human services group

OREGON DEPARTMENT OF HUMAN SERVICES

STABILIZATION AND CRISIS UNIT (SACU)
PROPOSED STRATEGIC PLAN
APRIL 2025

TABLE OF CONTENTS

01 EXECUTIVE SUMMARY

Oregon's Stabilization and Crisis Unit (SACU) was originally designed to provide short-term crisis stabilization for individuals with intellectual and developmental disabilities (I/DD) and co-occurring behavioral health needs. However, due to systemic gaps, SACU has evolved into a long-term residential program, with average stays exceeding seven years for many adults. This extended use has strained resources, disconnected residents from community life, and limited SACU's ability to serve as a true crisis intervention model.

After interviewing more than 280 people, it is clear that transitioning SACU to a more focused short-term crisis and responsive role, is not only the right thing to do, it is possible. This report outlines a plan to ensure that long-term residents can move from SACU into supportive communities of their choice and thrive.

Individualized person-centered plans are at the heart of what should drive this transition. Respondents were overwhelming supportive of this direction throughout the discovery process and clear that imperative to making the transition sustainable, is that Oregon provide a state-wide, community-based crisis delivery system for people with I/DD that ensures preventative, short-term, and long-term support. This report provides a plan to both redesign SACU in accordance with budgetary decisions and create a sustainable direction that supports Oregonians with I/DD in a way that honors their dignity and ensures their health and safety.

This strategic plan outlines the necessary transformative opportunities:

- Positioning SACU as a Short-Term Crisis Stabilization Resource, aligned with best practices and supported by an actionable 18-month transition plan, contingent on the proposed legislative and governor's office budget changes.

- Redesigning Oregon's Crisis Response System by addressing root causes—such as a lack of community-based alternatives and coordinated system response—and establishing a unified, person-centered continuum of care.

Summary tables are provided on pages 6 and 7 that outline the overall recommendations for change.

KEY ISSUES

Key issues driving the need for SACU's redesign based on steering committee input and review of SACU's current environment:

Prolonged Lengths of Stay: Individuals often remain in SACU for extended periods of time (7+ years on average for adults with behavioral health needs) for a variety of reasons including the lack of appropriate transition options, person-centered planning and an integrated case management model. This results in SACU functioning as a long-term residential service provider for many people.

KEY ISSUES

Misalignment with Best Practices: SACU's workplace and its culture are not aligned with national best practices in person-centered, trauma-informed, and community-based crisis stabilization services. Interest holders highlighted inconsistencies in service delivery and quality, including the lack of a continuum of crisis options to meet people where they are and adequately support them through recovery. During most one-on-one interviews, family members and self-advocates expressed significant dissatisfaction with how they or their loved ones were treated and the services provided by SACU, from the point of intake through the duration of their stay.

Non-integrated System of Care: Oregon lacks a robust, clearly articulated, state-wide crisis response continuum of care and practice model which leads individuals with I/DD and behavioral health needs to experience long stays in SACU, isolated from their communities of natural supports and struggling to stabilize and transition back to their community. There is also inconsistent collaboration between SACU, community providers, and entities responsible for physical, oral, and behavioral health services and care coordination.

Financial Unsustainability: The current SACU model is operating well over budget and presents as financially unsustainable requiring significant resources that could be better leveraged to support more person-centered, community-based services leading to improved outcomes.

Regulatory Compliance: SACU homes are not operating in alignment with Home and Community-Based Services (HCBS) requirements under Oregon's Medicaid program and Federal requirements. They must transition to a more appropriate Medicaid authority to meet the intended purpose of SACU. If they do not, they risk significant financial penalties.

Data-Driven & Informed Operations: SACU struggles to get and use reliable data for decision-making. Without timely and accurate information, leaders and staff lack the insights needed to provide appropriate, person-centered care to support a smooth and timely transition back to community settings.

The plan outlines specific actions to align SACU's operations with proposed budgetary decisions and strengthen partnerships with community-based organizations, creating responsive, person-centered crisis services for individuals with I/DD and co-occurring behavioral health needs.

> "We can get there but it is going to take bravery"
> -State Staff

Recommendations to design the Stabilization and Crisis Unit (SACU) are highlighted here in priority order and follow a logical sequence for implementation. Detailed explanations for each recommendation are provided in the main body of the report.

RECOMMENDED STEPS-STABILIZATION

Steps needed to position SACU as a Short-Term Crisis Stabilization Resource in an 18-month period of time, should the legislature and governor choose to move forward with the current proposal, are presented here in priority order and follow a logical sequence for implementation. Detailed explanations for each recommendation are provided in the main body of the report.

RECOMMENDATION	POSITION SACU AS A SHORT-TERM STABILIZATION RESOURCE	ANTICIPATED RESULT
Establish SACU Transition Leadership Team (STLT)	Establish leadership and communication structure with self-advocates, families and trusted supporters, state leadership, SACU, ODDS, OHA, county, coordinated care representative, community-based providers, and advocacy organizations to lead the transition process.	Accountability and Oversight
Develop Person-Centered Plans for All Residents	Hire an external expert to create comprehensive person-centered plans identifying what is important 'to' and 'for' each resident to guide transitions and support planning. Create prioritization to guide individual transition timeline.	Individualized Transition and Support Plans
Establish a Resource Development Unit for Provider Recruitment	Establish a unit dedicated to recruiting, licensing, and supporting providers capable of serving individuals with high behavioral health needs and co-occurring disorders.	Expanded Capacity of Community-Based Providers
Engage Key Providers Early to Support Transitions	Immediately identify and engage providers to co-develop housing and service options aligned with person-centered plans, including individualized rates and transition collaboration. Begin implementation of transition of long-term residents.	Faster, More Successful Transitions from SACU
Establish One Medically Complex Home	Establish one, state operated, medically complex HCBS-licensed home, separated from SACU.	Meet Needs of Medically Fragile Residents
Align Medicaid Authority with SACU Service Model	Choose an alternative Medicaid authority for remaining SACU homes that is aligned with short-term, crisis stabilization services.	Aligned Service Model and Regulatory Compliance
Set Clear Goals to Reduce Long-Term SACU Reliance	Implement 'exit upon entry' planning, with immediate access to behavioral health services and strong community reintegration planning from day one.	Reduced Long-Term Use of SACU
Update Policy & Practice Guidelines and Workforce Training Aligned With Short-Term Crisis Stabilization	Update SACU's policy and practice guidelines and provide a structured and rigorous training plan to prepare staff for SACU's role providing short-term crisis stabilization. This plan should be anchored around a person-centered, trauma-informed model of crisis response and care.	Skilled Workforce Delivering High-Quality Care
Staffing Strategy for Operational Sustainability	Adjust staffing levels based on individual resident needs as long-term residents transition to community. Create a flexible pool of staffing to provide support based on the individuals in the home at any given time, versus based on the home itself.	Efficient Staffing Aligned to Needs and Budget

RECOMENDED STEPS-CRISIS RESPONSE

To support the long-term sustainability of SACU as a short-term crisis stabilization service, recommendations to design Oregon's Crisis Response System are highlighted here in priority order, and follow a logical sequence for implementation. Detailed explanations for each recommendation are provided in the main body of the report.

RECOMMENDATION	REDESIGN OREGON'S CRISIS RESPONSE SYSTEM	ANTICIPATED RESULT
Focus SACU as a Short-Term Crisis Stabilization Program	Transition long-term residents of SACU to homes in the community based on person-centered plans. Implement 'exit upon entry' planning with immediate access to behavioral health services and strong community reintegration planning from day one. Update SACU's policies and practice guidelines and provide staff training accordingly.	Reduce Reliance on SACU
Design and Develop a Comprehensive Crisis Response System	SACU must provide short term crisis stabilization as part of a broad, integrated crisis response system. A full continuum of care and case management model is essential to support individuals through crisis and recovery.	Stronger Community Based Crisis Supports
Address Financial and Operational Sustainability	Operational inefficiencies and high overtime make the current model unsustainable. Redesigning and choosing an alternative Medicaid authority is critical and must be aligned with short-term, crisis stabilization services.	Sustainable Workforce Strategy
Build Community-Based Crisis Alternatives	Extended SACU stays stem from limited community-based crisis options. Building strong alternatives will support timely transitions to less restrictive, more supportive settings.	Reduce Reliance on SACU
Enhance Coordination and Communication	Poor coordination between SACU, community providers, mental health services, and law enforcement disrupts crisis stabilization and transitions. Strengthening collaboration is key to seamless, person-centered care.	Improved System Coordination
Strengthen Workforce Capacity and Training	Effective crisis stabilization requires well-trained staff proficient in trauma-informed care, positive behavioral supports and person-centered practices. Ensuring needed training is critical to achieving SACU's mission.	Sustainable Workforce Strategy
Establish Independent Oversight and Compliance	To secure funding and public trust, SACU must meet the chosen Medicaid authority standards and stay compliant. Independent oversight can strengthen accountability and transparency.	Alignment of SACU with its Intended Purpose and Person Centeredness
Implement Data-Driven Decision Making	Reliable data is essential for evaluating the effectiveness of changes and ensuring continuous improvement. Through crucial, data-driven decision-making is secondary to establishing the foundational changes outlined in the higher-ranked recommendations.	Stronger Community Based Crisis Supports

02 CURRENT ENVIRONMENT

SACU currently operates beyond its intended role to provide short-term crisis stabilization. The following section describes SACU's current environment based on available data and interest holder perspectives. In this report, 'complex needs' refers to individuals who experience co-occurring intellectual or developmental disabilities (I/DD) and other challenges such as mental health conditions, substance use needs, medical conditions, or behavioral support needs.

PRESENTING NEEDS

Residents enter SACU for a variety of reasons, including mental health crises, behavioral health support needs, and situational emergencies. They often arrive at SACU exhibiting complex, co-occurring needs.

DEMOGRAPHICS OF INDIVIDUALS SERVED

As of April 2025, SACU is providing residential services to 77 individuals. Of these, 61 are adults (age 18 and older) and 16 are children. According to data from the Oregon Department of Human Services (ODHS), 62 individuals (80.5%) identify as white and non-Hispanic, 9 individuals (11.7%) identify as Black, Indigenous, or people of color (BIPOC), and 6 individuals (7.8%) have no race or ethnicity identified.

When compared to Oregon's overall demographics, SACU's population has a higher proportion of white, non-Hispanic individuals. According to the U.S. Census Bureau, approximately 72.8% of Oregon's population identifies as white and non-Hispanic, while people of color make up about 27.2% of the population. This suggests that SACU's residential population is less racially and ethnically diverse than the state's population as a whole.

Understanding these demographic differences is important for ensuring equitable access to services and for informing future outreach and service development.

GUARDIANSHIP

Per ODHS, 34 out of the 65 current individuals living in adult homes (52%) have a legally appointed guardian. The remaining 48% can make their own planning decisions but may still benefit from some type of advocacy support to assist with transition planning.

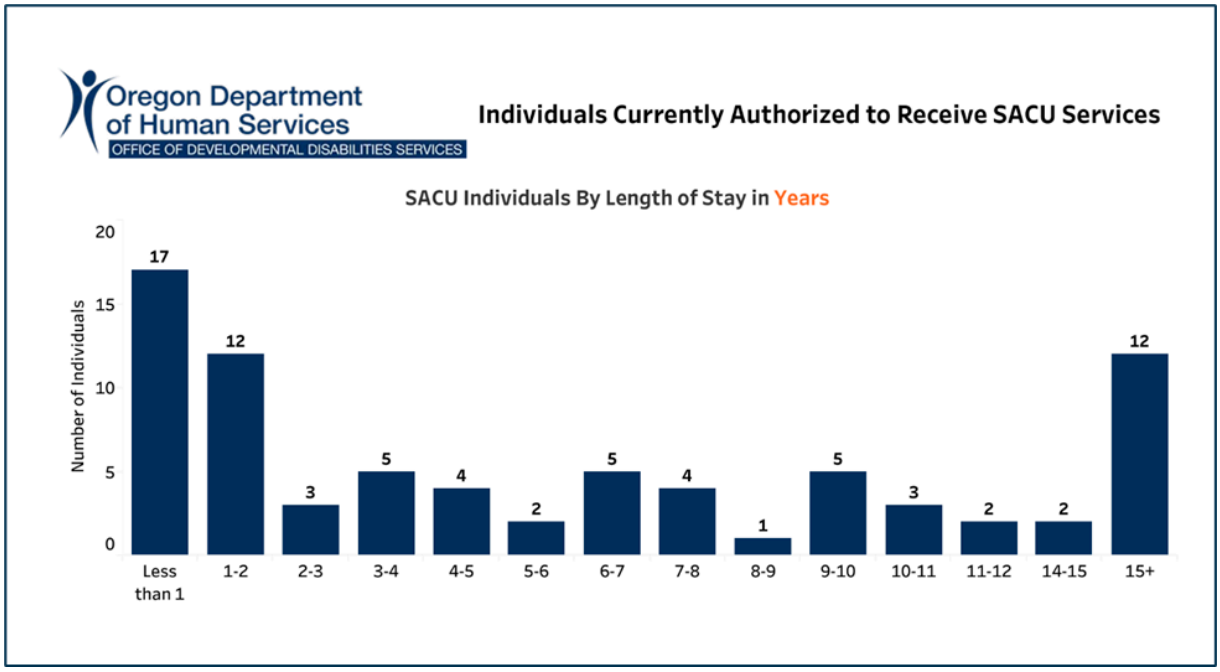
PRE-ADMISSION

Before a person is accepted for services at SACU, their placement history is reviewed to assess what less restrictive environments or other short-term interventions were considered for an individual. Interventions and resources typically include community mental health services or hospital acute care facilities. A thorough inventory of services and programs offered by Oregon's state agency was completed by the System of Care Advisory Council (updated July 2024). While the volume of total services is robust, it is noteworthy that Oregon's I/DD system currently lacks internal crisis resources apart from SACU.

CURRENT ENVIRONMENT

LENGTH OF STAY

Per ODHS, the average length of stay for adults with and without complex medical needs is seven years. Youth have the shortest average length of stay of eight months.



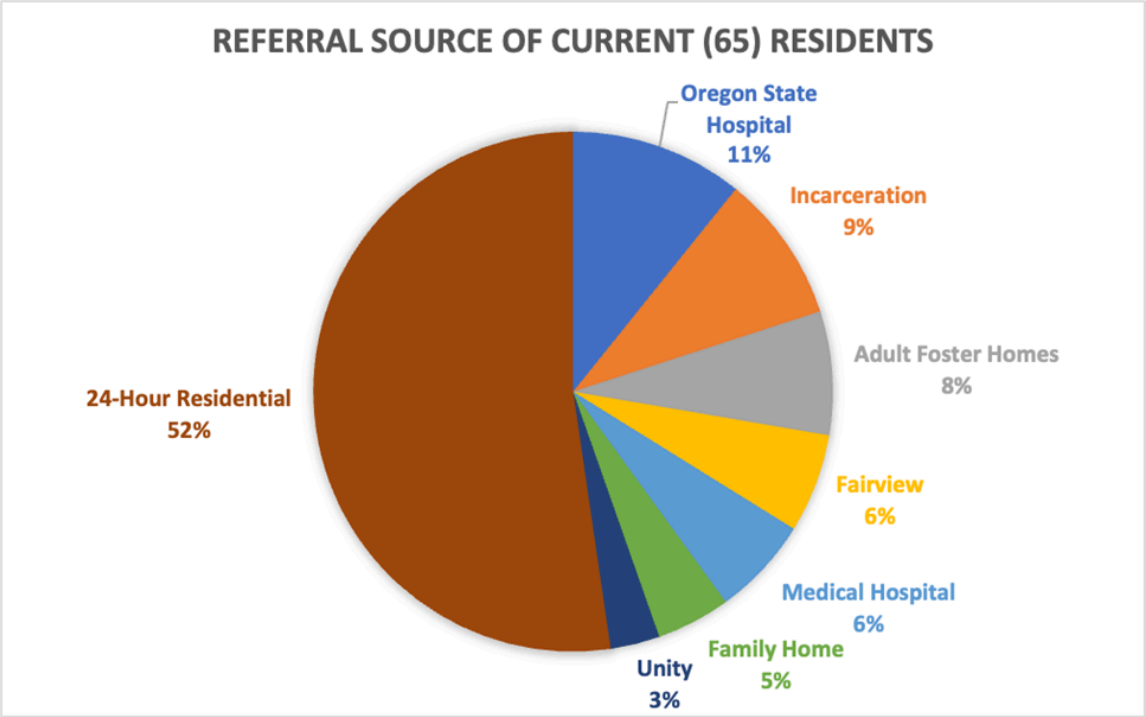
COST OF CARE

Over the past 10 years, annual costs for SACU services have increased from $47.8 million in fiscal year 2014 to $96.1 million in fiscal year 2024. Operating costs per resident at SACU have increased from approximately $40,000 per month in 2016 to more than $103,000 per month in 2024. Given current budget constraints and uncertainty related to federal Medicaid funding, it is more important than ever to make prudent use of limited resources to promote effective community integration.

CURRENT ENVIRONMENT

REFERRAL SOURCES

SACU residents enter from a variety of referral sources including locations such as hospitals, jails, and other HCBS settings.



It is noteworthy that 60% of referrals to SACU originated from either a similarly licensed 24/7 Home and Community Based (HCBS) provider or Adult Foster Care. SACU is a less restrictive environment than the state hospital or incarceration, but it is a much more restrictive environment than a family home or other HCBS licensed providers.

"FOREVER HOMES"

According to interest holders interviewed and data provided by ODHS, there are six residents who formerly lived at Fairview Training Center and left there when it closed, but later returned to a SACU home and have now lived there for many years. Family members of these individuals report having been promised a "forever home" by the state, so when SACU transitioned to providing short-term crisis stabilization services, these residents chose not to move.

CURRENT ENVIRONMENT

TRANSITION PLANNING

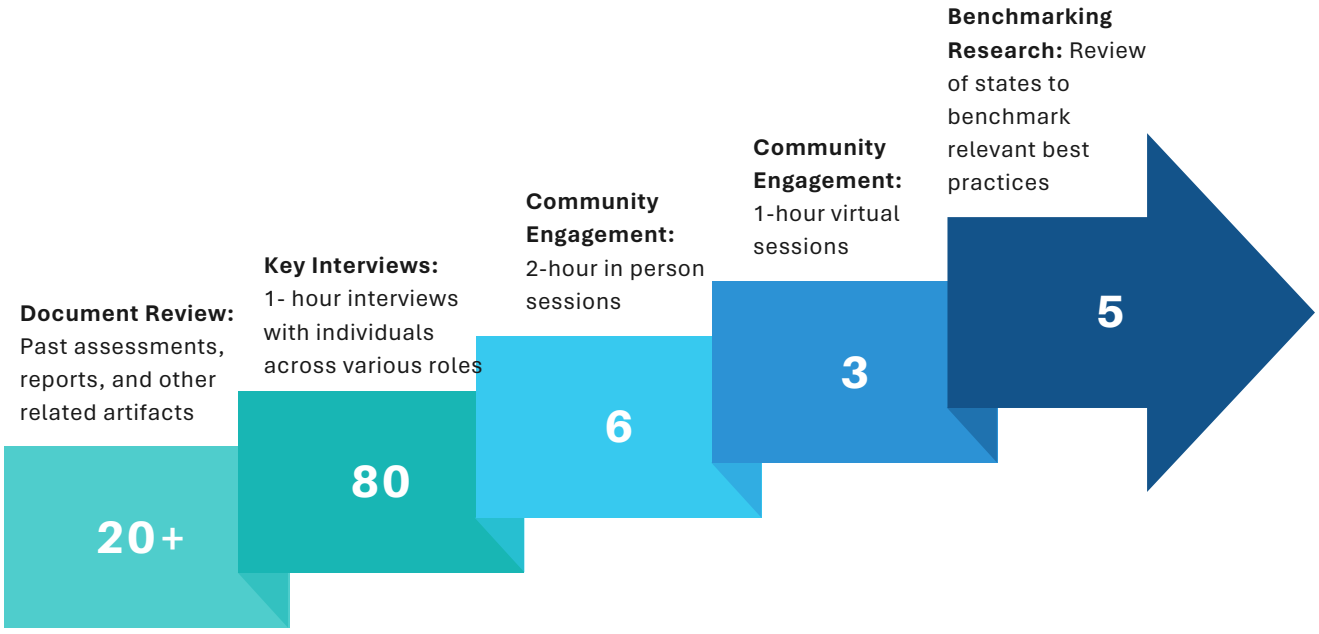
Interest holder feedback reveals a need for a more responsive, person-centered model that offers a continuum of options for people with I/DD and co-occurring mental or behavioral health. This will be essential to prevent unnecessary long-term placements at SACU in the future. If an individual requires a short-term crisis stabilization placement, the desire is for a system with clear process that would facilitate more intentional and timely transitions back to the community than is happening now.

> "We need to start planning for transition right when someone walks in the door—not six months later."
> — SACU staff

03 APPROACH TO DISCOVERY

MULTI-PRONGED APPROACH

The following section reflects input from interest holders across Oregon, gathered through interviews, listening sessions, and written responses. In total, the project team engaged 245+ individuals, including self-advocates, family members and trusted supporters, service providers, advocates, SACU staff, ODDS staff, and more (see Appendix A).



MULTI-PRONGED APPROACH

While this process included input from a wide range of interest holders, there were some important limitations. Individuals interviewed were identified by ODDS in collaboration with the State DD Council, Oregon DD Coalition, Case Management Entities, as well as other partners, who provided the project team with a list of recommended contacts. We reached out to each of these individuals to request an interview; however, not everyone was able or willing to participate.

In addition to conducting interviews with those identified by ODHS, the project team hosted open community listening sessions to invite broader public input from anyone who wished to share their perspective. While this helped expand the range of voices, the overall discovery process was constrained by the project's timeline and scope. Most interviews and listening sessions focused on adults receiving crisis or stabilization services, and while the project team did engage some individuals involved in youth and family systems, issues specific to child welfare and youth services were not a central focus of the discovery process. Additionally, although language interpretation was made available at all community sessions, no participants requiring interpretation attended.

These limitations—particularly the short project timeline—underscore the need for future planning efforts to include more targeted outreach strategies across age groups, cultural communities, and linguistic backgrounds to ensure more comprehensive and inclusive representation in service design and implementation.

04 RESULTS OF DISCOVERY

VALUES

Many interest holders emphasized the importance of centering values in the planning process for SACU. To effectively move through the challenges of implementing the "what" of future services, decision-makers must understand and start by leading with the "why." The following values were shared by interest holders and reflect a commitment to equity, person-centered practices, and respect for individual rights and community inclusion.

RESULTS OF DISCOVERY

A strong consensus exists among interest holders that SACU should focus on its intended role of short-term crisis stabilization, emphasizing person-centered practices and coordinated transitions back to community. Key challenges hindering this shift include gaps in community-based services, inconsistent transition planning, culture and practices that are not fully aligned with HCBS standards, workforce capacity and training needs, coordination gaps with other systems, and negative community perceptions.

> I should not lose an ability to decide where I want to live due to having a mental health crisis I did not choose to have."
> -Self-advocate

RESULTS OF DISCOVERY

THEMES

A strong consensus exists among interest holders that SACU should focus on its intended role of short-term crisis stabilization, emphasizing person-centered practices and coordinated transitions back to community. The following themes emerged during the discovery process.

1

Broad Support for SACU Focus on Short-term Crisis Stabilization

2

Community-Based Service Gaps

3

Inconsistent Transition Planning

4

Culture, Practice, and Compliance with Home and Community-Based Service Standards

5

Workforce Capacity and Training Needs

6

Coordination Gaps

7

Institutional Responses Instead of community Inclusion

BROAD SUPPORT FOR SACU TO FOCUS ON SHORT-TERM CRISIS STABILIZATION

Across interviews, listening sessions, community engagements, and written feedback, there was near unanimous alignment that SACU should focus on its intended role as a short-term crisis stabilization service.

Interest holders from diverse backgrounds, including SACU staff, family members and trusted supporters, providers, advocates, and self-advocates—recognized the importance of this and voiced optimism that it is achievable with the right services, supports and collaboration. Interest holders expressed the desire for a system that is grounded in Person-Centered Practices. Respondents value a system of services and supports that reflects each individual's unique needs, preferences, and lived experience. This aligns with Governor Kotek's stated goal of "Improving the (SACU) program to offer better, more personalized services to help people in crisis."

Many interest holders emphasized that the focus on short-term crisis stabilization is possible and necessary to uphold person-centered values.

Staff and community partners reflected that SACU once operated more effectively to support timely transitions back to community settings and could do so again with intentional system-level coordination.

SACU is often seen as a group of small, institutional living facilities with locked and controlled environments. Self-advocates and their allies stressed that long-term placements in restrictive settings contradict Oregon's commitment to deinstitutionalization and community living.

A crisis is a short-term situation. If an individual with an I/DD and co-occurring behavioral health challenges experiences a crisis, the crisis should not define the next several years of their life.

Many interest holders emphasized the importance of building a robust continuum of crisis services to help individuals remain in their homes and communities and prevent the need for lengthy residential placements. A commonly cited barrier to timely transitions from SACU is the limited availability of appropriate community-based support across the state, including step-down options for individuals who are ready to leave SACU but still need intensive support. Examples include homes with modifications to the physical environment related to individual behavioral health needs, and experienced staff, well-trained to provide positive behavioral support to residents. Interest holders noted a lack of providers willing or equipped to support people with complex behavioral and medical needs.

COMMUNITY BASED SERVICE GAPS

There is concern among interest holders about the lack of therapeutic mental health providers who serve the I/DD population. The wait for accessing mental health care for the general population can be lengthy but for a person with I/DD and co-occurring behavioral health needs the wait can be up to 6-9 months.

Many community-based providers expressed a willingness to step in and help but emphasized the need for support with the costs of additional staffing, specialized training, and home modifications. Several participants mentioned geographic inequities, with rural and frontier regions lacking community-based crisis services.

Some interest holders emphasized the need for a more culturally responsive provider network, including organizations and professionals who reflect the racial, cultural, and linguistic diversity of the individuals they serve. They noted that for many communities, particularly BIPOC and immigrant communities, residential crisis placements outside the home may not be culturally appropriate or trusted.

Several interest holders noted that families and informal supporters are often the primary source of day-to-day support for individuals with complex needs. To be effective, these supporters need access to training, peer mentorship, and resources that help them navigate crisis systems, support transitions, and promote long-term stability—including real-time access to consultation or mobile crisis support during moments of escalation.

Union and SACU staff emphasized that transitions would require the building of community-based capacity that is compensated adequately to provide intensive support.

SACU has recently been working hard to improve intake and transition service and support, participants described SACU's approach to discharge and transition planning as inconsistent or unclear. Many felt that transitions out of SACU happen too slowly—or not at all—because structured planning is not focused on the long-term needs or the goal to move people out of SACU. Others cited the lack of Case Manager initiative as contributing to this issue, at times driven by a belief that it is not possible for the individual to live anywhere else.

INCONSISTENT TRANSITION PLANNING

Several interest holders pointed to Oregon's experience closing Fairview Training Center as a model for how to conduct individualized, person-centered planning and support informed choice during system change.

Interest holders advocated for transition planning to begin at intake, with clear timelines, milestones, and definitions of safety and stability. Some shared frustration that current transition plans are often vague and driven by SACU's structure versus individual needs.

Another issue raised by interest holders is the delay that occurs after transition planning begins. Once an individual is stabilized and a referral packet is prepared and sent to the county case manager to seek community supports, these packets reportedly can sit with county case managers for weeks or months before being shared with potential providers. This lag in initiating provider searches results in extended stays and missed opportunities for timely discharge.

Family members emphasized having experienced emotional and logistical challenges caused by the inconsistent and unclear transition process when planning for their loved ones to return to the community after spending years in SACU. They stressed that a respectful, engaging, organized, methodical, highly communicative process, which includes frequent progress updates to families and trusted supporters, is needed.

CULTURE, PRACTICE, AND COMPLIANCE WITH HOME AND COMMUNITY-BASED SERVICE STANDARDS

Many interviewees described SACU as culturally and operationally isolated from Oregon's broader disability services system. There is strong concern that SACU practices resemble institutional norms of past eras and are not rooted in or in alignment with required HCBS practices and the principles of disability justice. Interviewees emphasized the need for trauma informed, person-centered practices, and a consistent, rights-based approach across all service settings and regions, and called for SACU to meet the same expectations applied elsewhere in Oregon's HCBS system.

> I have caused trauma... and I have been traumatized."
> — SACU staff

CULTURE, PRACTICE, AND COMPLIANCE WITH HOME AND COMMUNITY-BASED SERVICE STANDARDS

- A historical perspective shared by some interest holders emphasized that SACU evolved from institutional origins and has not embraced HCBS principles or standards.
- Interest holders cited concerns about restrictions to community access, transportation and employment opportunities, as well as rights restrictions within the homes including locked doors, access to personal belongings, kitchens, and communication tools, such as specialized communication devices and telephones.
- Legal advocates and disability rights representatives expressed concern that SACU operates in a locked capacity and unethically uses “liability waivers” to get individuals to voluntarily agree to live in a locked facility.
- Several interest holders raised concerns about the absence of therapeutic or rehabilitative services, including psychiatry, counseling, enrichment activities, employment opportunities and structured skill-building opportunities.
- Some state staff and family members described SACU as a "closed system" that resists oversight and external collaboration, and excludes individuals, families, case managers, and prospective future providers from decision-making.
- Some interest holders emphasized that the physical environment in SACU homes contributes to crisis rather than recovery, describing conditions as noisy, stressful, and lacking spaces for privacy or calming sensory input.
- Several interest holders described SACU’s model as one of “readiness”, whereby individuals are expected to prove they are ready to transition to the community, versus holding the belief that everyone can succeed in the community with the right support. This “readiness” model reflects outdated assumptions about safety and risk that conflict with modern person-centered care principles.
- Many interest holders called for differentiating individuals in crisis who need stabilization services from those who have on-going support needs that are more complex. Complex care is needed for many individuals and does not necessitate crisis level interventions.
- If SACU continues to operate under HCBS waiver authorities, changes are needed to its service delivery model and the home environment themselves. These changes should be further evaluated and incorporated into implementation of the SACU strategic plan, to ensure compliance and sustainable federal funding.

COMPLIANCE WITH HOME AND COMMUNITY-BASED SERVICE

Several interest holders emphasized that SACU does not currently adhere to federal Home and Community-Based Services (HCBS) standards. The HCBS Settings Rule, outlined in 42 C.F.R. § 441.530, is intended to ensure that individuals receiving Medicaid services have full access to the greater community and retain autonomy in daily life. Specific requirements include integration with the broader community, unit doors that are lockable by the individual (with access limited to appropriate staff), and the ability for individuals to receive visitors of their choosing at any time.

WORKFORCE CAPACITY AND TRAINING NEEDS

SACU staff are praised for their commitment and have recently been more focused on training. Interest holders identified workforce challenges that limit the unit's effectiveness as a short-term crisis stabilization program. SACU staff are not licensed mental health professionals or trained mental health case managers. SACU's Behavioral Analysts are not mental health professionals, are shared among residences and not always available to consult with the direct support staff.

Interest holders noted a lack of integrated mental health services in SACU homes and emphasized the need for sustained, therapeutic support, particularly for individuals with co-occurring disorders.

There were repeated calls from interest holders for SACU staff to have training in person-centered thinking and planning, trauma-informed practices, positive behavioral supports, de-escalation techniques, and safety practices. There is a concern SACU staff are not using these principles in their service delivery methodologies.

Some noted staff burnout and inconsistent expectations across SACU homes as a challenge to service quality.

Providers and families emphasized the need for experienced and well-trained staff in both SACU and community settings to support smooth stabilization and transition back to community.

COORDINATION GAPS

A recurring theme from interest holders was a lack of coordination between SACU and other parts of Oregon's behavioral health and I/DD systems. Participants described fractured communication, unclear roles, and limited cross-system planning to support effective crisis stabilization. Many raised concerns about disjointed transitions, limited shared accountability, and overreliance on law enforcement in the absence of more appropriate crisis response services. Interest holders noted that people with I/DD do not have access to the mental health services provided in Oregon, such as mobile crisis services, and that there is a lack of coordination between ODDS and OHA.

Transition efforts are often siloed, with limited communication and unclear handoffs between SACU, families, case managers, and community-based providers. The need for dedicated transition planning roles and overlap between SACU and community providers to promote continuity of care was repeatedly heard.

Roles and responsibilities across systems are unclear, particularly when it comes to decision-making about services, supports, and discharge planning. Greater collaboration and shared accountability, noting that SACU staff should not unilaterally decide what individuals need or want, was expressed.

Crisis responses often default to law enforcement, especially in areas without mobile crisis services. Parents, caregivers, and SACU staff described the trauma and risks that can result when law enforcement becomes involved.

Several interest holders emphasized that many of the needed behavioral health services simply do not exist—or are not accessible—for people with I/DD. While local service gaps were acknowledged, participants also pointed to a broader lack of coordination and leadership from Oregon's behavioral health system. Some noted that OHA, as the state agency responsible for behavioral health, has not been consistently engaged in crisis planning or service development for people with I/DD and co-occurring needs. Interest holders stressed that meaningful change would require OHA's direct involvement in system design, funding, and oversight.

Innovative partnerships exist but are limited in reach. Interest holders pointed to the CAHOOTS program in Eugene as an example of a promising collaboration between trained crisis staff and emergency responders.

INSTITUTIONAL RESPONSES INSTEAD OF COMMUNITY INCLUSION

Many interest holders challenged the common belief that SACU is needed to serve people who cannot be supported anywhere else. They emphasized that with the right support, anyone can live successfully in a home or community-based setting and that past struggles with transition should not prevent positive expectations for the future. This theme points to deeper concerns about public and professional perceptions that reinforce long-term, institutional responses instead of community inclusion, and contribute to long-term stays at SACU.

> "People believe some folks just can't live in the community. That's about the system's limits, not the person's."
> -Disability Advocate

Several interest holders noted that these perceptions are shaped more by system limitations than by individual capacity. Others warned that assuming certain people are "too complex" or "too risky" to live in the community undermines the principles of disability rights and reinforces unnecessary segregation.

As noted above, many called for intentional public messaging to reinforce the expectation that everyone can live in the community with the right support. A self-advocate expressed it best: "With the right supports, people can heal and grow."

Perception challenges also appeared in stories shared by families and self-advocates. One parent described SACU as "a crisis emergency room with no transition out," and others shared fears that SACU had become a default long-term solution because community opportunities were underdeveloped or inaccessible. These perspectives highlight the urgent need to address broader public narratives around disability, mental health, and inclusion.

As SACU is refocused, interest holders maintain it must be with the assumption that people with complex needs can live—and are living—successfully long-term in community-based settings. SACU should not be treated as a long-term placement option, but as one part of a broader system that supports timely stabilization and lasting community inclusion.

KEY TAKEAWAYS OF DISCOVERY

This discovery process reflected input from a diverse group of interest holders broad and agreement emerged on a shared vision. SACU should function as a short-term, person-centered crisis stabilization service—not a default long-term placement.

SACU should function as a short-term, person-centered crisis stabilization service—not a default long-term placement.

OPPORTUNITIES

- Investment in intensive support models, culturally responsive providers, and mobile crisis teams across all regions is needed.
- Allocation of stable funding, training, and infrastructure to help community providers serve individuals with complex needs can produce results.
- Choosing a new Medicaid structure to support short term crisis stabilization services and ensure compliance with federal Medicaid requirements.
- Fostering shared leadership between ODDS, OHA, and local partners in service design and oversight could enhance the system.
- Reduced reliance on law enforcement by expanding appropriate, I/DD-competent crisis response options provides an opportunity for system change.

05 IMPLEMENTATION PLAN

Individualized, person-centered planning is the foundation of this transition. Interested parties overwhelmingly endorsed this direction, emphasizing that success also depends on building a statewide crisis response system that delivers preventive, short-term, and long-term supports for people with I/DD.

Outlined below, are two interrelated tracks designed to meet Oregon's crisis response needs for individuals with I/DD and co-occurring behavioral health challenges. While each part has a different focus, they are meant to move forward together, with shared planning and lessons learned along the way.

Together, the strategies aim to responsibly reduce SACU's footprint while creating a sustainable, community-based system that upholds the dignity, safety, and well-being of every individual served.

TRACK 1: SHORT-TERM CRISIS STABILIZATION

SACU was originally intended to provide short-term stabilization services for individuals in crisis, but today it functions largely as a long-term residential program. Repositioning SACU will require both a shift in service philosophy and an operational transition to ensure that individuals receive timely, person-centered support and return to community living when stabilized.

Should the Governor's proposed budget be adopted by the Legislature, SACU would need to implement significant changes on an accelerated timeline. In preparation for that potential scenario, this report outlines an 18-month transition plan designed to support current residents and staff, strengthen provider capacity, and realign SACU with its intended role as a short-term crisis stabilization resource. The plan is offered to guide implementation if that timeline is adopted—not to endorse a particular policy decision.

TRACK 2: DESIGN OREGON'S CRISIS RESPONSE SYSTEM

While refocusing SACU is critical, doing so without addressing upstream system gaps would risk repeating the same patterns. Oregon currently lacks a fully integrated, person-centered crisis response model that spans the full continuum of need—from prevention to post-crisis recovery.

This report outlines an implementation strategy to design and scale a coordinated system that prevents crises where possible, responds effectively when they occur, and promotes long-term stability in the community.

TRACK 2: DESIGN OREGON'S CRISIS RESPONSE SYSTEM

Key components of this system should include:

1. Preventative care and early intervention
2. Community-based mobile crisis response
3. Residential crisis stabilization options
4. Transition supports that promote coordinated reintegration and continuity of care
5. Ongoing community-based services and supports

A critical component of this system is the availability of short-term, community-based housing that provides stabilization services outside of hospitals or institutional settings. These settings should be designed for individuals with co-occurring needs and staffed by multidisciplinary teams that include mental health, disability, substance use, and medical professionals. Services must be person-centered, trauma-informed, and rooted in positive behavioral supports. Transitions back to the community should be coordinated, reduce the risk of future crises, and ensure continued support for individuals and their families.

The following sections provide a phased implementation approach for each track, along with supporting examples and key recommendations.

REAL LIFE SCENARIOS

Below are three concrete examples from community providers in Oregon that make this work real and are evidence that a person-centered transition from SACU to community is both possible and in SACU residents best interest.

(Transition from SACU to community in 2023): There were multiple planning meetings and visits which helped the new ISP team understand actual risks vs. environmental modifications that limited access for all in the SACU home. This person was questioning our staff if they were sure she could really have access to their own clothes, perfume and makeup in the bedroom of their new home. They were ecstatic to have access to these items again, even though there was no apparent reason why they shouldn't have been allowed access during their time in SACU. Their transition was very smooth, they where very quiet and uncertain at first because they had become accustomed to not having access to things like food, their own clothing and hygiene items etc. Once they were assured this was ok they started to "come out of their shell" talking more to staff and housemates, developing friendships with other individuals at other homes and challenging behaviors documented while at SACU became rarely notable.

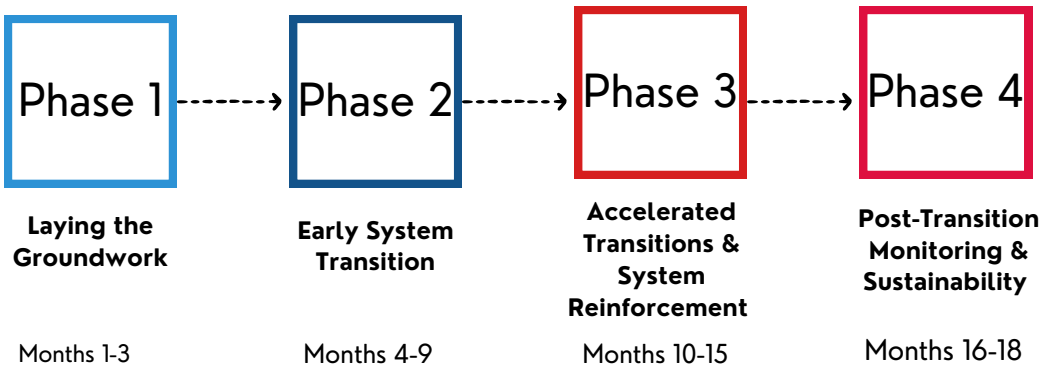
(Transitioned from SACU to community in 2020): This person endured significant trauma early in life resulting in spending a lot of time in/out of psychiatric units before "landing" in SACU for decades. During the transition planning it was made clear they requested to be put on a civil commitment every year so their ISP goals couldn't be modified, they ONLY wanted to do the same few activities and nothing else. McDonalds, Wal-Mart and Panda Express- nothing more. Upon their entry into community, we provided those activities and offered more and more, pretty soon they were joining us for agency parties, community walking events, a gym membership, trying new restaurants and stores, attending and participating in a beach clean-up event and within 1 year stated "I don't need that commitment anymore". All those years their fear wasn't trying something new; it was fear of having those few activities not happen.

(Transitioned from SACU to community provider): This person had bounced around from SACU home to SACU home for 19 years before coming to us. Was reported to us to be nicknamed "hell on wheels", while screening the referral we picked up a theme in the many incident reports I reviewed- POWER STRUGGLES. … After visiting him at the SACU home we had him over to our program for lunch then planned his transition to our home. There were still some challenges, however, each time I saw him when I visited his program he would hold his hands up like he was cheering and shout to me "You, you broke me out of there!!!" Today, 10 or so years later, he now assists in making his favorite meal- tamales, he is heard by staff and has self-direction over his daily routine and activities. He has become a welcome customer at the local coffee shop, they all know him by name and love getting to see him and he them. Those challenging behaviors are very few and far between with positive behavior supports in place, he is living a life with dignity, respect and meaningful relationships.

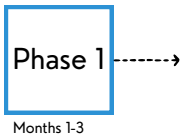
SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

If the Legislature adopts the Governor's proposed SACU budget beginning in July 2026, current long-term residents will need to transition to community-based homes within 18 months, and short-term residents will need to move out as they stabilize.
This plan outlines how Oregon can meet that timeline while maintaining a person-centered approach. Proven practices—both in Oregon and nationally—show that with the right support, individuals with I/DD and co-occurring needs can thrive in community settings. The plan also aims to improve outcomes for future SACU residents by aligning services with short-term crisis stabilization goals.



IMPLEMENTATION PLAN



OBJECTIVES

- Establish leadership and communication structures
- Begin person-centered transition planning
- Launch provider outreach and capacity-building
- Initiate new Medicaid Authority

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 1 ------→

Months 1-3

KEY ACTIONS-MONTH 1

Laying the Groundwork

- Establish SACU Transition Leadership Team (STLT) with self-advocates, families and trusted supporters, state leadership, SACU, ODDS, OHA, county, coordinated care organization, community-based providers, and advocacy organizations to lead the transition process. This team will be responsible to guide and oversee the transition of long term residents from SACU, as well as the implementation of a new practice model for SACU.
  - Finalize transition goals and metrics.
  - Initiate moratorium on new entries to SACU to support downsizing process.
  - Create communication plans and protocols. Ensure clear communication of the plan to residents, families/trusted supporters, case managers, SACU staff, and other interest holders.
  - Create prioritization for transition implementation based on the complexity of each person's support needs.
  - Create a shared dashboard to track prioritization transition status and progress.
- Case managers compile comprehensive resident profiles for each SACU resident, including interdisciplinary team members, support needs, positive behavioral support plans, legal/guardianship status, and any supported decision-making needs.
- Create a Resource Development Unit within ODDS
  - Launch focused community provider outreach to gauge specific interest and capacity gaps.
  - Identify engagement opportunities for developing needed community-based services and supports.
- Choose a new Medicaid Authority that aligns with the provision of short-term crisis stabilization services.

TRACK 1

Phase 1 ------→

Months 1-3

KEY ACTIONS-MONTH 2

Laying the Groundwork

- Use an independent contractor to co-create, with residents and family/trusted supporters, a comprehensive person-centered transition plan for each resident (including desired future state, what is important to and for the individual, residential and ongoing support needs, medical, behavioral, social, cultural preferences, and addresses the social determinants of health).
- Based on the person-centered transition plan, case managers create a service delivery and support plan to address transition and ongoing needs (e.g., housing, staffing, specialized supports, rates, provider home modifications, etc.) for each person. Include needs related to supported decision-making, guardianship, and legal representation, and support needed from SACU staff in the transition process.
- Case managers schedule weekly interdisciplinary team meetings for each individual to implement the transition plan.
- Provide SACU staff training on person-centered thinking, transition planning, trauma-informed care, and positive behavioral supports to support the transition process.
- Outline the practice model to be used under the new Medicaid Authority, including entry, continuous stay and exit criteria.
- Map and assess existing community provider network and identify district and regional gaps.
- Begin to engage community-based providers to address and support transition needs.

KEY ACTIONS-MONTH 3

Laying the Groundwork

- Finalize the practice model to be used under the new Medicaid Authority, including entry, continuous stay and exit criteria.
- Finalize all contracts and/or agreements with providers identified to serve transitioning residents.
- Match each resident to potential community providers or service models, formally engaging them to support identified transition needs.
- Design and schedule training for community providers on dual-diagnosis care, as necessary.
- Finalize funding models to support enhanced supports (staffing, housing, home modifications, transportation, etc.).
- Implement systemwide data dashboard on community stability, crisis incidents, and quality of life.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 2 ------→

Months 4-9

OBJECTIVES

- Start transitions for individuals with less complexity or barriers to transition
- Refine processes and tools through lessons from implementation
- Expand provider engagement and system capacity
- Finalize practice model with corresponding policy manual and training.

Early Transition & System Testing

KEY ACTIONS-MONTH 4

- Based on prioritization, implement person-centered transition plans for the first 25% of residents, with involvement from the individual, their family/trusted supporters, the case manager, SACU staff, and the identified provider.
- Hold weekly care coordination meetings with the interdisciplinary team to coordinate, support, and implement transition plans for each resident.
- Provide ongoing support and training to SACU staff as needed to support the transition process.
- Create policy and practice manual for the new the practice model to be used under the new Medicaid Authority.

KEY ACTIONS-MONTH 5

Early Transition & System Testing

- Continue initiation of person-centered transition plans for the first 25% of residents.
- Case managers monitor first cohort transitions with daily progress reports from the provider; share with the full interdisciplinary team.
- Provide on-site support from SACU staff in the new residence as deemed necessary.
- Continue to support and engage community-based providers; troubleshoot provider capacity and housing modifications.
- Develop staff training curriculum for the new practice model to be used under the new Medicaid Authority.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 2 ------→

Months 4-9

KEY ACTIONS-MONTH 6

Early Transition & System Testing

- Train all SACU staff on the practice model under the new Medicaid Authority.
- Complete moves and implementation of person-centered transition plans for the first cohort.
- Continue to support and engage community-based providers; troubleshoot provider capacity and housing modifications.
- Case Managers continue to monitor first cohort transitions with weekly progress reports from providers; shared with the full interdisciplinary team.
- Leverage state-funded and mandated mental health mobile stabilization teams, augmented with I/DD-behaviorally trained SACU staff for rapid community response.
- Provide targeted mental health consultation to community providers.
- Share lessons learned and best practices from cohort 1 with system partners.

KEY ACTIONS-MONTH 7

Early Transition & System Testing

- Initiate peer support and mentoring for families and residents' post-transition.
- Based on prioritization, implement person-centered transition plans for the next 25% of residents with the individual, their family/trusted supporters, the case manager, SACU staff, and the identified provider.
- Hold weekly care coordination meetings with the interdisciplinary team to coordinate, support, and implement transition plans for each resident in the second cohort.
- Case managers monitor second cohort transitions with daily progress reports from providers; share with full interdisciplinary teams.
- Provide on-site support from SACU staff in the new residence as deemed necessary.
- Continue to support and engage community-based providers; troubleshoot provider capacity and housing modifications.
- Case mangers continue to monitor first cohort transitions with bi-weekly progress reports from providers; share with full interdisciplinary teams.
- Pilot new practice model; evaluate use at staffing and resident level.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 2 ------→

Months 4-9

KEY ACTIONS-MONTH 8

Early Transition & System Testing

- Analyze evaluation of new SACU practice model; make adjustments, update policy manual and retrain staff, if necessary.
- Continue initiation of person-centered transition plans for the second cohort, with on-site SACU staff support as needed.
- Continue to engage and support community-based providers; troubleshoot provider issues and capacity.
- Case managers monitor second cohort transitions with weekly progress reports from providers; share with full interdisciplinary teams.
- Case managers continue to monitor first cohort transitions with bi-weekly progress reports from providers; share with full interdisciplinary teams.
- Identify any early re-admission risks or service breakdowns.
- Expand provider training on trauma-informed care and cultural competence as needed.

KEY ACTIONS-MONTH 9

Early Transition & System Testing

- Fully implement new SACU practice model.
- Complete moves and implementation of person-centered transition plans for the second 25% cohort.
- Continue to support and engage community-based providers; troubleshoot provider capacity and housing modifications.
- Case managers continue to monitor first cohort transitions with bi-weekly progress reports and second cohort with weekly progress reports from providers; share with full interdisciplinary teams.
- Decommission vacated beds from first 50% of transitions.
- Evaluate staffing patterns at SACU. Engage Human Resources to evaluate staffing patterns and Collective Bargaining Agreement implications; create plan to redeploy resources to community stabilization or other roles.
- Evaluate moratorium on new entries and create a plan for lifting the moratorium to begin to allow new entries under the new practice model.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 3 -------→

Months 10-15

OBJECTIVES

- Scale up transitions for remaining residents.
- Begin accepting new entries to SACU, based on capacity.
- Reinforce community infrastructure and provider readiness.
- Engage residents and families for continuous improvement of new practice model.

KEY ACTIONS-MONTH 10

- Transition cohort 3 (the next 25% of residents, or as ready for transition based on stabilization goals) using the same person-centered planning and implementation process as prior cohorts.
- Address remaining high-complexity housing and provider gaps; begin planning with providers to ensure capacity for individuals requiring ongoing supports after SACU discharge.
- Host statewide community of practice engagement and learning sessions for provider agencies.

KEY ACTIONS-MONTH 11

- Continue transitions for cohort 3, following established processes.
- Provide clinical wraparound teams for individuals with the highest needs.
- Evaluate and adjust the statewide provider payment model based on real cost data. Review the "rate exception" process to ensure it is streamlined and responsive to provider feedback.

Accelerated Transitions & System Reinforcement

KEY ACTIONS-MONTH 12

- Complete transitions for cohort 3, following the established process for monitoring, support, evaluation, and communication.
- Continue to provide intensive technical assistance and consultation to new community providers.
- Conduct reviews with residents, families, trusted supporters, staff, providers and other partners to identify any needed adjustments to licensure, rate-setting, and service design.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 4 ------→

Months 16-18

Accelerated Transitions & System Reinforcement

KEY ACTIONS-MONTH 13

- Initiate any remaining planned transitions, following established processes.
- Conduct a statewide review of transition outcomes, including length of stay, incidents, satisfaction, and costs.
- Align staff roles with new crisis service delivery model.

KEY ACTIONS-MONTH 14

- Finalize the future use or redesign of identified SACU sites based on regional needs (e.g., repurpose as short-term stabilization or respite homes).
- Initiate post-transition individual and family satisfaction surveys.
- Begin developing a post-transition sustainability plan.

KEY ACTIONS-MONTH 15

- Publish a report on transition outcomes and recommendations for long-term system improvement.

Phase 3 ------→

Months 10-15

Post-Transition Monitoring & Sustainability

OBJECTIVES

- Monitor transitions and ensure long-term stability
- Finalize oversight structures and sustainability planning
- Capture and share lessons learned

KEY ACTIONS-MONTH 16

- Conduct follow-up reviews for all transitioned individuals.
- Adjust care plans and community supports as needed.
- Finalize contracts with long-term stabilization homes and respite options to provide ongoing support for future needs and former SACU residents.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 1

Phase 4 ------→

Months 16-18

KEY ACTIONS-MONTH 17

Evaluate remaining workforce and system redesign needs post-transition.

KEY ACTIONS-MONTH 18

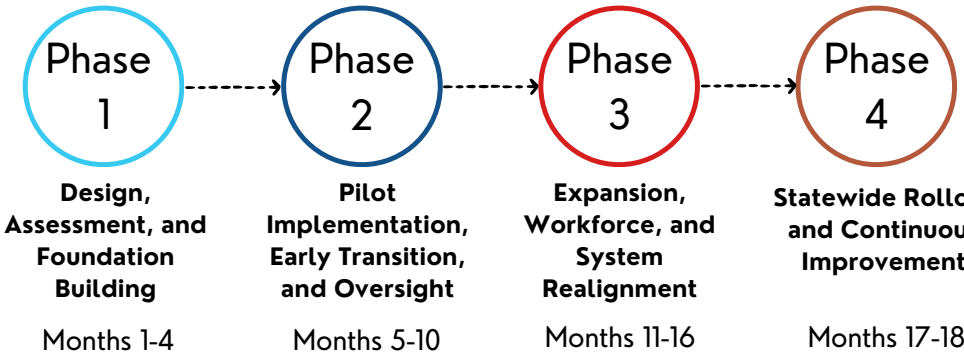
Post-Transition Monitoring & Sustainability

- Sunset the SACU Transition Leadership Team and establish a Community Integration Oversight Committee.
- Develop a five-year strategic plan for continued investment in person-centered community living.
- Issue a final report to the Legislature and the public on transition outcomes and lessons learned.

CRISIS RESPONSE SYSTEM - IMPLEMENTATION PLAN

TRACK 2

Key recommendations below are organized in priority order based on the most critical issues identified during the engagement process and outline for a 18-month timeline to start the implementation of the redesign of Oregon's Crisis Response System.



Phase 1

OBJECTIVES

- Design and agree upon, in detail, the future state crisis response system for individuals with I/DD and co-occurring mental health needs.
- Assess actual system demand and gaps statewide.
- Establish shared interagency accountability.
- Lay the foundation for sustainability (funding, operations, and workforce).

Phase 1

KEY ACTIONS

- Establish a Transformation Taskforce made up of ODHS, ODDS, SACU, OHA, local providers, people with lived experience, and advocates.
- Conduct a comprehensive crisis needs assessment, examining:
  - Geographic gaps
  - Population demand (youth, adults, medically complex)
  - Crisis types and presenting conditions
- Design the future crisis system, including:
  - Prevention and diversion strategies
  - 24/7 mobile crisis teams
  - Short-term residential crisis stabilization
  - Therapeutic respite and step-down housing
- Launch ODDS Resource Development Unit to:
  - Build provider capacity
  - Design a new "medically complex" model
  - Identify community partners for transitions
- Create a draft financial model identifying current SACU resource use, reinvestment needs, and alternate funding (Medicaid, waiver, local match, etc.).
- Begin engagement sessions with interest holders statewide to validate design and co-create solutions.

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 2

Phase 2

OBJECTIVES

- Launch pilot sites for the new crisis system
- Begin long-term SACU resident transitions
- Establish oversight and program integrity structures

Phase 2

KEY ACTIONS

- Begin transitions of SACU residents, using person-centered plans to move those ready for community living.
- Operationalize the "medically complex" home model outside of SACU.
- Launch crisis response system pilots in at least 3 sites that include:
  - Mobile crisis response
  - Crisis case management
  - Community stabilization options
- Decommission SACU beds as individuals move out and reallocate resources to pilot efforts.
- Establish an Independent Oversight Entity, led by ODDS and including external compliance and quality experts, to:
  - Monitor licensing and program standards
  - Ensure SACU alignment with HCBS and waiver rules
  - Develop a core data metrics framework, including:
    - Utilization (calls, transports, stabilization episodes)
    - Avoidable hospitalizations and institutionalization
    - Workforce capacity and training completion
    - Interest holder satisfaction and outcome tracking

Phase 3

OBJECTIVES

- Complete transitions of long-term SACU residents
- Scale the new crisis response model
- Ensure the workforce is trained and ready

SHORT-TERM STABILIZATION - IMPLEMENTATION PLAN

TRACK 2

Phase 3

KEY ACTIONS

- Finalize all long-term SACU transitions with tailored housing and support plans.
- Expand pilot components statewide, refining them based on lessons learned (e.g., adapting the case management model for rural areas).
- Recruit and train crisis response staff across the state, ensuring proficiency in:
  - Trauma-informed care
  - Positive behavioral supports
  - Crisis de-escalation
  - Co-occurring condition support
- Develop provider readiness plans for each county or region, including technical assistance and start-up resources.
- Engage community members and families through public forums and communication campaigns.

Phase 4

OBJECTIVES

- Fully implement the new statewide crisis response system
- Institutionalize evaluation and continuous improvement mechanisms

Phase 4

KEY ACTIONS

- Achieve full implementation of community-based crisis response, short-term stabilization, and transition supports across Oregon.
- Complete transition of all long-term SACU residents.
- Conduct formal outcome evaluation, measuring:
  - Reduced use of institutional beds
  - Increased successful community placements
  - Service access by geography and population group
  - Resident and family satisfaction
- Refine programs based on data, including service models, funding flows, and policy alignment.
- Publish an annual report on the system transformation, with recommendations for continued evolution and legislative support.

VALUE PROPOSITION

By implementing these recommendations, Oregon can achieve the following outcomes that are in direct alignment with the values of what interest holders said matters most to them, captured on page #11:

Community Living as the Default: Expand access to long-term, community-based homes and services for current SACU residents and others with complex needs. Reinforce the expectation that SACU is not a long-term placement, and that with the right support, everyone can succeed in the community.

Effective Crisis Stabilization: SACU functions as a short-term, person-centered stabilization resource that provides immediate and intensive support to individuals with I/DD experiencing crises.

Timely Transitions to Community: Individuals stabilize and transition back to community-based services within timelines aligned with best practices for crisis care.

Strengthened Community-Based Crisis Supports: Enhanced coordination with mobile crisis teams, behavioral health services, and other community providers to prevent unnecessary SACU placements.

Financial Sustainability: A cost-effective and transparent financial model that aligns resources with individual needs while ensuring long-term system sustainability.

Regulatory Compliance: Full alignment with HCBS standards, ensuring SACU operates within federal Medicaid guidelines and prioritizes the least-restrictive environment.

Transparent and Consistent Practices: Clear policies and procedures that reflect best practices in trauma-informed care, person-centered planning, positive behavioral support, and crisis intervention.

Workforce Development: A trained and supported workforce equipped to assist individuals in crisis and facilitate successful transitions back to community settings.

Quality Data: Real-time, reliable data to support continuous quality improvement, inform decision-making, and promote accountability across SACU operations and system partners.

06 PLANNING CONSIDERATIONS

Planning for the future of SACU must account for the complexity of the broader systems in which it operates. SACU is shaped by its own organizational culture and legacy practices and by the structures, policies, and gaps across Oregon's developmental disabilities and behavioral health systems. Focusing SACU as a short-term crisis stabilization program requires thoughtful alignment across multiple elements of the system. This includes decisions about how employees are assigned, and individuals are supported, how rules and expectations are structured, how SACU connects with others in the service system, how day-to-day services are delivered, and how coordination and accountability are built into the system. These planning considerations are described below.

PEOPLE

"People" includes both SACU employees and the individuals supported by SACU. Each group plays a vital role in shaping SACU's present and future. As planning for SACU's refocus continues, both employees and individuals served - along with their families and trusted supporters—should be actively engaged in the process.

SACU EMPLOYEES

Planning for SACU's future must carefully consider how staff are supported, assigned, and equipped to carry out the program's services. Staff experience, training, and structure are essential for delivering high-quality, person-centered services in a short-term stabilization model. It is especially important to ensure that staff are placed in positions where their roles, responsibilities, and core attributes align with the specific needs of supporting individuals at SACU. Matching the right staff to the right roles helps ensure effective, compassionate, and specialized care.

Person Centered Staffing Model: Staffing ratios should be flexible and based on the assessed needs of people supported in each home, rather than having a set number of staff assigned to each home, regardless of who is receiving services at the time. This staffing model may result in fewer staff being assigned to individual homes or at different times, depending on need, and the need for cross-training for staff. Planning should also consider geographical locations and ensure sufficient capacity for short-term stabilization and active transition planning—including roles such as behavior support professionals, communication specialists, and psychiatric or mental health consultants. The net result of how many staff are needed and in what roles should be based on a more complete analysis in a future pre-implementation phase.

SACU EMPLOYEES

Management and Oversight: Planning efforts should evaluate SACU's supervisory structure, including adjusting span of control, enhancing on-site leadership roles, and establishing pathways for frontline coaching using lead workers and shift supervisors. Consideration should be given to how staff roles are supervised and supported to maximize alignment with SACU's purpose.

Training and Development: Based on feedback from interest holders, staff training today appears to be informal or "on-the-job." A more structured and rigorous training plan is needed to prepare staff for SACU's role providing short-term crisis stabilization. This plan should be anchored around an adopted person-centered crisis response model of care, begin at onboarding and include regular retraining opportunities to ensure consistent practice over time. It should also build staff capacity to deliver short-term, person-centered, trauma-informed stabilization services, positive behavioral supports and support timely transitions. Core competencies should include person-centered planning, positive behavior supports, de-escalation, effective communication, support for individuals with dual diagnoses, and strategies for ensuring safety—for both individuals and staff—through proactive, non-restrictive approaches wherever possible. Overall staff training should be aligned to the needs of those being served. It is also important to recognize that SACU staff are not licensed behavioral health clinicians or treatment providers—they are direct support professionals. While SACU's future model must incorporate behavioral health services, that will require partnerships with licensed mental health and substance use professionals who can provide those services in SACU homes.

Workload and Retention: SACU's current operations rely heavily on overtime and mandated shifts, contributing to unsustainable workloads and significant pressure on operating budgets. Staff report routinely working 16-hour shifts and having limited ability to take the time earned off. To improve retention and service quality, SACU must adopt staffing strategies that proactively manage workload, reduce reliance on overtime, and promote long-term staff well-being. This includes ensuring adequate staffing levels, streamlining responsibilities, and empowering managers to monitor staffing in real time. Additionally, the agency should analyze correlations between staffing patterns and overtime costs to identify targeted adjustments that balance fiscal responsibility with staff and individual needs.

INDIVIDUALS SERVED

Individuals served by SACU—many of whom have experienced significant trauma, instability, or exclusion—must remain central to the planning process. While much of the system discussion focuses on policy, staffing, or funding, the lived experience of people receiving crisis services must guide how services are structured and delivered. Anchored in the HCBS waiver is the concept of "Dignity of Risk" where individuals have the right to take risks and make their own choices, even if those choices involve potential harm or failure. It acknowledges that personal growth, autonomy, and self-determination often involve taking risks, and that protecting people from all potential harm can limit their independence and quality of life. In human services, honoring the dignity of risk means supporting individuals to make informed decisions while respecting their autonomy.

Duration of Stay: SACU is intended to be a short-term stabilization program, yet many people remain in SACU for years. Future planning must ensure that people are not kept in restrictive settings longer than necessary and that there is a clear path back to community life. At the same time, interest holders expressed concern about the pendulum swinging too far in the other direction—where stays are arbitrarily limited without adequate stabilization. As part of future planning, SACU should define timelines or ranges for length of stays (e.g., 60, 90, or 120 days), but ensure a person-centered process is in place for assessing what people need and want and adjusting timelines and services accordingly. Essential at intake is to develop a clear definition of what "stabilization" is defined as for each individual. Absent this, SACU staff reported the "stable enough to transition" bar just keeps moving throughout care leading to prolonged and unnecessarily long stays.

Individualized Planning for Current Residents: A person-centered plan must be developed for each person currently residing at SACU. An intensive, person-centered approach should guide decisions about a transition plan for each person, and ensure that people are not left behind simply because new options do not yet exist. Transition planning should focus on matching people's needs with the right environment and supports, whether that includes continued crisis stabilization, returning to a family home or one's community or transition to community-based services.

INDIVIDUALS SERVED

Individualized Crisis Supports: Individuals deserve person-centered, therapeutic support that leads to healing and recovery. This support must be available before, during, and following a crisis to promote stabilization and prevent future crises. Services should be active, rehabilitative and include opportunities for mental health services, needed therapy, emotional regulation, employment, and meaningful daily engagement. Individuals should have access to structured activities that promote healing and connection, such as expressive arts, peer interaction, and opportunities to contribute meaningfully (e.g., employment, volunteer opportunities, etc.). Physical environments should be trauma-informed, calming, and designed to reduce stress.

Family & Informal Supports: Families and informal support play a crucial role in the lives of individuals entering SACU, both during the crisis and throughout their recovery journey. Their involvement is essential in providing emotional support, continuity of care, and a sense of familiarity that promotes stability and well-being. Engaging families and informal supports not only helps residents feel more connected and valued but also fosters stronger, more person-centered care plans. Additionally, involving these supports during the transition back to the community ensures that residents have the necessary relationships and resources to maintain progress and continue thriving after leaving SACU's care.

By actively collaborating with families and informal supports, SACU can enhance both the immediate and long-term outcomes for residents. Future planning efforts should also ensure that families and informal supporters have access to training, peer support, and real-time consultation during times of crisis, recognizing their central role in supporting stability both during and after SACU stays.

POLICY

Continuity and Connection: It is essential to promote continuity of care and ongoing relationships with family, friends, and trusted supporters. Crisis stabilization should be embedded in a broader arc of support that prioritizes healing, identity, and inclusion. Future planning should include intentional strategies for helping people maintain or rebuild relationships throughout their stay including regular, supported contact with loved ones and trusted supporters, consistent staffing, and clear pathways for reconnection to their home communities.

Family and other natural supports should be actively engaged in services and transition planning. The individual's ongoing case manager is best positioned to facilitate this engagement and ensure continuity across service settings, so it is important they play an active and leading role in supporting individuals served by SACU.

MEDICAID AUTHORITIES AND STRUCTURAL ALIGNMENT

SACU's current Medicaid funding through Oregon's long-term services and supports (LTSS) authorities—primarily the K Plan (1915(k)) and I/DD waivers (1915(c))—limits the ability to operate as a short-term, crisis stabilization program. These authorities are designed for long-term care and do not accommodate the time-limited, acute nature of crisis services. Without a revised waiver structure or dual Medicaid licensing, Oregon risks non-compliance with federal regulations. This could jeopardize federal matching funds, which would have devastating financial consequences for the state's service system.
To avoid this outcome and support SACU's planned transformation, Oregon must choose an alternative Medicaid authority that is better aligned with short-term, crisis-focused services. Options include the following.

Redesigning SACU requires a thoughtful policy framework that aligns legal authorities, regulatory structures, and funding mechanisms with the vision of short-term, person-centered crisis stabilization. This section outlines three key areas for policy change: Medicaid authorities, licensing and quality assurance, and rate setting for community-based providers.

- Continuing under existing HCBS authorities in full compliance with the HCBS Settings Rule, though this would limit SACU's ability to operate with time-limited goals or transitional expectations. For example, they would not be able to operate as a locked/secure setting, as that violates HCBS rights.
- Transferring oversight to Oregon Health Authority (OHA) and operating SACU under Medicaid behavioral health authorities, such as 1915(a) or 1115 waiver, which are more compatible with short-term, clinical crisis services.
- Creating a new, targeted 1915(c) waiver specifically for individuals with I/DD and behavioral crisis needs. This could allow for time-limited services, specialized staffing, and targeted provider qualifications while keeping SACU within the I/DD system.

MEDICAID AUTHORITIES AND STRUCTURAL ALIGNMENT

Any of these options would require a clear definition of SACU's role and alignment of the service model with appropriate Medicaid structures, including person-centered planning, transition supports, and coordination with community services. The comparison table below summarizes the key policy options and how some other states are approaching similar challenges.

COMPARISON OF MEDICAID OPTIONS FOR CRISIS STABILIZATION SERVICES

Approach	Description	Pros	Cons	Examples
1) Fully HCBS-Compliant under 1915(k)/1915(c)	Maintain SACU under ODDS, fully compliant with HCBS Settings Rule (no locks, no time limits). Focus on long-term support.	Aligns with I/DD values and continuity of care; maintains current funding structure.	Limited ability to operate as a true short-term crisis model; lacks discharge triggers or requirements.	Oregon's current SACU (aspirational); some group homes in states like Vermont
2) Behavioral Health Oversight (OHA) via 1915(a)/1115	Shift oversight to OHA; use clinical Medicaid authorities to operate SACU as a short-term behavioral health crisis program.	Legally and clinically aligned with short-term crisis care	May conflict with disability rights goals; risks shifting away from I/DD-centered values.	Arizona (Long-term care + behavioral health), North Carolina (MCOs), New York (1115 BH carve-outs)
3) New 1915(c) Waiver for Crisis Services	Create a new targeted waiver for individuals with I/DD and behavioral crisis needs, with time-limited services and specialized support.	Stays in I/DD system while allowing customization and defined timelines for services.	Requires CMS approval and new infrastructure; still must ensure HCBS compliance.	Conceptual – Maine exploring crisis-specific I/DD waiver; model from parts of what California is doing.
4) Hybrid Model using Multiple Authorities*	Combine existing authorities (e.g., 1915(k) for LTSS + 1915(I) or rehab option for crisis). Tailor services based on individual needs.	Flexible, can tailor services to diverse needs; supports continuity across settings.	Complex to administer and coordinate; risks fragmentation or duplication of services.	California (Claim), Michigan (layers I/DD and MH services under Prepaid inpatient health plans); Minnesota (mix of 1915(c), general funds, and regional MH partnerships)

COMPARISON OF MEDICAID OPTIONS FOR CRISIS STABILIZATION SERVICES

A hybrid model would offer flexibility across populations and settings and could support a "step-down" system of care. If adopted, this approach would require seamless case management across service settings to prevent fragmentation and ensure continuity of care across services.

Additionally, because SACU is an HCBS service, Medicaid prohibits billing for additional HCBS services during that time, as it would constitute duplicate billing. As a result, individuals at SACU are effectively cut off from services designed to promote long-term stability and reintegration. This disconnect contributes to prolonged stays and disrupts continuity of care, so the state of Oregon should invest state funding to bridge identified gaps.

LICENSING AND QUALITY ASSURANCE

ODHS staff and other interest holders emphasized the need for clearer standards and expectations related to quality oversight and regulatory compliance, particularly for a program as unique as SACU. Observations from multiple interviews pointed to gaps in accountability and consistency, including ambiguity around which rules apply, how they are enforced, and how SACU's services are evaluated. Specific concerns included inconsistencies in how quality is measured across homes, unclear responsibility for monitoring practices such as incident response and medication administration, and limited oversight of individual spending accounts and other personalized supports.

There are two distinct but related oversight challenges that require planning attention. First, SACU's status as a state-operated program presents unique challenges for internal accountability, especially when oversight responsibilities are shared across multiple offices within ODHS. Interest holders noted the difficulty of holding a program accountable when the oversight body and the operator are part of the same agency, and some suggested a true conflict of interest. Second, many suggested the need for a more differentiated licensing or credentialing model for community-based providers—such as tiered credentials or enhanced requirements for homes serving individuals with complex needs. This type of structure could help ensure that providers are matched to individuals' support needs and held to consistent expectations for quality and safety.

As ODHS continues to gather operational insights, planning teams should consider how SACU's future oversight structure can promote transparency, accountability, and alignment with its refocused role as a short-term crisis stabilization program.

RATE SETTING FOR COMMUNITY-BASED PROVIDERS

Successfully focusing SACU as a short-term crisis stabilization program will require strong partnerships across Oregon's I/DD, behavioral health, and broader human services systems. Today, SACU often operates in isolation from the very providers and agencies that should be working in coordination to support individuals through crisis and transition.

Interest holders consistently emphasized the need to break down silos and build more collaborative systems of care. This includes creating new opportunities for shared training, data sharing, coordinated planning, and sustained cross-system engagement. It will take intentionality and grace by all involved to complete this "partnership" work given the realities of past efforts resulting in challenging outcomes.

The following are key partnership priorities that should be addressed through future planning efforts:

PARTNERSHIPS

Effective transition back to community from SACU, and prevention of unnecessary admission, requires a robust provider network capable of supporting people with complex needs in the community. Current rate methodologies were widely described by interest holders as insufficient to reflect the staffing, training, and environmental needs associated with high-acuity individuals. Providers noted several key areas not adequately accounted for in current rate structures:

- Wages for staff commensurate with specialized skills (e.g., positive behavior support specialists).
- Appropriate levels of supervision or on-call clinical consultation.
- Environmental modifications to ensure safety and accessibility.
- Funding for increased staffing during times of crisis or transition.

Several interest holders, including ODDS licensing staff, suggested exploring a tiered licensing or credentialing model to help distinguish providers equipped to support individuals with more complex needs. Aligning rate structures and licensing models could better match provider capacity with the support needs of individuals transitioning from SACU or at risk of entering SACU without adequate community support. On many occasions, interest holders and providers referenced the current annual cost of caring for an individual at SACU to what providers are paid to care for some challenging situations.

INTEGRATED PLANNING AND COMMUNICATION

- Communication and shared planning should begin before intake at SACU, as part of prevention, and continue through stabilization and transition. SACU should coordinate closely with case managers, families, and future community providers from the beginning of each stay.
- SACU should proactively invite community providers into homes and send SACU staff to visit community placements prior to transition to build relationships and ensure continuity.
- Shared planning tools and consistent roles across SACU, case management, and providers can promote smoother handoffs and reduce delays.

CROSS-SYSTEM COLLABORATION

- SACU should collaborate with OHA and mental and behavioral health systems to ensure individuals receive whole-person care, including psychiatric and therapeutic supports during and after a crisis. This includes initiating or expanding specialized contracts with external providers and addressing current procurement processes, which are often lengthy and prevent timely access to essential services such as psychiatry or counseling.
- Oregon law requires mobile crisis response teams be available statewide to address behavioral health crises in the community. Many areas are still building capacity to meet this requirement, and the current teams are not trained to support individuals with I/DD and co-occurring behavioral health needs. SACU and ODDS build on this state requirement, partner with these teams more closely and advocate for expanded infrastructure that includes the skills, training, and multidisciplinary expertise needed to respond effectively to people with complex needs—both during crises and as individuals transition out of SACU.
- Effective crisis response requires coordination not only at the individual level, but also at the systems level. ODHS, OHA, and county partners must work together to define shared responsibilities, align funding streams, and ensure consistent access to services across regions. Without formal structures for interagency collaboration, efforts to expand or improve services risk fragmentation, duplication, or delay.
- OHA—as the single state Medicaid agency and responsible for the behavioral health system—must play an active leadership role in addressing the long-standing service gaps faced by people with I/DD and co-occurring mental health needs. Without OHA's leadership in strategy, funding, and oversight, Oregon cannot build a truly integrated crisis response system, and the behavioral health needs of people with I/DD will continue to go unmet.

SPECIFIC POPULATIONS AND CRITICAL SYSTEM PARTNERS

- Children and youth entering SACU must be supported through partnerships with Child Welfare, school districts, and early intervention programs to ensure access to the right support early on.
- Family caregivers and informal supporters are critical and should be engaged as the foundational support for individuals – they must also have access to support such as mobile consultation, respite, and peer mentorship.
- Stronger partnerships are needed with Vocational Rehabilitation, housing agencies, and dental and medical providers to ensure access to community-based, whole-person support. Employment has been shown to be an important component of the recovery and stabilization process.
- Family members, guardians, and self-advocates must remain engaged through intentional strategies, including advisory committees or other structures that provide input on SACU operations.

COMMUNITY ENGAGEMENT AND CAPACITY BUILDING

- Community providers shared interest in partnering with ODDS and SACU but noted the need for clear expectations, role clarity, and resources to support transitions.
- Future planning should include formal structures for ODDS to work with community providers in designing individualized transitions and to identify the support needed to ensure long-term success.
- Community providers need to reflect the racial, cultural, and linguistic diversity of the people they support. Building an inclusive provider network—with professionals who understand and represent the lived experiences of BIPOC individuals and families—is essential to delivering equitable, person-centered care.
- Reimbursement structures must account for the actual costs of supporting people with complex needs. Interest holders cited specific cost drivers not addressed in current rates, including pre-planning activities, home modifications, specialized staffing assignments, and increased supervision.
- There may be opportunities to build regional, county-based, and district partnerships, such as Minnesota's Metro Crisis Coordination Program (MCCP), which blends funding across systems to support flexible, community-based crisis responses. SACU could play an active role in supporting local crisis response

LAW ENFORCEMENT AND FIRST RESPONDER COORDINATION

Many interest holders raised the need to strengthen partnerships with law enforcement (police) and emergency responders to reduce unnecessary institutional admissions and ensure people with I/DD are served in the most appropriate settings.

Interest holders want to see both increased availability of mobile crisis teams as alternatives to law enforcement response and expanded cross-training for law enforcement and first responders to reduce the trauma and risks associated with those interactions.

PRACTICE

Delivering effective crisis support for people with I/DD, especially those with co-occurring mental health needs, requires a clearly defined and person-centered practice model. This model must encompass the entire crisis continuum, prevention, intervention, stabilization, and recovery, and be aligned with the principles of community inclusion, trauma-informed care, and individual dignity.

Interest holders consistently expressed a desire to see SACU operate as one part of a broader, integrated crisis response system. They emphasized that services should be proactive, time-limited, and designed to help people stabilize and return to their home or community with the right support in place.

This section describes how services could be delivered across the crisis continuum and where SACU fits within that vision.

COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

Crisis services should not begin at the point of crisis. Oregon must invest in upstream support that helps people with I/DD and co-occurring behavioral health challenges remain stable in their homes and communities. These services can prevent escalation, reduce admissions to SACU, and improve quality of life. Key practices include:

COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

- Proactive identification of individuals at risk of crisis through collaboration with case managers, providers, and families.
- Preventive behavioral and mental health supports, including outpatient therapy, crisis planning, and skill-building.
- Prevention support must also equip families and informal caregivers with tools to respond to early signs of distress. Proactive supports for families—including access to training, coaching, and peer connection—can reduce caregiver burnout and help prevent crises before they occur.
- Clear processes for referring and connecting people to additional supports before a crisis occurs.

SACU's existing Crisis Outreach and Assistance Team (COAT) could play a stronger role in providing home- and community-based support during times of escalating need. Interest holders described opportunities for COAT to partner with individuals, families, and providers to stabilize situations in the community and prevent unnecessary admission to SACU.

CRISIS RESPONSE (SOMEONE TO CALL AND SOMEONE TO RESPOND)

When a crisis does occur, individuals and families need access to timely, appropriate, and integrated crisis response services. Today, most regions in Oregon lack effective mobile crisis teams that are equipped to serve people with I/DD. Interest holders noted that existing mobile response options often default to law enforcement or are not designed for people with co-occurring conditions. This leaves family members and trusted supporters with little real-time assistance during high-stress situations—often resulting in avoidable trauma, escalation, or emergency system involvement. A well-functioning crisis response system should support not only the individual in crisis, but also those who care for them. Best practices in this area include:

- Expanding non-law enforcement mobile crisis response teams trained in supporting people with I/DD and dual diagnoses.
- Embedding mental health professionals within emergency response systems.
- Build on Oregon Health Authority's (OHA) Chapter 309 mandate by cross-training mobile crisis teams to respond to both behavioral health and disability-related crises.
- Equipping teams to respond in homes or community settings to avoid unnecessary institutional placement.

SACU's COAT team, Eugene's CAHOOTS program, and other similar efforts could serve as a foundation for this work. offering mobile outreach and assessment capabilities that are tailored to individuals with I/DD.

STABILIZATION SUPPORT AT SACU

SACU should serve as a short-term stabilization program for individuals who need structured, intensive support to regain stability. Interest holders were clear that services must be active and therapeutic, not passive, or custodial. Key components of high-quality stabilization services include:

- A clear, person-centered definition of stabilization for each person, created in partnership with the person and their trusted supporters.
- Individualized services that promote emotional regulation, communication, and healing.
- Active daily programming such as expressive arts, movement, skill-building, and social connection.
- Therapeutic supports integrated into daily routines and environments, not siloed or limited to one staff role.
- Behavioral health services must be delivered through partnerships with licensed professionals or integrated into the staffing model, as SACU staff are not currently licensed treatment providers.
- Trauma-informed environments designed to reduce stress and promote safety, privacy, and autonomy.

Services should begin with intake and include clear goals and timelines. While SACU should establish target durations for stays (e.g., 60, 90, or 120 days), length of stay decisions must be flexible and grounded in the person's needs and preferences, not arbitrary time limits or system constraints. The underlying assumption must always be that people belong in the community and can succeed with the right support.

TRANSITION SUPPORTS

Successful crisis stabilization must include a clear path to community reintegration. Interest holders emphasized that transition planning should begin at intake and include shared milestones and supports that help individuals and teams define what stabilization looks like in the context of each person's goals. Entry to SACU should trigger a comprehensive bio-psycho-social assessment to identify the person's support needs and help determine the types of services and environments that will best promote recovery, as well as a person-centered plan to address long-term needs and stability. While short-term stays should be the default, all planning must begin with the assumption that everyone can live successfully in the community with the right supports. The goal is not to wait for someone to meet institutional criteria for discharge, but to identify what will help them succeed after they leave. Best practices include:

- Developing a transition plan at intake with clearly defined goals and milestones, including a shared definition of what "stabilization" means for each person.
- Developing a person-centered plan.
- Creating overlaps between SACU and community providers to build relationships and shared understanding.
- Ensuring access to transition-focused services such as behavioral supports, peer mentoring, and home visits.

Interest holders also recommended extending SACU's role beyond discharge. SACU's COAT or other outreach teams could provide follow-up support to individuals as they settle into their new homes, offering consistency and proactive problem-solving to prevent re-entry.

INTEGRATED, PERSON-CENTERED MODEL OF CARE

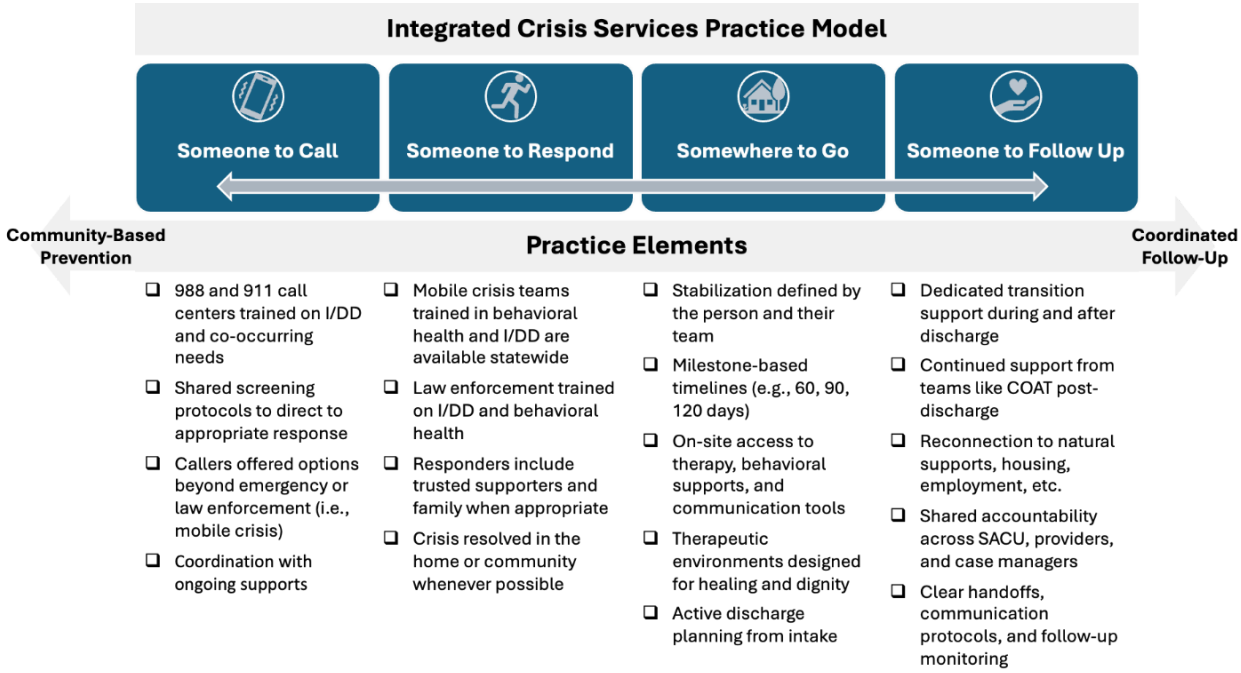
Across the continuum, services must be grounded in the needs and preferences of individuals with I/DD, not service silos or institutional defaults. Practice models should reflect a whole-person approach that integrates behavioral health, physical health, and developmental support. This includes the below:

INTEGRATED, PERSON-CENTERED MODEL OF CARE

- Interdisciplinary teams that bring together different areas of expertise, including mental health, I/DD, communication expertise, and trauma-informed care.
- Shared person-centered planning and decision-making processes that include the person, their family or trusted supporters, and their broader care team.
- Active coordination between SACU and other parts of the system, including mobile crisis teams, hospitals, case management, and community providers.

As Oregon works to focus SACU and strengthen the broader crisis response system, a clear and coordinated practice model is essential to delivering high-quality services that uphold the values of person-centered planning, community inclusion, and human dignity.

The visual below outlines an integrated practice model for delivering crisis services across a full continuum, from community-based prevention to coordinated follow-up. It reflects the elements of SAMHSA's national crisis framework, integrated with strategies tailored to individuals with I/DD and co-occurring behavioral health needs. Each stage highlights what people may need and how services can be delivered in a person-centered, trauma-informed, and community-integrated way.



INTEGRATED, PERSON-CENTERED MODEL OF CARE

While the full crisis continuum should include a range of support across settings and time, the following graphic focuses specifically on SACU's role as a short-term "Place to Go" during a crisis. The graphic contrasts SACU's current approach with a future-state practice model grounded in short-term stabilization, person-centered practices, and integrated crisis response.

SACU Current Practice	SACU Future Practice
• Long-term residence • Isolation from community • Containment-based supervision • Staffing based on historical norms • Compliance-focused training • Limited use of data in practice • Unclear or inconsistent on-site leadership • Disconnected from broader crisis system • Inconsistent or delayed transition planning	• Short-term stabilization and transition • Community reintegration and connectedness • Person-centered therapeutic supports • Staffing tailored to individual needs and service demand • Integrated training and coaching aligned with practice • Real-time data used for decisions and continuous improvement • Defined supervisory roles and coaching • Embedded in coordinated crisis continuum • Early and shared transition planning with milestones

To fully adopt an integrated practice model, several components will need further definition and development. These include team composition and staffing models; expectations for interdisciplinary collaboration; qualifications and training of staff; expectations for communication and coordination with case managers and community providers; standards for trauma-informed physical environments; and mechanisms for tracking and evaluating outcomes. These elements will need to be developed in tandem with policy, people, and infrastructure planning efforts described previously.

PROCESS

Adopting an integrated practice model for crisis services will require clear and consistent operational processes to support it. Interest holders described several points in the current system where roles, workflows, and expectations are ambiguous— resulting in delays, confusion, or inconsistent outcomes. While many of these process challenges intersect with policy or practice issues, they deserve dedicated attention to ensure that SACU can function as a coordinated, person-centered part of Oregon's crisis response system.

The following areas emerged as key process priorities:

INITIATION OF TRANSITION PLANNING

- Interest holders emphasized that transition planning should begin before or at intake, not weeks or months into a stay.
- The individual and their trusted supporters must be central to defining what stabilization looks like and identifying meaningful milestones that guide their return to the community.
- SACU and case managers should work together to align early transition goals and timelines that support the person's vision for community living and person-centered plan.

CLARITY IN ROLES AND RESPONSIBILITIES

There is often confusion about who is responsible for decisions related to service planning, behavior supports, and discharge readiness.

Interest holders called for clearer definitions of staff roles (including SACU vs. case management) and stronger coordination across teams.

USE OF SHARED MILESTONES AND TIMELINES

Process improvements should include the use of shared person-centered planning tools and agreed-upon milestones to track progress toward stabilization and transition. For example, delays in sharing referral packets or initiating provider searches can create unnecessary barriers to discharge. A streamlined, time-bound process should be established to support timely transition once stabilization goals are met.

These tools could also help identify and resolve barriers before they lead to extended stays.

STANDARDIZED WORKFLOWS AND PROTOCOLS

Planning should include efforts to document and streamline key workflows, such as intake, team meetings, transition handoffs, and communication between SACU and external providers.

Written protocols can help improve consistency across homes and ensure that best practices are embedded in day-to-day operations.

07 EXAMPLES OF INTEGRATED CRISIS MODELS

Across the country, some organizations and government agencies have successfully integrated behavioral health and I/DD services to provide comprehensive crisis support. These models highlight best practices for a more seamless approach to crisis intervention:

ARIZONA'S COORDINATED CRISIS SYSTEM

Arizona has developed a highly coordinated statewide crisis system that aligns closely with SAMHSA's and ACL's principles. The system includes:

1. **Specialized Mobile Crisis Teams** trained in both behavioral health and I/DD, ensuring immediate and appropriate intervention (Someone to Respond).
2. **Crisis Stabilization Services** that support short-term residential intervention while focusing on returning individuals to their communities (Somewhere to Go).
3. **Follow-Up Care and Coordination** with Medicaid-funded behavioral health services to promote long-term stability (Someone to Follow Up).
4. **Comprehensive Funding Strategy**, leveraging Medicaid, federal grants, and local sources to ensure accessibility regardless of whether an individual enters the system through the behavioral health or I/DD pathway.

MAINE'S ENHANCED COMMUNITY-BASED SERVICES

Maine has taken steps to prevent unnecessary institutionalization and improve access to behavioral health services for individuals with I/DD. Key features include:

1. **Crisis Prevention and Intervention Services** (CPIS), offering a statewide crisis hotline and regional crisis teams that provide community-based stabilization (Someone to Call & Someone to Respond).
2. **Crisis Houses i**n multiple locations, providing structured, short-term stabilization for individuals in crisis while prioritizing transitions back home (Somewhere to Go).
3. **A DOJ-Mandated Expansion of Community-Based Care**, focusing on keeping individuals with I/DD in their homes with appropriate behavioral health support (Avoiding Institutionalization).

BARBER NATIONAL INSTITUTE (PENNSYLVANIA)

This nonprofit provides crisis intervention, residential programs, and community-based services tailored to individuals with I/DD and co-occurring mental health conditions. Their approach prioritizes keeping individuals in their communities while ensuring access to specialized crisis stabilization services.

HOWARD CENTER (VERMONT)

The Howard Center offers mobile crisis response, crisis stabilization, and long-term community-based support, demonstrating how behavioral health and I/DD services can be effectively coordinated. Their 24/7 crisis support model helps prevent unnecessary hospitalization and ensures individuals receive the right level of care.
These examples illustrate the benefits of a well-integrated approach that prioritizes community-based solutions over institutional placements, aligning with best practices outlined by SAMHSA and ACL.

MINNESOTA: COORDINATED PARTNERSHIPS AND COMMUNITY-BASED STABILIZATION

Minnesota has developed a layered crisis response model that reflects many elements of an integrated continuum of care.

For Someone to Respond, each county operates a Mobile Crisis Response team that can be dispatched through the national 988 crisis line or local 911. State law requires 911 dispatchers to coordinate with mobile crisis teams in situations that do not involve violence, or an immediate law enforcement need. Law enforcement officers are also required to complete crisis de-escalation training, promoting safer and more trauma-informed responses.

To provide Somewhere to Go, Minnesota utilizes multiple community-based stabilization options. The Metro Crisis Coordination Program (MCCP) is a network of providers offering short-term crisis stabilization for individuals with I/DD and co-occurring behavioral health needs. These services are supported through a combination of public and private payers and are designed to help individuals stabilize in the community. In addition, Minnesota's Intensive Residential Treatment Services (IRTS) model provides up to 90 days of residential stabilization in licensed community settings for individuals with serious mental illness. While not specific to I/DD, IRTS reflects the state's commitment to flexible, non-institutional crisis support.

As part of Someone to Follow Up, several counties embed social workers within local police departments to provide follow-up after crisis events. These embedded staff help connect individuals with mental health, substance use, and community-based services (including ongoing case management), addressing underlying needs and preventing future crises.

08 EXAMPLES OF INTEGRATED CRISIS MODELS

INTEGRATING BEHAVIORAL HEALTH AND I/DD

Across the country, individuals with intellectual and developmental disabilities (I/DD) face significant challenges in accessing appropriate behavioral health services. Traditionally, service systems categorize individuals as needing either behavioral health or I/DD services, leading to fragmented care that does not serve the whole person. This separation is particularly concerning given that a substantial proportion of individuals with I/DD experience co-occurring mental health conditions. Estimates of prevalence vary, but according to a 2023 research review published in the journal Frontiers in Psychiatry, approximately 33% to 59% of individuals with I/DD have at least one co-occurring mental health condition. This high prevalence highlights the urgent need to integrate best practice models across behavioral health and developmental disability services, ensuring that individuals receive seamless, person-centered support that addresses both their mental health and developmental needs.

SAMHSA'S CRISIS SERVICES CONTINUUM

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has established a best-practice framework for behavioral health crisis services based on four essential components. These elements create a comprehensive, person-centered approach to crisis stabilization and recovery for a person experiencing a mental health or substance use crisis:

1. **Someone to Call** – A crisis call service such as the 988 Suicide & Crisis Lifeline, providing 24/7 immediate support to individuals in crisis. These hotlines serve as the first point of contact for individuals seeking help.
2. **Someone to Respond** – Mobile crisis response teams, staffed by behavioral health professionals, dispatched to provide on-site crisis intervention and de-escalation.
3. **Somewhere to Go** – Crisis stabilization programs, such as short-term crisis residential services, offering structured care to help individuals recover and transition back to the community.
4. **Someone to Follow Up** – Post-crisis care and support, ensuring individuals receive ongoing services to address the root causes of their crisis and prevent future recurrences wherever possible.

SAMHSA's framework prioritizes immediate access to crisis support, stabilization in the least restrictive setting, and long-term follow-up care to prevent repeated crises.

Importantly, SAMHSA emphasizes that law enforcement should not be the default responders to behavioral health crises. Instead, mobile crisis teams should serve as the primary responders, with law enforcement engaged only when there is an immediate safety concern. When law enforcement is involved, it is critical that officers are trained in crisis de-escalation, behavioral health, and disability awareness to minimize trauma and ensure appropriate care.

ADMINISTRATION FOR COMMUNITY LIVING'S BEST PRACTICES FOR CRISIS SUPPORT IN THE I/DD COMMUNITY

The federal Administration for Community Living (ACL) has outlined key best practices for crisis prevention and response specific to individuals with intellectual and developmental disabilities (I/DD). The ACL framework emphasizes.

1. **Community-Based Crisis Prevention** – Building proactive support to prevent crises before they escalate, including behavioral health supports, housing stability, and caregiver assistance.
2. **Crisis Intervention Tailored for I/DD Needs** – Crisis responses must be trauma-informed, person-centered, and consider the unique communication and support needs of individuals with I/DD.
3. **Avoiding Institutionalization** – The goal is to prevent unnecessary hospitalization or institutionalization by ensuring that individuals receive the right level of support where they live.
4. **Coordinated Follow-Up Services** – Post-crisis support must include wrap-up case management, behavioral health support, person-centered planning, and home- and community-based services to maintain stability and independence.

ACL's approach ensures that individuals with I/DD receive specialized crisis interventions that prioritize community-based care rather than more restrictive settings. An integrated model also helps reduce reliance on institutional settings or hospitalization by offering more appropriate, person-centered responses to crisis in community-based environments.

INTEGRATING SAMHSA AND ACL APPROACHES INTO A UNIFIED MODEL

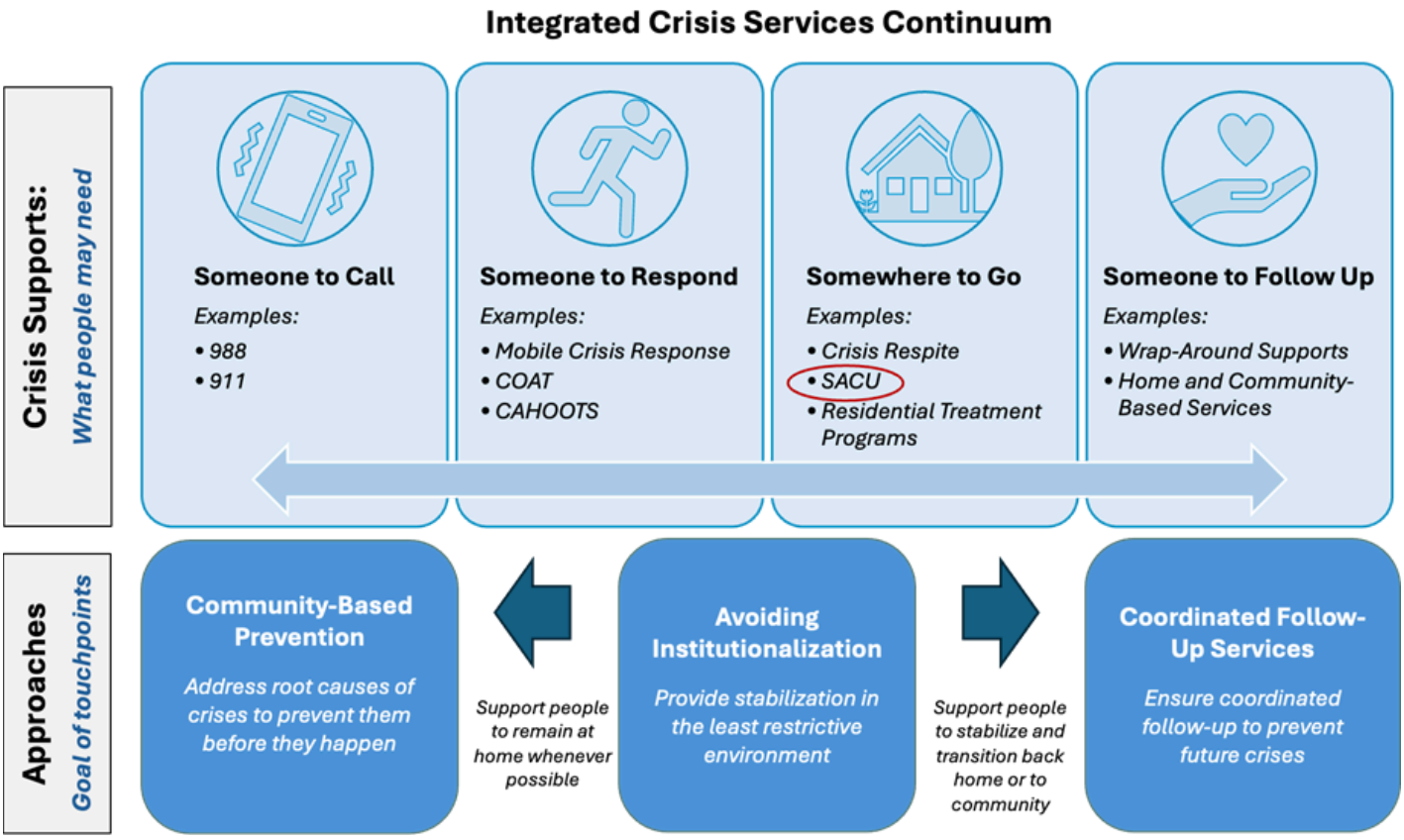
While SAMHSA and ACL focus on different populations, their crisis service models share key principles. Integrating these frameworks creates a comprehensive, person-centered crisis response system that addresses people's behavioral health and I/DD needs together. The following are core components of an integrated model:

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has established a best-practice framework for behavioral health crisis services based on four essential components. These elements create a comprehensive, person-centered approach to crisis stabilization and recovery for a person experiencing a mental health or substance use crisis.

1. **Ensuring Access to Crisis Support for All** – Expanding 988 and other call services (i.e., mobile crisis response) to include responders trained in supporting people with I/DD.
2. **Strengthen and Expand Mobile Crisis Teams with Dual Expertise** - Build on Oregon Health Authority's (OHA) Chapter 309 mandate by cross-training mobile crisis teams to respond to both behavioral health and disability-related crises. Leverage and coordinate existing mobile crisis services to create teams equipped to meet the needs of individuals with complex challenges. This integrated approach can help reduce avoidable emergency room visits, prevent housing disruptions, and limit unnecessary institutional placements.
3. **Providing Crisis Residential Services for People with I/DD** – Ensuring that short-term, crisis stabilization programs (such as SACU) are equipped to support individuals with dual diagnoses to effectively stabilize and transition back home or to their community. This includes incorporating specialized skills and training in positive behavioral supports (PBS), trauma-informed practices, person-centered thinking, assistive technology, and sensory integration.
4. **Coordinating Follow-Up Care Across Systems** – Establishing clear integration points between crisis teams, behavioral health services, I/DD support providers and case management to create long-term stability for individuals.

INTEGRATING SAMHSA AND ACL APPROACHES INTO A UNIFIED MODEL

The below visually describes both the necessary crisis supports (based on SAMHSA best practices) and approaches (based on ACL standards) of an integrated crisis service model.



In this integrated model, SACU plays a critical role as part of a coordinated, statewide crisis continuum that meets the needs of individuals with complex behavioral health and developmental disabilities. Importantly, SACU facilities should not be viewed as a one-size-fits-all solution to crisis support needs for people with I/DD in Oregon.

Effective crisis services are not simply a physical place but rather a continuum of resources that can be accessed at various times and based on each person's unique circumstances, needs, and preferences.

09 ADDITIONAL PLANNING CONSIDERATIONS

Organizational Structure: To strengthen accountability and ensure consistent oversight, SACU must no longer operate as a semi-independent structure within ODHS. All SACU operations should be fully integrated within the Office of Developmental Disabilities Services (ODDS). This includes aligning finance, operations, practice oversight, personnel, and compliance under a single leadership structure. Doing so will promote consistent expectations, streamline decision-making, and ensure that SACU's services and expenditures align with ODDS policies and philosophy. A unified structure is essential for transparency and for SACU to operate effectively as a short-term, person-centered crisis stabilization program.

Individual Representation: It should be a top priority to assure individuals receiving services at SACU have timely access to supportive decision making, guardians or other legal representatives. These representatives play a critical role in advocating for people's preferences, safeguarding their rights, and supporting care planning and transitions. Without adequate representation, individuals may experience delays in services or decisions that do not reflect their best interests.

Medically Complex Home: It is recommended that the medically complex home within SACU, which provides long-term, intensive medical care, be transitioned out of SACU and developed as a separate service model. Unlike SACU's short-term stabilization focus, this home serves individuals requiring intensive, ongoing medical support. Creating a separate, specialized model for medically complex individuals would help ensure their care remains high quality and continuous, while also supporting SACU's intended focus on short-term crisis response and stabilization.

Respite Care: Oregon's crisis system currently lacks dedicated respite capacity for individuals with I/DD and co-occurring behavioral health needs. Developing respite services, whether state-operated or community-based, would fill a critical gap in the continuum. Respite care can prevent crisis by relieving caregiver stress and can also serve as a short-term stabilization strategy during times of heightened need. Establishing this capacity would enhance crisis prevention efforts and reduce reliance on more restrictive interventions like SACU.

ADDITIONAL PLANNING CONSIDERATIONS

Facility and Support Location: Today, SACU homes are not evenly distributed across the state, often requiring individuals to relocate far from their home communities. This disconnection can make it harder to maintain relationships and complicates transitions back to community life. Future planning should prioritize the regional availability of crisis response services, including mobile response teams and stabilization homes, to ensure timely, person-centered support closer to where people live. This geographic alignment supports continuity and community integration.

Establishing Independent Oversight for SACU Licensure Compliance: To promote accountability and build public trust, SACU should establish independent oversight of licensure compliance, separate from ODHS's internal operations. Today, SACU self-monitors its compliance with licensing standards, creating a potential conflict of interest. Establishing an independent body or mechanism to conduct regular reviews and audits would bring SACU into alignment with the expectations for other licensed providers in the state. Independent oversight would also reinforce SACU's commitment to high-quality, person-centered care and ensure consistent adherence to regulatory standards.

10 METRICS AND EVALUATION

To effectively support SACU's goals and the continuum of care model, it is essential to establish data metrics that provide visibility and track progress. A robust metrics evaluation plan enables real-time analysis to identify successful implementation components and ongoing challenges, allowing for strategic adjustments. It also ensures transparent access for interest holders to monitor changes over time, helping Oregon demonstrate its commitment to transitioning SACU and the crisis continuum of care to a more effective model.

Metrics should be benchmarked against baseline values and, where available, comparable national or regional data.

While reducing the length of stay is a key goal, additional metrics aligned with SACU's mission and the needs of those served should also be included to provide a comprehensive view of progress. The table below outlines potential metrics aligned to key issues raised by interest holders.

Priority Area	Example Metrics	Purpose/Use
Prolonged Length of Stay	• Average length of stay • % with transition planning started in first 30 days • Re-admission rates post-discharge	Track duration and timeliness of transitions
Alignment with Best Practices	• % with person-centered transition plans • Individual/family satisfaction scores • Staff-to-resident ratios • ED/hospitalization rates	Monitor quality and effectiveness of person-centered supports
Transitions to Community Living	• % of discharges to HCBS Time from stabilization to transition Continuity of services post-discharge • Referral vs. admission rate • Use of shared planning tools	Assess cross-system coordination and transition outcomes to community living
Financial Sustainability	• Cost per person per month • Admission vs. discharge rates • Re-admission rates	Track cost trends and avoidable system use
Regulatory Compliance	• HCBS compliance rate • Time from stabilization to discharge	Ensure adherence to Medicaid and policy standards
Data-Driven Operations	• Plan completion and update cadence • Public reporting frequency • Use of data in quality improvement	Support accountability and continuous improvement

11 CONCLUSION

Oregon residents with I/DD and co-occurring behavioral health needs deserve equitable access to crisis response services that are person-centered, trauma-informed, timely, and grounded in community inclusion. This strategic plan outlines opportunities for transformative change.

This strategic plan details how SACU can evolve into a short-term crisis stabilization resource within 18 months, should the legislature and governor move forward with the proposed legislation, and also presents a comprehensive approach to addressing the need for a well-defined and responsive crisis system.

This strategy offers a bold vision to shape Oregon's crisis services, ensuring individuals receive timely, respectful, and effective support that upholds their dignity, promotes autonomy, and supports their full participation in community life.

"We must challenge the status quo and dismantle barriers that prevent individuals with disabilities from thriving."- Ed Roberts, Disability Rights Advocate

DISCOVERY ENGAGEMENT

APPENDIX A

PARTICIPANT LIST

Feedback was gathered through one-on-one interviews, open community meetings, and group video discussions.

COMMUNITY MEMBERS

The following were represented in community members interviewed.

- Self Advocates
- Family Members/Parents of those in SACU
- Guardians
- Strategic Executive Consultant

COMMUNITY ORGANIZATIONS

The following were represented in community organizations interviewed.

- Disabilities Rights Oregon
- Oregon Nurses Association
- Oregon Council on Developmental Disabilities
- AFCSME
- DD Coalition
- Oregon Resource Association
- Trade Organizations
- Case Management Organizations and Staff
- Provider Organizations

OREGON STATE STAFF

The following were represented in staff interviewed.

- Policy
- Field Liaisons
- Licensing
- Child Welfare
- ODDS Licensing
- Policy Staff
- Assessment Teams
- OHA Behavioral Health Services
- Individual Support Coordinators
- Business Operations
- SACU Staff
- Strategic Consultants
- Service Equity
- Contracts
- Employment
- Individual Support Coordinator
- Previous Leadership Executives
- Emergency Management Services
- Engagement & Innovation Specialist of ODDS Exceptions Unit
- Residential Facilities Ombudsman Team
- SACU RN & ONA Union Steward
- ODDS Exceptions Unit Manager
- Business Operations
- OEMS