAC data analysis.
- Community partners consistently pointed to a need to expand both behavioral health and substance use services, and particualrly the high rate of co-occuring disorders. When discussing populations of high-priority, indviduals with SMI, SUD, and their health-related social needs was discussed frequently.

TRAUMA SYSTEM AREA 1 (PORTLAND / N COAST)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 1 is below. The numbers below represent the total number of beds.

Table 57. Five Year Plan for Increasing Capacity – Trauma System Area 1

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	46	46	46	46	45	229
Mental Health Residential Facility *(RTF & RTH)*	10	10	10	9	9	48
Secure Residential Treatment Facility	19	19	19	18	18	93
SUD Residential Facility	222	222	222	222	222	1110
Withdrawal Management Facility *(Medical & Clinical)*	54	54	54	54	53	269
Total	351	351	351	349	347	1749

TRAUMA SYSTEM AREA 2 (MID-WILLAMETTE VALLEY / N CENTRAL COAST)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 2 is below. The numbers below represent the total number of beds.

Table 58. Five Year Plan for Increasing Capacity – Trauma System Area 2

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	18	18	17	17	17	87
Mental Health Residential Facility *(RTF & RTH)*	4	4	4	3	3	18
Secure Residential Treatment Facility	8	7	7	7	7	36
SUD Residential Facility	85	85	85	85	84	424
Withdrawal Management Facility *(Medical & Clinical)*	21	21	21	20	20	103
Total	136	135	134	132	131	668

TRAUMA SYSTEM AREA 3 (S WILLAMETTE VALLEY / S CENTRAL COAST)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 3 is below. The numbers below represent the total number of beds.

Table 59. Five Year Plan for Increasing Capacity – Trauma System Area 3

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	14	13	13	13	13	66
Mental Health Residential Facility *(RTF & RTH)*	3	3	3	3	2	14
Secure Residential Treatment Facility	6	6	5	5	5	27
SUD Residential Facility	65	64	64	64	64	321
Withdrawal Management Facility *(Medical & Clinical)*	16	16	16	15	15	78
Total	104	102	101	100	99	506

TRAUMA SYSTEM AREA 5 (SOUTHERN OREGON / S COAST)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 5 is below. The numbers below represent the total number of beds.

Table 60. Five Year Plan for Increasing Capacity – Trauma System Area 5

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	8	8	8	7	7	38
Mental Health Residential Facility *(RTF & RTH)*	2	2	2	1	1	8
Secure Residential Treatment Facility	4	3	3	3	3	16
SUD Residential Facility	37	37	37	37	37	185
Withdrawal Management Facility *(Medical & Clinical)*	9	9	9	9	9	45
Total	60	59	59	57	57	292

TRAUMA SYSTEM AREA 6 (COLUMBIA GORGE)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 6 is below. The numbers below represent the total number of beds.

Table 61. Five Year Plan for Increasing Capacity – Trauma System Area 6

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	2	1	1	1	1	6
Mental Health Residential Facility *(RTF & RTH)*	1	0	0	0	0	1
Secure Residential Treatment Facility	1	1	1	0	0	3
SUD Residential Facility	6	6	6	6	6	30
Withdrawal Management Facility *(Medical & Clinical)*	2	2	1	1	1	7
Total	12	10	9	8	8	47

TRAUMA SYSTEM AREA 7 (CENTRAL OREGON)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 7 is below. The numbers below represent the total number of beds.

Table 62. Five Year Plan for Increasing Capacity – Trauma System Area 7

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	8	8	8	8	7	39
Mental Health Residential Facility *(RTF & RTH)*	2	2	2	1	1	8
Secure Residential Treatment Facility	4	3	3	3	3	16
SUD Residential Facility	38	38	38	38	38	190
Withdrawal Management Facility *(Medical & Clinical)*	10	9	9	9	9	46
Total	62	60	60	59	58	299

TRAUMA SYSTEM AREA 9 (EASTERN OREGON)

Using the above methodology, the five-year plan for increasing capacity in trauma system area 9 is below. The numbers below represent the total number of beds.

Table 63. Five Year Plan for Increasing Capacity – Trauma System Area 9

Facility Type	CY 25	CY 26	CY 27	CY 28	CY 29	Total
Inpatient Psychiatric Facility *(Freestanding & Unit)*	4	4	4	4	4	20
Mental Health Residential Facility *(RTF & RTH)*	1	1	1	1	0	4
Secure Residential Treatment Facility	2	2	2	1	1	8
SUD Residential Facility	20	19	19	19	19	96
Withdrawal Management Facility *(Medical & Clinical)*	5	5	5	4	4	23
Total	32	31	31	29	28	151

STATEWIDE PLAN

The five-year plan allocates the needed behavioral health bed capacity across each trauma system area for Calendar Year 25 to Calendar Year 29. The total capacity increase (in number of beds) for each calendar year is noted below.

Table 64. Five Year Plan for Increasing Capacity – Statewide

Calendar Year	CY25	CY26	CY27	CY28	CY29
Bed Capacity	757*	748*	745*	734*	728*

**Includes inpatient psychiatric facility beds*

While the outlined five-year plan aims to incrementally add capacity each year to support the projected bed growth outlined in this report, it is essential to recognize that creating or adding new beds or constructing new facilities may not fully resolve all access issues identified through our research and community engagement sessions. While new beds or facilities may alleviate some of the pain points accessing services at the time of need, the following items should be considered by the State to successfully implement the five-year capacity plan to the fullest extent possible:

1. **Workforce Capacity**: Ensuring sufficient workforce capacity to support the addition of new beds or facilities.
2. **Behavioral Health and Substance Abuse Services**: Availability, access, and funding for other behavioral health or substance abuse services that support individuals to remain in the community.
3. **Supportive and Transitional Housing**: Availability and access to supportive and transitional housing options.

By addressing these factors, the State can enhance the effectiveness of the capacity plan and better meet the needs of Oregonians.

FUNDING RECOMMENDATIONS FOR FIVE YEAR PLAN

INTRODUCTION AND METHODOLOGY

The five-year plan strategically organizes the capacity building plans over a span of five years, aligning with State funding opportunities. This comprehensive plan serves as a guiding framework for critical decisions, particularly related to funding, which will shape the trajectory of behavioral health facility capacity in Oregon. By establishing target numbers, the plan aims to address gaps in the State's behavioral health infrastructure, specifically focusing on bridging disparities in access to specific bed types across different trauma system areas. An overview of the plan is below:

1. Capacity Building: The plan kicks off by initiating capacity building in the areas of highest priority during the first year. These priority regions receive initial attention and resources to prioritize additional capacity in the expanding capacity in the behavioral health facilities.
2. Yearly Progression: Over the course of the five years, priorities are sequentially scheduled. Each year, a certain number of beds are added to different regions and trauma system areas. This gradual approach ensures steady progress and targeted improvements.
3. Targeted Projects: Trauma system areas with the greatest need in terms of capacity needs are prioritized for projects that commence earlier. This strategic allocation ensures that urgent requirements are addressed promptly.

The inclusion of inpatient facilities in the five-year capacity-building plan demonstrates both the demand and potential strategies for expanding capacity. However, we excluded projected capital investment costs for inpatient beds, as these are typically covered by for-profit or non-profit entities, hospitals, or organizations looking to expand their inpatient capacity. Such endeavors often receive support from the State in the form of subsidies, tax credits, incentives, and assistance in securing funding.

FUNDING ALLOCATION

The five-year plan funding allocation uses the total number of beds from our five-year capacity plan and the average cost per bed from our analysis to determine the total estimated funds for each calendar year. As noted above, inpatient facility capacity needs were included in the five-year plan for expanding capacity across each calendar year. However, the focus for this report is residential facilty needs. Therefore, the funding allocation plan utilizes the total number of beds each calendar year for mental health residential facilities (RTF, RTH, & SRTF), SUD Residential Facilites, and Withdrawal Management Facilites (Clinical & Medical). The total number of beds for the five-year plan for these facilities and their associated costs is noted below in Table 65.

Table 65. Projected Five-Year Plan Funding Allocation

Calendar Year	CY 25	CY 26	CY 27	CY 28	CY 29
Capacity Total	657**	650**	648**	638**	634**
Funding Total	$170,308,595	$168,287,174	$167,658,873	$165,022,865	$164,121,780

***Does NOT include inpatient psychiatric facility beds. These numbers solely reflect residential beds.*

QUICK WINS

PCG understands that Oregon is prioritizing increasing its facility capacity to serve individuals across the State seeking behavioral health services. With the five-year plan created, Oregon has a roadmap to guide decisions to increase mental health residential, SUD residential, and withdrawal management facilities. Though the plan is for five years, there are several "quick wins" from this plan which are noted below:

- In the first year (Calendar Year 25), the plan details adding 657 residential facility beds across the State of Oregon.

- In the first year (Calendar Year 25), 67 of those 657 residential facility beds will benefit those seeking mental health residential services in RTFs, RTHs, and SRTFs.
- In the first year (Calendar Year 25), 590 of the 657 residential facility beds will serve those seeking SUD residential or withdrawal management services.
- Additionally, those 657 beds are distributed appropriately across the State to serve Oregonians in **every** trauma system area in the State.
- The first year (Calendar Year 25) includes additional capacity for mental health residential facilities (RTFs, RTHs, SRTFs,), SUD residential facilities, and withdrawal management facilities in every trauma system area in Oregon which will allow individuals in every region of the State to see additional capacity built across the behavioral health services.
- The five-year plan also allocates mental health residential and SUD residential capacity in every calendar year so capacity in each area is expanding for the individuals in Oregon who are seeking these needed services.

IMPORTANT CONSIDERATIONS

We acknowledge that in considering the distribution of funding, any allocation towards building new residential facilities must correspond with aggressive and highly coordinated efforts to address workforce development and capacity issues in already existing facilities, and strengthen community-based, crisis, housing, and outpatient services. Our engagement with community partners, particularly those with lived experience, underscores that it is imperative to prioritize the adaptability of facilities to meet the diverse needs of all Oregonians. This involves a thoughtful consideration of individuals with co-occurring disorders, the increasing acuity of those seeking behavioral health and substance use services, and the expansion of culturally specific services. Although the scope of this analysis is limited to the distribution of capital funding for new residential facilities, all such workstreams must be coordinated to effectively expand behavioral health care across the State.

Additionally, a holistic approach to the behavioral health continuum in Oregon is crucial. While expanding residential facility capacity is vital, it's just one facet of a broader system. Community partners emphasize the significance of strengthening community-based support and health-related social needs, particularly in housing. This approach can pave the way for robust community-based paths to care, reduce acuity among individuals seeking services, and shorten their length of stay. When contemplating expansion of residential capacity, it's imperative to recognize that strengthening other components of the behavioral healthcontinuum can mitigate the need for increased capacity.

RECOMMENDATIONS

Evaluating the entire behavioral health care continuum is a complex process that requires a comprehensive understanding of the various factors that contribute to the delivery of effective care. This report analyzes a portion of the facilities within the behavioral health continuum in Oregon and our recommendations are based on the data collected and analyzed as part of this Study, coupled with feedback and input from community partners.

CARE MODEL AND STRATEGY

Currently, Oregon has several pieces in place that make up the behavioral health care continuum; however, the succinctness and interchangeability of the different levels of care required for individuals, especially people with complex needs, causes difficulty moving throughout the system. Geographically, some areas are devoid of services and facilities, thus requiring people to travel great distances outside their home communities to receive the appropriate mental health and substance use treatment, thus overloading facilities and resources in another region to care for an increased number of individuals. Further straining the system is the lack of available resources to provide care and treatment, current workforce challenges, a general lack of capacity in areas throughout the care continuum, and transparent pathways for individuals seeking the most integrated care in the next level of care down in the continuum.

PCG would recommend developing a care model and strategy similar to a Hub and Spoke Model[xliv] to care for individuals within a geographic region and supporting the majority of needs based in a geographic region. Further, creating a strategy which stabilizes existing infrastructure, invests in new capacity, enhances coordinated care, invests in new technology, develops current models of care and facilities, and explores new models, including creating pathways to stepdown services is imperative to meet the needs of Oregonians. There must be a focus on the infrastructure and needs of Intensive Services, Community Based Care, Outpatient Treatment Services and Crisis Services, including capacity, workforce, and funding, and a well laid out strategy driven by thoughtful leaders positioned to create change and enhance treatment service delivery. Also, as emphasized by our community partners, customizing care models to suit the unique needs of rural and urban areas is crucial, and implementing a regional approach would effectively address this priority.

WORKFORCE DEVELOPMENT

To expand the capacity of behavioral health services in Oregon, it is essential to prioritize workforce investments. Most of the current facilities are understaffed and building more facilities could exacerbate the workforce challenges faced by existing facilities. Additionally, there is a need for culturally specific providers to offer culturally and linguistically appropriate care for the diverse and Indigenous populations in Oregon. There should be a continued focus on building a diverse, well-trained, and skilled workforce that can meet the needs of the communities across Oregon, both in rural and urban settings with State funding or programs. Workforce development should be prioritized so that every facility can operate effectively and efficiently with the appropriate level of staff to serve Oregonians who are seeking behavioral health services.

ADDITIONAL FACILITIES

Additional beds and facilities are needed to expand the infrastructure within mental health and SUD to meet the demand. Based on the current facility capacity in Oregon, if the decision is made to build new facilities, Oregon can expand capacity in the following areas and facility categories:

- Expand Mental Health Residential Treatment for those with medical comorbidities
- Expand Mental Health Residential Treatment Home and Secure Residential Treatment Facility capacity to enhance access especially for those with co-occurring diagnosis, forensic and elderly populations.
- Expand capacity for Substance Use Disorder Residential Treatment in general and populations with co-occurring diagnosis.
- Expand capacity for Withdrawal Management facilities

- Support additional inpatient psychiatric beds by working with non-profit and for-profit entities to develop capacity to optimal levels of care to meet the demand based on regional needs, policies and the State of Oregon rule structure.
- Develop Crisis Center Models, Strategies and Rules to implement within the State mirroring the RI International report recommendations, national and/or federal guidelines to support 24-hour crisis care for mental health and substance abuse.

If the decision is made to build more behavioral health facilities in Oregon, there should be adequate workforce investments and capital/start-up costs included to account for the human capital and operational costs to fund a new facility thoroughly.

AWARENESS, EDUCATION AND ENGAGEMENT

Developing awareness, education and interactive engagement opportunities with community partners surrounding mental health and SUD services, access, treatment options, opportunities, legislative updates, statistics, and funding will impact all levels of the continuum to create transparency and understanding. Some ways to accomplish this are noted below:

- Develop websites with easy to access information, treatment options, resources, contact information, and statistics for consumers and families.
- Create streamlined websites and links for providers and facilities to have a “one stop shop” experience for all things related to their work.
- Create public education awareness regarding treatment, what the State is doing to improve the care continuum, where funding is going, State-level behavioral health strategies, and five-year plans.

AREAS FOR FURTHER ANALYSIS

PCG understands there are a multitude of factors and considerations when identifying recommendations to expand behavioral health capacity in Oregon. There are many pieces of information that are outside of scope for our current report, but that should be further explored and reviewed to provide a more holistic representation of the behavioral health landscape in the State. These considerations are noted below:

- **Youth Population**: Our study currently focuses on the adult population. A similar analysis of current capacity and capacity needs for the child and youth population would provide beneficial information when considering funding priorities, capacities, and gaps in the care continuum for youth in Oregon.
- **Geriatric Population**: While the data does not account for different types of needs within adult residential treatment beds, the State of Oregon would benefit from completing an additional study focusing on geriatric mental health treatment and continuum of care and services, further defining if there is a need for increasing services and funding for this specialized population. During our community engagement sessions, the geriatric population with behavioral and medical needs was identified as a challenge in finding the appropriate community, residential or hospital facility to deliver care to this population. In addition, it is noted that through our analysis, Geriatric Psych Units are very limited.
- **Complex Needs**: An additional analysis and study of the services and capacity of behavioral health facilities to adequately care for those with complex, co-occurring behavioral, substance use, and medical needs would be a critical component in further analyzing the continuum of care. It was noted during Community Engagement how challenging it can be for people to find beds when they have both physical health and behavioral health needs.
- **Forensic Population:** Analysis of the current forensic population in relationship to mental health and substance abuse treatment and care needs while in State facilities, within the judicial system, community, residential or outpatient settings would be warranted. This population often suffer from a multitude of severe psychiatric, substance use and social problems and the interventions or

treatment to effectively care for these individuals is scarce, therefore creating gaps within the care continuum for this population. Analysis of the current forensic population in relationship to mental health and substance abuse treatment and care needs while in State facilities, within the judicial system, community, residential or outpatient settings would be warranted. This population often suffer from a multitude of severe psychiatric, substance use and social problems and the interventions or treatment to effectively care for these individuals is scarce, therefore creating gaps within the care continuum for this population.

- **Staffing and Workforce**: A thorough analysis of the staffing challenges and workforce development barriers to providing services at behavioral health facilities could offer important insights into the feasibility of new facility construction. We also recommend that Oregon explores options for State-funded workforce retention strategies.
- **Crisis Facilities**: A further thorough review of the crisis facilities and services in coordination with OHA as they develop the administrative rules for crisis stabilization centers would provide valuable information on the entire continuum of care and where additional supports are needed. Crisis Stabilization facilities can provide diversions from other levels of care and be a valuable resource in Oregon. Once the administrative rules are determined, the capacity for these services and facilities can be analyzed more effectively.
- **Quality of Care:** Quality of care was mentioned throughout Community Engagement as an area that could be further explored. Understanding the type of care being provided at the facilities is crucial, as well as understanding the culturally appropriate care available and the areas for expansion. Evaluation of quality care metrics within the State as well as dashboards to analyze the quality of care and associated costs to increase transparency.
- **Housing and Outpatient Programs:** Housing and outpatient programs were mentioned throughout our community engagement sessions as a significant need in Oregon. It was noted during our conversations that facilities often face discharge challenges and therefore provide services to individuals who no longer require a residential setting. With more housing options, facilities could discharge individuals to appropriate levels of care more efficiently which would then allow the residential facility to be able to serve more individuals.
- **Analysis by Insurance Type:** A further review of behavioral health services by insurance type could be beneficial as the State considers how individuals are served in each facility setting.
- **Operating Costs:** An analysis on the operating costs for the facility types included in this report would be valuable information as the State considers the feasibility of expanding behavioral health services.
- **Evaluation of Public Messaging:** A review of public-facing documents, messaging, websites, and policies could provide clarification around OHA policies, rules, requirements, etc.
- **Advisory Committee:** OHA should consider an advisory council to oversee and provide strategic guidance on the evaluation and assessment of behavioral health and substance use services in the State.

We acknowledge that in considering the distribution of funding, any allocation towards building new residential facilities must correspond with aggressive and highly coordinated efforts to address workforce development and capacity issues in already existing facilities, and strengthen community-based, crisis, and outpatient services. Our engagement with community partners, particularly those with lived experience, underscores that it is imperative to prioritize the adaptability of facilities to meet the diverse needs of all Oregonians. This involves a thoughtful consideration of individuals with co-occurring disorders, the increasing acuity of those seeking behavioral health and substance use services, and the expansion of culturally specific services. Although the scope of this analysis is limited to the distribution of capital funding for new residential facilities, all such workstreams must be coordinated to effectively expand behavioral health care across the State.

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