Oregon Heath Authority Behavioral Health Residential+ Facility Study

January 2024 Draft Report

Public Consulting Group LLC

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PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

PURPOSE AND SCOPE

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

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

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

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

PCG was directed to use the Trauma System Areas in Oregon to map facilities across the State. The Area Trauma Advisory Board (ATAB) connects the providers and the public in each of the Trauma System Areas. According to the Oregon Secretary of State website and Arron Heriford at ODHS, the Trauma System Areas are listed below:

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

Figure 1. Trauma System Areas

Figure 2 below graphically depicts the Trauma System Areas in Oregon.

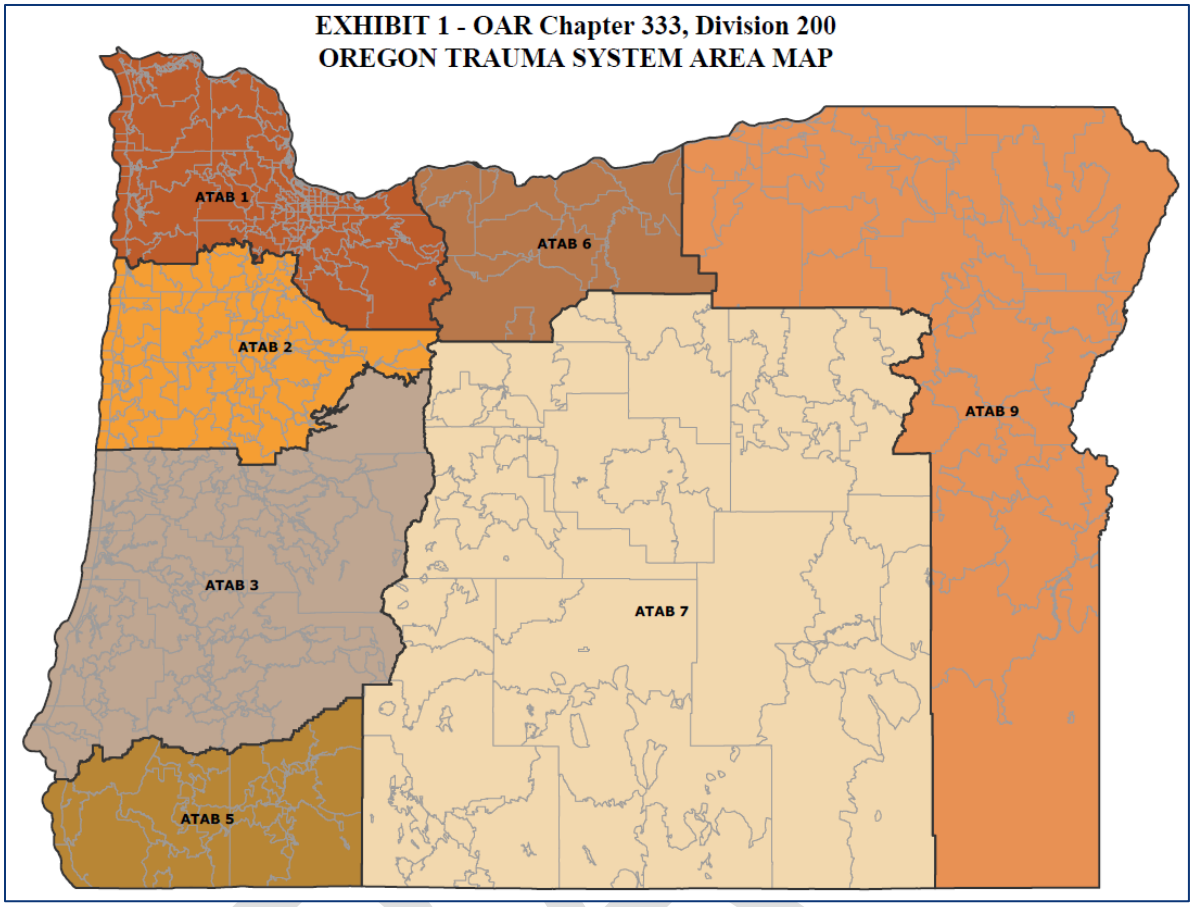

Figure 2: Oregon Trauma System Area Map

This Draft Report details:

- The current adult behavioral health capacity in Oregon's behavioral health system by Trauma System Area for the facilities identified as in scope.
- The emerging key themes from the community were gathered through focus groups and key informant interviews.
- Draft initial estimates for forecasted capacity and funding needs for behavioral health facilities in Oregon.

This Draft Report provides the initial estimates and calculations as of January 31, 2024. The facility capacity data, projections of needed capacity for each facility type, and cost estimates for expanding capacity will be further refined and analyzed for the June 2024 Final Report.

CURRENT AND PENDING FACILITY CAPACITY

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

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

Current capacity was determined by utilizing the licensing and certification data and the provider survey responses. SDOH data was used to determine the currently funded facilities in progress and/or under construction. Based on this data, Table 1 identifies the current and pending bed count for the facilities within scope across all trauma service areas.

Key Findings:

1. Residential Substance Use Disorder facilities have the highest bed count per capita with 1,650 total beds across the State representing 38.54 beds per 100,000 population.
2. Freestanding Acute Care Psychiatric Facilities are only present in Trauma Service Areas 1 & 2 with a total of 109 beds across the State and 2.55 beds per 100,000 people.
3. There are 365 withdrawal management beds across the state which is inclusive of 12 clinically managed withdrawal management beds and 353 medically monitored withdrawal management beds representing .28 and 8.25 beds per 100,000 people, respectively.
4. Trauma Service Area 6 has the least number of total beds in the State with 12 Residential Treatment Facility beds serving the region.
5. Trauma Service Area 1 has 2,062 total beds which is the highest number of beds in the State compared to the other service areas. Additionally, Trauma Service Area 1 has 829 Residential SUD beds which is the most of any service area in this facility category.

Trauma System Area		ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
State Hospitals	Beds	0	472	72	0	0	0	0	544
	Beds per 100k	0	64.28	15.37	0	0	0	0	12.71
Acute Care Psychiatric Facility	Beds	84	25	0	0	0	0	0	109
	Beds per 100k	3.82	3.40	0	0	0	0	0	2.55
Acute Care Psychiatric Unit in Hospital	Beds	191	34	48	24	0	15	0	312
	Beds per 100k	8.69	4.63	10.24	7.74	0	4.30	0	7.29
Residential Treatment Facility (RTF)	Beds	340	118	98	26	12	26	43	663
	Beds per 100k	15.47	16.07	20.92	8.38	28.80	7.45	24.00	15.49
Secure Residential Treatment Facility (SRTF)	Beds	147	106	147	72	0	96	55	623
	Beds per 100k	6.69	14.44	31.37	23.21	0	27.52	30.69	14.55
Residential Treatment Home (RTH)	Beds	169	87	70	40	0	15	25	406
	Beds per 100k	7.69	11.85	14.94	12.90	0	4.30	13.95	9.48
Adult Foster Home (AFH)	Beds	147	107	54	105	0	48	42	503
	Beds per 100k	6.69	14.57	11.52	33.85	0	13.76	23.44	11.75

Trauma System Area		ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Residential SUD Facility	Beds	829	128	237	114	0	136	206	1,650
	Beds per 100k	37.71	17.43	50.58	36.76	0	38.99	114.96	38.54
Clinically-Managed Withdrawal Management Facility	Beds	4	0	0	0	0	0	8	12
	Beds per 100k	0.18	0	0	0	0	0	4.46	0.28
Medically-Monitored Withdrawal Management Facility	Beds	151	43	55	24	0	36	44	353
	Beds per 100k	6.87	5.86	11.74	7.74	0	10.32	24.55	8.25
Total	**Beds**	**2,062**	**1,120**	**781**	**405**	**12**	**372**	**423**	**5,175**

Table 1: Current and Pending Capacity in Oregon

COMMUNITY ENGAGEMENT

To provide important context to this project, PCG conducted Community Engagement activities through interviews, focus groups, and discussions that engaged participants across Oregon. The goal of Community Engagement was to learn more about the behavioral health care continuum from those who have diverse experiences, knowledge, and involvement in behavioral health, and to understand how their needs and challenges reflect the areas for improvement and growth in the behavioral health landscape across the State. PCG conducted seventeen key informant interviews, two focus groups, and one tribal discussion during the Community Engagement period.

Key Findings:

- Nine respondent types were included in the key informant interviews to ensure a diverse range of perspectives and experiences. This included individuals with lived and living experience. Across all respondent types, three key thematic challenges emerged. The following themes centered around residential facilities, but also extended across the behavioral health continuum:
    - ***Staffing.*** Staffing issues have hindered facilities' ability to operate at full capacity and recruit and retain necessary staff.
    - ***Facility Access, Availability, and Experience***. A lack of access to facility-based care leads to long wait-times, a mismatch in the level of care needed and the level of care received, and poor overall experience.
    - ***Funding and Facility Expansion Priorities.*** There is a need to expand availability of services across the behavioral health continuum, but specifically SUD services, culturally specific services, care to meet complex and overlapping needs, services in rural areas, and peer-based services.
- Two focus groups were convened during the Stakeholder Engagement period with the Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC) and with Caregivers with Lived Experience. The following key themes emerged from these focus group sessions:
    - Racism and Stigma
    - Leadership
    - Support for Small Organizations and Culturally Specific Providers
    - Communication with Families

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

CAPACITY NEEDS

PCG conducted an initial capacity analysis related to crucial community-based services identified by Oregon Health Authority as high priorities which included mental health treatment facilities and homes, secure residential treatment facilities, substance use disorder residential treatment and withdrawal management treatment facilities. During the capacity analysis, key areas emerged as opportunities to increase capacity to improve access to care and provide the right treatment at the right time to those in need. Highlights for each service modality and capacity needs are reflected below in Table 2 and discussed in more detail further in the report. In terms of Inpatient Psychiatric Bed capacity, limited analysis was completed; however, it appears this treatment modality does require additional beds to support the infrastructure. The target numbers which materialized during our analysis, identified as capacity opportunities, are intended to provide a baseline of how Oregon can fill gaps in its care continuum across the state, bridging regional disparities in access to specific bed types. According to Mental Health America *"Access to Care Data"* from 2022, Oregon is 19th among other states in relationship to access to care, which the assessment included nine variables to determine ranking such as access, unmet need, uninsured, education and workforce to name a few. This ranking places Oregon in the mid-range related to care access, further showing opportunities to improve access for Oregonians.

Key Findings:

1. Acute Psychiatric Inpatient Beds account for 421 of the inpatient psychiatric beds in the state, which are not evenly distributed across the trauma service regions. Trauma Service Area (TSA) 6 and 9 have zero acute psychiatric inpatient beds with a combined population of 220,865. Initially a projection of 529 beds is needed to increase the number of beds in acute psychiatric inpatient facilities to support the infrastructure.
2. Funding from SDOH 5202, 5024 and Measure 110 has created 351 new mental health residential, SUD residential and withdrawal management beds, which are currently under construction and scheduled to be open by 3rd quarter 2025.
3. Oregon is projected to have 1,069 Mental Health Treatment Facility or Home beds, equivalent to 24.97 beds per 100,000 population by the 3rd quarter of 2025, meeting the anticipated needs. Nevertheless, considering an average of 26.71 patients in this type of facility over a 10-year period, an additional 74 beds could be added to further expand capacity.
4. Secure Residential Treatment Facilities appear to require up to 171 beds, however this capacity could be spread across Mental Health Treatment Facilities, Homes or Secure Residential to meet community or geographical regional needs as determined by advisory groups.

5. Substance Use Disorder (SUD) Residential Treatment facilities appear to need the largest number of beds to improve capacity by a range of 1,156 to 2,169 from an analysis of the CAST model and the OHA Behavioral Health Rapid Assessment.
6. Withdrawal Management is projected to need an additional 523 beds based on the re-analysis of the CAST model.

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Number of Beds (Current + Pending + Needed)	% Increase
Acute Care Inpatient Psychiatric Beds	421	Unknown	421	529	950	125.65%
Mental Health Residential (RTF & RTH only)	855	214	1,069	74*	1,143	6.92%
Secure Residential Treatment Facility (SRTF only)	546	77	623	171	794	27.45%
SUD Residential	1,606	44	1,650	1,662**	3,312	100.72%
Withdrawal Management	349	16	365	523	888	143.29%
Totals	3,777	351	4,128	2,959	7,087	71.68%

*Given the estimated need ranged from 0-74, PCG used 74 for this analysis

**Given the estimated need ranged from 1,156 to 2,169, PCG used 1,662 for this analysis which is the average of the estimated range.

Table 2. Capacity Analysis

FUNDING NEEDS

PCG provides initial estimates for the forecasted costs to expand behavioral health capacity in Oregon for the facilities within our project scope in this Draft Report. These estimates will be further refined and analyzed in our subsequent June 2024 Final Report.

For mental health residential facilities, PCG determined an average cost per bed to build facilities based on available Oregon specific data provided by the Oregon Health Authority Social Determinants of Health. The dataset from SDOH included sixteen records categorized with the following facility categories:

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

PCG received copies of narrative proposals, specs and costs submitted to Oregon Health Authority for expanding capacity by building new facilities in Residential Substance Use Disorder and Withdrawal Management Treatment Facilities. The dataset from OHA included three records for these facilities, which are categorized as Residential Substance Use Disorder and Withdrawal Management Facilities to determine cost per bed.

The above-described data sets were used to determine our cost estimations for this analysis.

Key Findings

- **Mental Health Residential:** Based on the provided data, construction development costs for new residential facilities range from $515,658 to $12,494,000 with an average cost of $4,294,638. On a per-bed basis, this means a cost range of $85,943 to $780,875 with an average cost of $314,927.80 per bed for mental health residential facilities. Considering the restricted number of data points and the substantial ranges, particularly for Secure Residential Treatment Facilities, these figures are subject to change as more data on facility costs becomes available. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operational expenses.

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
Adult Mental Health Residential	$515,658	$12,494,000	$4,294,638	$314,928.80

Table 3. Mental Health Residential Estimated Costs

- **Residential SUD and Withdrawal Management:** Based on the provided data, construction development costs for new residential substance use disorder and withdrawal management facilities ranges from $5,500,000 to $8,000,000 with an average cost of $6,533,333 per facility. On a per-bed basis, this means a cost range of $105,172.41 to $550,000 with an average cost of $285,057.47 per bed for residential SUD and withdrawal management facilities. Considering the restricted number of data points and the substantial ranges these figures are subject to change as more data on facility costs becomes available. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operational expenses.

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
SUD Residential & Withdrawal Management Facility	$5,500,000	$8,000,000	$6,533,333.33	$285,057.47

Table 4. Residential SUD and Withdrawal Management Facility Estimated Costs

- **Forecasted Capacity Need Investment Costs:** To calculate the total projected investment costs for the capacity needs in Oregon, PCG utilized the projected capacity needs identified earlier in the report and the cost per bed derived from our above analysis. This resulted in a total projected investment cost for capital funds for each of the facility types in the analysis. Table 5 below provides the Total Projected Investment Costs for each facility type with a grant total cost of $507,752,218 to expand capacity in Residential Treatment Homes, Residential Treatment Facilities, Secure Residential Treatment Facilities, Residential SUD Facilities, and Withdrawal Management Facilities. This number reflects the initial maximum estimate and will be further refined and analyzed for the June 2024 Final Report.

Facility Type	Projected Capacity Needed	Cost per bed	Total Projected Investment Costs
Residential Treatment Home	37	$130,500	$4,828,500
Residential Treatment Facility	37	$249,558	$9,233,646
Secure Residential Treatment Facility	171	$415,982	$71,132,922
Residential SUD Facility	1,662	$193,390	$321,414,180
Withdrawal Management	523	$193,390	$101,142,970
Totals	**2,430**	**$236,564***	**$507,752,218**

*Represents the average cost per bed

Table 5. Forecasted Need and Costs

RECOMMENDATIONS

The recommendations included in this report are preliminary. The final recommendations will be included in the June 2024 Final Report.

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

Key Findings:

- **Care Model and Strategy:** Currently, Oregon has several pieces in place that make up the behavioral health care continuum; however, the succinctness and interchangeability of the different levels of care required for individuals, especially complex consumers with more than one need, causes difficulty moving throughout the system. PCG would recommend developing a care model and strategy similar to a Hub and Spoke Model to care for individuals within a geographic region and supporting the majority of needs based in a geographic region. Further, creating a strategy which stabilizes existing infrastructure, invests in new capacity, enhances coordinated care, invests in new technology, develops current models of care and facilities, and explores new models is

imperative to meet the needs of Oregonians. There must be a focus on the infrastructure and needs of Acute Care, Community Based Care, Outpatient Treatment Services and Crisis Services, including capacity, workforce, and funding, and a well laid out strategy driven by thoughtful leaders positioned to create change and enhance treatment service delivery. Also, as emphasized by our community partners, customizing care models to suit the unique needs of rural and urban areas is crucial, and implementing a regional approach would effectively address this priority.

- **Workforce Development:** To expand the capacity of behavioral health services in Oregon, it is essential to prioritize workforce investments. Most of the current facilities are understaffed, and building more facilities could exacerbate the workforce challenges faced by existing facilities. Additionally, there is a need for culturally specific providers to offer culturally appropriate care for the diverse and indigenous populations in Oregon. There should be a continued focus on building a diverse, well-trained, and skilled workforce that can meet the needs of the communities across Oregon, both in rural and urban settings. Workforce development should be prioritized so that every facility can operate effectively and efficiently with the appropriate level of staff to serve Oregonians who are seeking behavioral health services.
- **Additional Facilities:** Additional beds and facilities are needed to expand the infrastructure within mental health and SUD to meet the demand. Based on the current facility capacity in Oregon, if the decision is made to build new facilities, Oregon can expand capacity in the following areas and facility categories:
    - Expand Mental Health Residential Treatment for those with medical comorbidities
    - Expand Mental Health Residential Treatment Home and Secure Residential Treatment Facility capacity
    - Expand capacity for Substance Use Disorder Residential Treatment
    - Expand capacity for Withdrawal Management facilities
    - Support additional acute care inpatient psychiatric beds by working with non-profit and for-profit entities to develop capacity to optimal levels of care to meet the demand
    - Develop Crisis Center Models

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

- **Awareness, Education and Engagement:** Developing awareness, education and interactive engagement opportunities with community partners surrounding mental health and SUD services, access, treatment options, interactive opportunities, legislative updates, statistics, and funding will impact all levels of the continuum and create transparency and understanding. Some ways to accomplish this are noted below:
    - Develop websites with easy to access information, treatment options, resources, contact information, and statistics for consumers and families.
    - Create streamlined websites and links for providers and facilities to have a “one stop shop” experience for all things related to their work.
    - Create public education awareness regarding treatment, what the State is doing to improve the care continuum, where funding is going, state-level behavioral health strategies, and five-year plans.
- We acknowledge that in considering the distribution of funding, any allocation towards building new residential facilities must correspond with aggressive and highly coordinated efforts to address workforce development and capacity issues in already existing facilities, and strengthen community-based, crisis, and outpatient services. Our engagement with community partners, particularly those with lived experience, underscores that it is imperative to prioritize the adaptability of facilities to meet the diverse needs of all Oregonians. This involves a thoughtful consideration of individuals with co-occurring disorders, the increasing acuity of those seeking behavioral health and substance use services, and the expansion of culturally specific services. Although the scope

of this analysis is limited to the distribution of capital funding for new residential facilities, all such workstreams must be coordinated to effectively expand behavioral health care across the State.

- Areas for Further Analysis: PCG understands there are a multitude of factors and considerations when identifying recommendations to expand behavioral health capacity in Oregon. There are many pieces of information that are outside of scope for our current report, but that should be further explored and reviewed to provide a more holistic representation of the behavioral health landscape in the State. These considerations are noted below:
    - **Youth Population**: Our study currently focuses on the adult population. A similar analysis of current capacity and capacity needs for the child and youth population would provide beneficial information when considering funding priorities.
    - **Geriatric Population**: While the data does not account for different types of needs within adult residential beds, the State of Oregon would benefit from completing an additional study focusing on geriatric mental health treatment and continuum of care and services, further defining if there is a need for increasing services and funding for this specialized population.
    - **Complex Needs**: An additional analysis and study of the services and capacity of behavioral health facilities to adequately care for those with complex needs would be a critical component in further analyzing the continuum of care. It was noted during Community Engagement how challenging it can be for people to find beds when they have both physical health and behavioral health needs.
    - **Staffing and Workforce**: A thorough analysis of the staffing challenges and workforce development barriers to providing services at behavioral health facilities could offer important insights into the feasibility of new facility construction.
    - **Crisis Facilities**: A thorough review of the crisis facilities and services in coordination with the Oregon Health Authority as they develop the rules would provide valuable information on the entire continuum of care and where additional supports are needed.
    - **Quality of Care:** Quality of care was mentioned throughout Community Engagement as an area that could be further explored. Understanding the type of care being provided at the facilities is crucial, as well as understanding the culturally appropriate care available and the areas for expansion.

INTRODUCTION

PROJECT SCOPE & REPORT OVERVIEW

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

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

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

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

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

Figure 3. Project Phases

Data Collection & Analysis: The first phase of this project is the Data Collection & Analysis phase. During this phase, PCG collected available data on the number and type of behavioral health facilities in each

Trauma System Area and their associated capacities. To supplement the existing data, PCG also collected original data by designing and distributing a survey to identify behavioral health facilities across the State and their associated capacities and challenges. The methodology and analysis details are described below in the *Capacity Analysis* section.

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

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

Funding Methodology & Forecast: The fourth phase is the Funding Methodology & Forecast phase. Once the Recommendations & Prioritization phase is complete, PCG will determine the costs and funding needs associated with the recommendations proposed. The funding allocation methodology will inform future capital funding requests and the distribution processes. The draft funding needs are detailed below in the *Forecasted Costs for Additional Capacity* section.

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

PURPOSE OF THIS REPORT

This Draft Report details the current adult behavioral health capacity in Oregon's behavioral health system by Trauma System Area for the facilities within scope and provides emerging key themes from the community that were gathered through focus groups and key informant interviews. PCG's analysis of Oregon's current capacity combines quantitative facility data with input from community partners representing varying backgrounds and perspectives. Community engagement, supported by quantitative data, provides a first-hand perspective on the gaps in the continuum of care throughout the State. Additionally, initial capacity and funding needs are identified in this report for further refinement and exploration in the June 2024 Final Report.

LIMITATIONS, CONSIDERATIONS, & KEY ASSUMPTIONS

Given the limited timeline and scope for this preliminary report, PCG presents the following limitations, considerations, and key assumptions for the January 2024 Draft Report:

- This study is focused on facilities in Oregon. Facilities in other states were not included in the capacity analysis.
- The capacity analysis is focused on the adult population. Child, Youth, and Adolescent facilities are not included in this report.
- The following facility types are not included within our current scope – they were reviewed and discussed with OHA and community partners, but are not included in the capacity analysis:
    - Supported Housing
    - Supportive Housing
    - Community-Based Structured Housing
    - Permanent Supportive Housing
    - Sobering Centers
    - Outpatient Treatment Facilities
    - Enhanced Care Services

- Problem Gambling Residential Treatment and Recovery Services are included in the Substance Use Disorder Residential Facility inventory list.
- Community Hospitals: Community Hospitals are smaller local hospitals, which serve a localized population for general medical conditions usually without offering specialized services. While Community Hospitals serve a purpose and are vastly needed in the continuum of care, in the realm of behavioral health and substance use disorder treatment, they usually serve as an entry point to access care. Community Hospitals typically do not have specialized services or units for behavioral health and/or substance use treatment and are not included in this study and report. However, during the survey portion of the study, PCG did solicit feedback from Community Hospitals in relationship to behavioral health and substance use disorder patients, and sought information including diagnoses, wait times, dispositions, and challenges experienced to better understand if there are unmet needs in this setting. Within subsequent reports, PCG may highlight collective survey responses from Community Hospitals to identify further gaps within the continuum.
- Acute Inpatient Psychiatric Facilities and State Psychiatric Hospital capacity, needs and analysis were limited during this project's scope. Oregon Health Authority determined the primary focus of this project needed to be on community treatment options including mental health residential treatment, substance use disorder residential treatment and withdrawal management.
- The project's scope was confined to facilities and bed capacities within the State of Oregon, focusing on bed capacity that could potentially be influenced by funding from the state. As of the January 31, 2024 report, the data and scope did not include considerations for Oregonians seeking treatment across state lines or payments for services provided within or outside the state.
- The data points represent a momentary measurement and a snapshot of Oregon's facilities and capacities. Facility data was recorded up to January 15, 2024, and should be approached as an ongoing iterative process, considering the incorporation of new information, facilities, or beds. Furthermore, the SDOH data was derived from the information received and calculated through the 3rd quarter of 2025.

FACILITY OVERVIEW

	Facility Type	Brief Description	Licensing Authority	Service Access
Adult Foster Homes	Adult Foster Homes (AFH)	Adult Foster Homes (AFH) are residential environments, providing services and assistance with activities of daily living to adults diagnosed with mental illness. Providers or a resident manager live on site, with up to 5 residents per home.	Licensed annually by Oregon Health Authority, Health Services Division	Referral through Community Mental Health Program (CMHP)
Mental Health Residential Treatment Facilities	Residential Treatment Homes (RTH)	Unlocked residential environment, providing treatment services and support for activities of daily living to adults diagnosed with mental illness, which are staffed twenty-four hours a day with a capacity of up to 5 residents.	Licensed every 2 years by Oregon Health Authority, Health Services Division	Persons seeking treatment at an RTH, RTF or SRTF may contact their local community mental health program (CMHP).
	Residential Treatment Facilities (RTF)	Unlocked residential environment, providing treatment services and support for activities of daily living to adults diagnosed with a mental illness, which are staffed twenty-four hours a day with a capacity of 6-16 residents. *One non-contracted licensed RTF facility has more than 16 residents (fully funded by Kaiser Permanente).	Licensed every 2 years by Oregon Health Authority, Health Services Division	
	Secure Residential Treatment Facilities (SRTF) Class 1 or 2	Provide locked residential environment, treatment services and support for activities of daily living to adults diagnosed with a mental illness, which are staffed twenty-four hours a day with a capacity of 6-16 residents. *Two licensed SRTF facilities within OSH have more than 16 residents.	Licensed every 2 years by Oregon Health Authority, Health Services Division	
	Class 1	Class 1 facility is approved under applicable administrative rules to be locked to prevent a person from leaving the facility, to use seclusion and restraint and involuntarily administer psychiatric medications.	Certified every 3 years by Oregon Health Authority, Health Services Division	
	Class 2	Class 2 facility is approved under applicable administrative rules to be locked to prevent a person from leaving the facility.	Certified every 3 years by Oregon Health Authority, Health Services Division	

	Facility Type	Brief Description	Licensing Authority	Service Access
	Substance Use Disorder and Problem Gambling Residential Treatment	These programs provide a residential environment and treatment services for individuals with substance use and problem gambling disorders for up to 16 individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Health Services Division	Persons seeking professional substance use disorder or problem gambling treatment can locate providers by 1. Contacting an individual's health plan to find providers. 2. Find local providers in the Oregon Substance Use Disorders Treatment Provider Directory.
Hospitals	Acute Care Mental or Psychiatric Hospital (Freestanding Facility)	A hospital that provides inpatient psychiatric services, has an inpatient psychiatric unit, and is devoted to the primary diagnosis and treatment of persons with mental illness.	Licensure is completed by the Public Health Department, Health Care Regulatory and Quality Improvement, and Certification is completed by Health Services Division.	Accessed through emergency department, urgent care, crisis center, or through behavioral health evaluation by psychiatric provider or general practitioner.
	Distinct Part Unit of an Acute Care Hospital (General or Low Occupancy Hospital)	A hospital classified as a general or low occupancy acute care hospital that may provide inpatient psychiatric services and has a distinct inpatient psychiatric unit.	Licensure is completed by the Public Health Department, Health Care Regulatory and Quality Improvement, and Certification is completed by Health Services Division.	Accessed through emergency department if the hospital has a dedicated inpatient psychiatric unit or by direct referral from another hospital emergency department, urgent care, crisis center, or through behavioral health evaluation by psychiatric provider or general practitioner.

	Facility Type	Brief Description	Licensing Authority	Service Access
	State Psychiatric Hospital	A hospital which provides the highest level of intensity of psychiatric inpatient care by limiting admissions to those most severely symptomatic individuals whose treatment and recovery needs cannot be met in a community treatment setting. State Hospital means any campus of the Oregon State Hospital (OSH) system.	Licensure is completed by the Public Health Department, Health Care Regulatory and Quality Improvement, and Certification is completed by Health Services Division.	Direct referral by provider for a patient meeting one of the following categories and the criteria listed below: 1. Civil Commitment 2. Voluntary by Guardian 3. Guilty except for Insanity 4. Aid and Assist **AND** The individual's condition or symptoms have not improved in an acute care setting despite having received a comprehensive psychiatric and medical assessment, and treatment with medications for at least 7 days at an adequate dose; and (b)the individual continues to require hospital level of care services, as evidenced by failure to meet the state hospital's criteria for readiness to transition. (c) the individual's condition is not related to a primary medical condition, or a diagnosis outlined in OARs.
SUD Facilities (Withdrawal Management Facilities)	SUD Residential Treatment	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders for up to 16 individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Health Services Division	Persons seeking professional substance use disorder or problem gambling treatment can locate providers by 1. Contacting an individual's health plan to find providers. 2. Find local providers in the Oregon Substance Use Disorders Treatment Provider Directory.
	SUD Withdrawal Management-Clinical	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders, under the guidance of clinical management, for up to 16 individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Health Services Division	

	Facility Type	Brief Description	Licensing Authority	Service Access
	SUD Withdrawal Management-Medical	These programs provide residential environments and treatment services for individuals with substance use and problem gambling disorders, under the guidance of medical management, for up to 16 individuals, including detoxification programs.	Licensed every 2 years by Oregon Health Authority, Health Services Division	

Table 6. Facility Overview

OREGON BEHAVIORAL HEALTH FACILITY CAPACITY ANALYSIS

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

DATA COLLECTION METHODOLOGY

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

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

4. Data Collection Sources

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

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

Existing Data Collection

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

- Oregon Health Authority, Health Policy & Analytics Division Team
- Oregon Health Authority, Licensing and Certification Team
- Oregon Health Authority, Intensive Services Team
- Oregon Health Authority Social Determinants of Health Team
- Oregon Health Authority, Health Systems Division Team
- Oregon Health Authority, Certified Community Behavioral Health Clinics Team
- Oregon Housing and Community Services Team
- Oregon Health Authority, Public Health Division Team
- Oregon State Hospital

- Oregon Health Authority, Office of Recovery and Resilience Team
- Oregon Health Authority, Equity and Inclusion Division Team
- Oregon Health and Science University
- Blackbox Healthcare Solutions
- Oregon Department of Human Services
- Apprise Health Insights
- Oregon Health Authority, All Payer All Claims Team
- Oregon Council for Behavioral Health

In addition to the conversations noted above, PCG has also been communicating and aligning with other projects that are running concurrently:

- **Public Consulting Group SUD Financial Inventory**: PCG is also contracted with OHA to provide an analysis and report on Oregon's Substance Use Disorder (SUD) funding and investments. The study will include a review of the total state funds spent across the continuum of care – prevention, harm reduction, substance use treatment, and recovery services and supports. PCG is working to identify inequities in spending and investments, in alignment with Oregon's goals to eliminate health inequities by 2030.
- **Oregon Behavioral Health Coordination Center (OBCC) Study**: OBCC is a state funded project, guided by OHSU, in a collaborative approach with other health systems, community partners, and OHA. The Coordination Center will efficiently, effectively, and ethically:
    - Facilitate placement of adult & pediatric individuals within Oregon in need of acute or residential behavioral health services
    - Provide real-time data to improve transparency, efficiency, and placement coordination efforts
- **Deloitte Housing Inventory Study**: The goal of this study is to develop Oregon's SMI Housing inventory. A full environmental scan was completed, which included qualitative interviews, data requests and synthesis, and a literature review. Qualitative interviews were conducted with State agencies and housing/community providers to identify challenges in service delivery and determine if the agency or provider collected quantitative data on the bed and service capacity of facilities that may provide services for individuals experiencing SMI and houselessness. Available quantitative data was requested, compiled, standardized across sources, and analyzed. Finally, a literature review of Oregon Administrative Rule (OAR), OHCS, OHA, and HUD webpages was conducted to supply context (in terms of staffing and service qualifications) for each of the facility types to support the data analysis.

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

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

Original Data Collection

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

- Name and location

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

The survey was distributed through the Oregon Association of Hospitals and Health Systems (OAHHS), the Oregon Council for Behavioral Health (OCBH), and the Association of Oregon Community Mental Health Programs (AOCMHP). The survey was distributed with the following timeline:

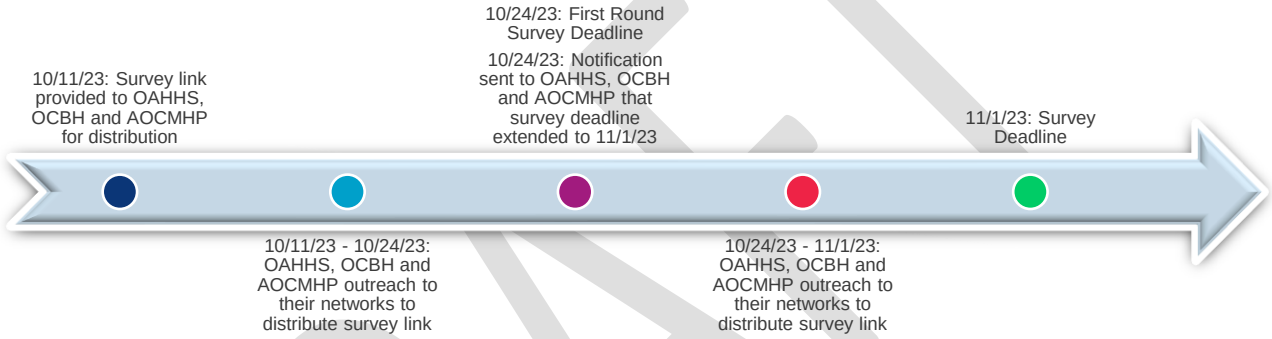

Figure 5. Survey Distribution Timeline

Following the close of the survey, PCG reviewed 218 responses and analyzed the results. Some notable survey highlights are included below:

Figure 6. Survey Highlights

MAPPING

PCG was directed to use the Trauma System Areas in Oregon to map facilities across the State. The Area Trauma Advisory Board (ATAB) connects the providers and the public in each of the Trauma System Areas. According to the Oregon Secretary of State website and Arron Heriford at ODHS, the Trauma System Areas are listed below:

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

Figure 7. Trauma System Areas

Figure 8 below graphically depicts the Trauma System Areas in Oregon.

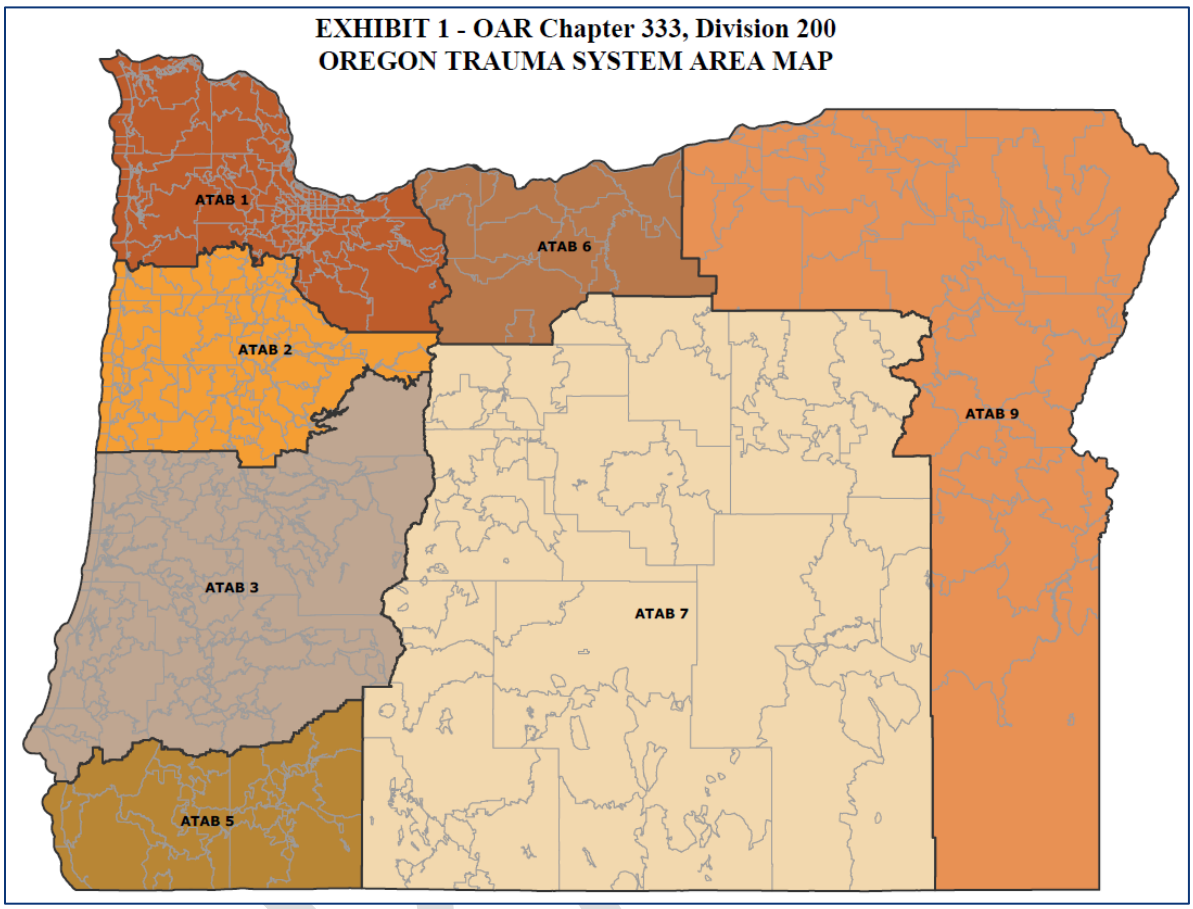

Figure 8: Oregon Trauma System Area Map

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

CURRENT CAPACITY

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

Hospitals

State Hospitals

A State Psychiatric Hospital provides the highest level of intensity of psychiatric care by limiting admissions to those most severely symptomatic individuals whose treatment and recovery needs cannot be met in a

community treatment setting. State psychiatric hospitals are dedicated to the diagnosis and treatment of psychiatric and mental health conditions and operate twenty-four hours per day with a dedicated nursing staff and organized medical staff of psychiatrists and physicians. Additionally, State Psychiatric Hospitals care for a forensic population or may have a "forensic hospital" co-located with the State Psychiatric Hospital, serving individuals in the penal system. State Psychiatric Hospitals are generally considered a longer-term treatment option than acute care hospitals. Admissions to this level of care are deemed appropriate when:

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

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

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

Additionally, the Oregon State Hospital admits the following patients meeting any one of the following categories:

1) Civil Commitment

2) Voluntary by Guardian

3) Guilty except for Insanity

4) Aid and Assist

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	0	472	72	0	0	0	0	544

Table 7. State Hospital Bed Capacity

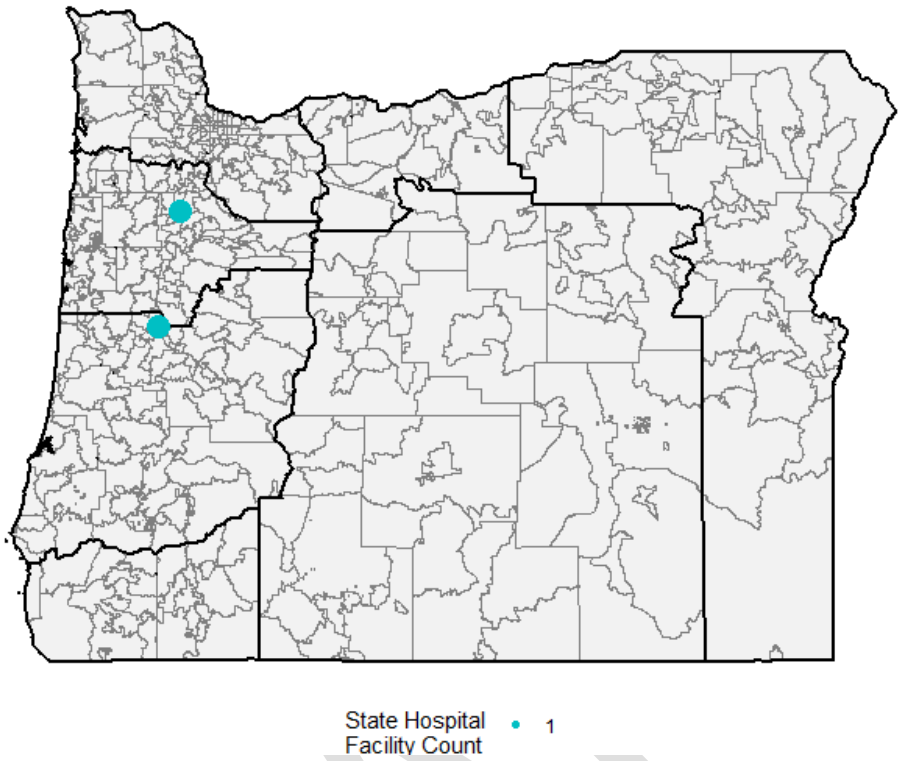

Figure 9. State Hospital Facility Count Map

Acute Care Psychiatric Facility (Freestanding)

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	84	25	0	0	0	0	0	109
Beds per 100,000 Population	3.82	3.40	0	0	0	0	0	2.55

Table 8. Acute Care Psychiatric Facility (Freestanding) Bed Capacity

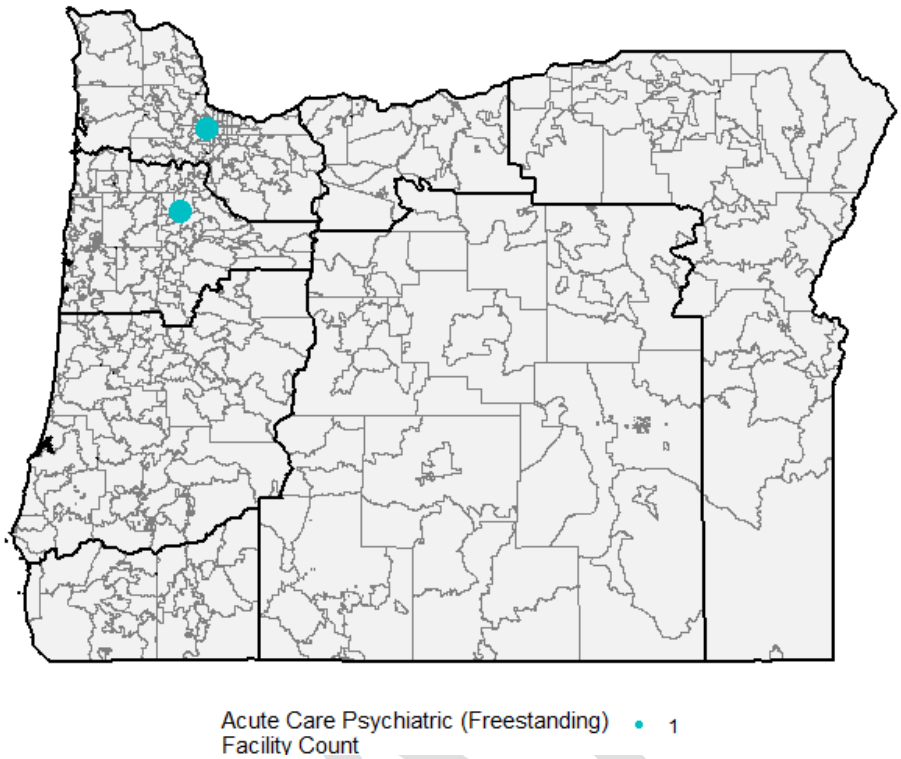

Figure 10. Acute Care Psychiatric Facility (Freestanding) Facility Count Map

Acute Care Psychiatric Unit in Community or General Hospital (Distinct Part Unit)

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	191	34	48	24	0	15	0	312
Beds per 100,000 Population	8.69	4.63	10.24	7.74	0	4.30	0	7.29

Table 9. Acute Care Psychiatric Unit in Community or General Hospital (Distinct Part Unit) Bed Capacity

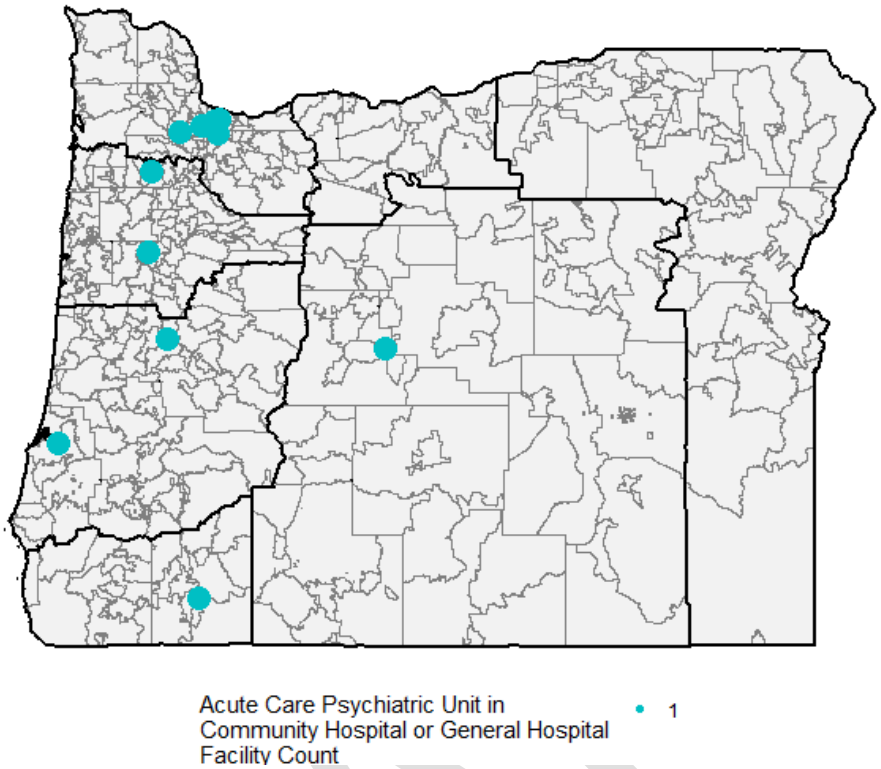

Figure 11. Acute Care Psychiatric Unit in Community or General Hospital (Distinct Part Unit) Facility Count Map

Mental Health Residential Facilities

Residential Treatment Facilities (RTF)

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	283	80	59	26	12	26	43	529
Beds per 100,000 Population	12.87	10.89	12.59	8.38	28.80	7.45	24.00	12.36

Table 10. Residential Treatment Facility (RTF) Bed Capacity

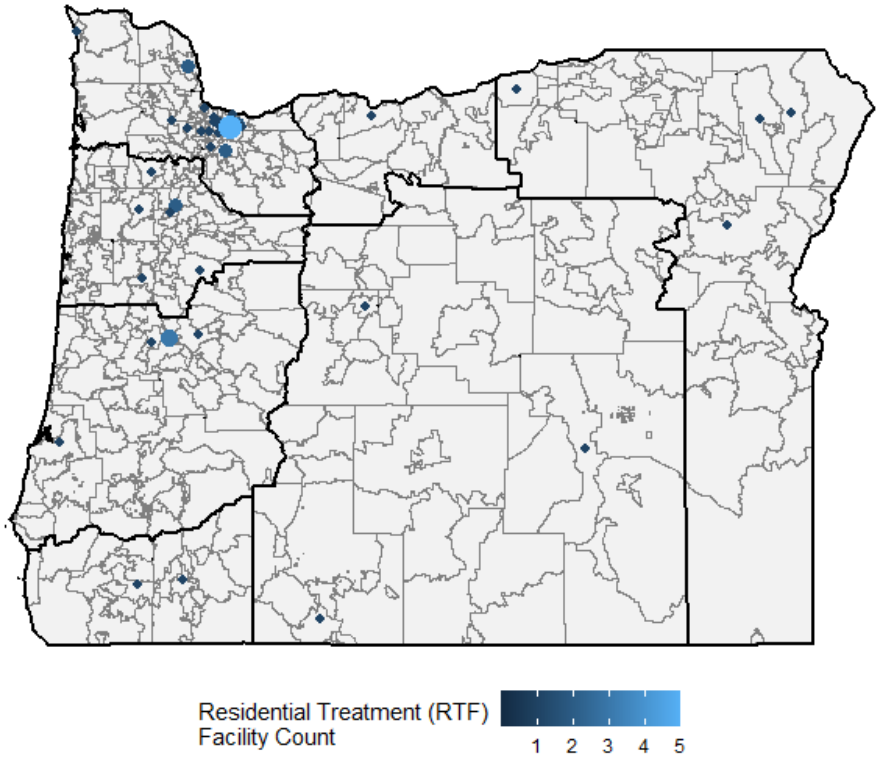

Figure 12. Residential Treatment Facility (RTF) Facility Count Map

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

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

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

Class 1

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

Class 2

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	147	106	131	72	0	48	42	546
Beds per 100,000 Population	6.69	14.44	27.96	23.21	0	13.76	23.44	12.75

Table 11. Secure Residential Treatment Facility (SRTF) Bed Capacity

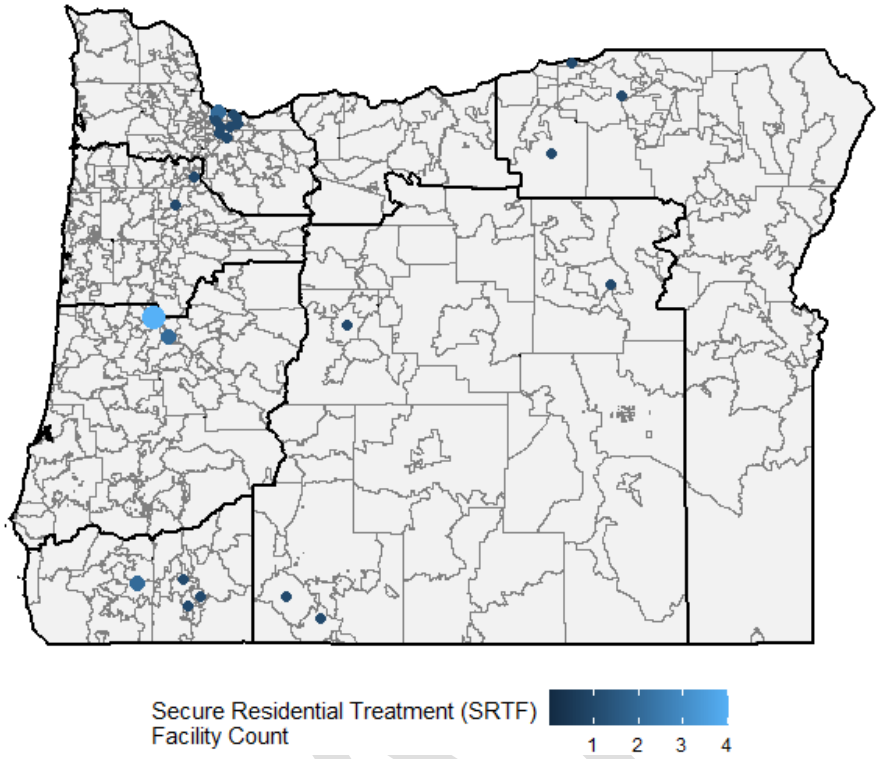

Figure 13. Secure Residential Treatment Facility (SRTF) Facility Count Map

Residential Treatment Homes (RTH)

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	159	67	40	20	0	15	25	326
Beds per 100,000 Population	7.23	9.12	8.54	6.45	0	4.30	13.95	7.62

Table 12. Residential Treatment Home (RTH) Bed Capacity

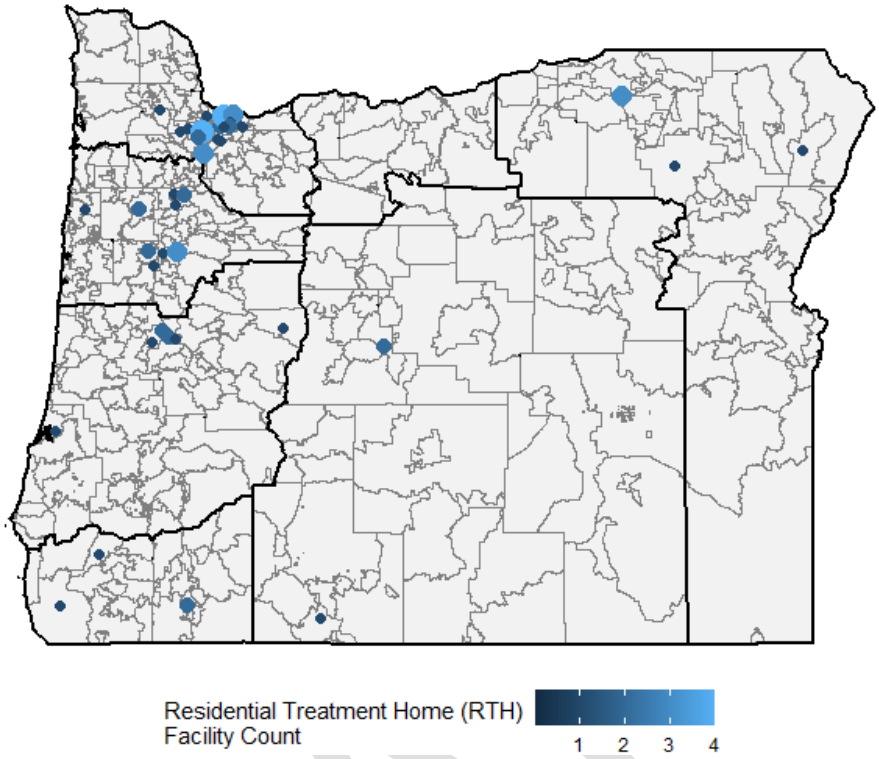

Figure 14. Residential Treatment Home (RTH) Facility Count Map

Adult Foster Homes (AFH)

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	147	107	49	105	0	48	42	498
Beds per 100,000 Population	6.69	14.57	10.46	33.85	0	13.76	23.44	11.63

Table 13. Adult Foster Home (AFH) Bed Capacity

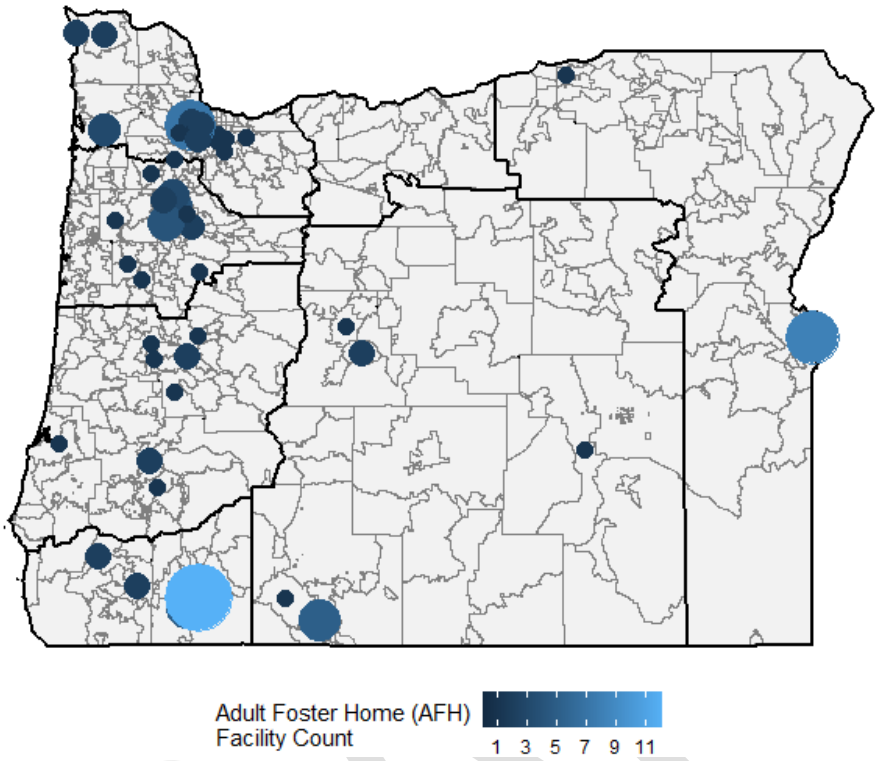

Figure 15. Adult Foster Home (AFH) Facility Count Map

Substance Use Disorder Residential Facilities

Residential Substance Use Disorder Facilities

Residential Substance Use Disorder Treatment Programs are publicly or privately operated programs, in a non-hospital setting, which provide assessment, treatment, rehabilitation, and twenty-four-hour observation and monitoring for individuals with substance use dependence, consistent with Level 3 of the ASAM Criteria, 3rd Edition. ASAM Criteria is a standardized nomenclature scale used to determine levels of care and interventions to treat individuals with substance use disorders. Residential Substance Use Disorder Treatment Programs can provide services for up to 16 individuals, including detoxification programs, in a twenty-four-hour structured environment for individuals who meet criteria, including diagnostic criteria for a moderate or severe substance use or addictive disorder, per Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). Services provided include assessment, stabilization, development of treatment plan, group and individual counseling, case management and peer support, relapse prevention, medication monitoring and/or medication assisted treatment, education, and transitional care or support. Residential Substance Use Disorder Treatment Programs are licensed by Oregon Health Authority, Health Services Division every 2 years.

Residential Substance Use Disorder Facilities may also include Problem Gambling Treatment within a facility as described below:

Substance Use Disorder and Problem Gambling Residential Treatment

Residential problem gambling treatment programs are publicly or privately operated programs, licensed in accordance with OAR 415-012-0000 through 415-012-0090 that provides assessment, treatment, rehabilitation, and twenty-four-hour observation and monitoring for individuals with gambling related problems. Treatment includes services such as group, individual, and family treatment consistent with addressing the challenges of an individual as they relate, directly or indirectly, to problem gambling behavior. Residential treatment may also include co-occurring disorders such as alcoholism, substance use, or other addictions, in addition to gambling. These programs provide residential environments and treatment services for up to 16 individuals, including detoxification programs, and are licensed every 2 years by the Oregon Health Authority, Health Services Division.

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	785	128	237	114	0	136	206	1,606
Beds per 100,000 Population	35.71	17.43	50.58	36.76	0	38.99	114.96	37.52

Table 14. Residential SUD Facility Bed Capacity

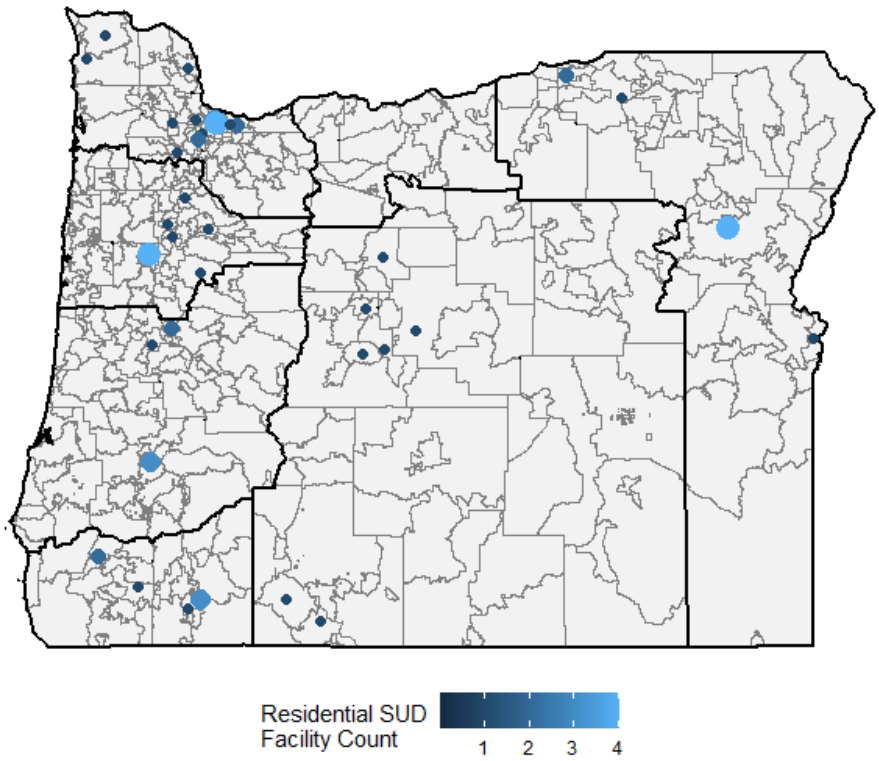

Figure 16. Residential SUD Facility Count Map

Clinically-Managed Withdrawal Management Facilities

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

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	4	0	0	0	0	0	8	12
Beds per 100,000 Population	0.18	0	0	0	0	0	4.46	0.28

Table 15. Clinically-Managed Withdrawal Management Bed Capacity

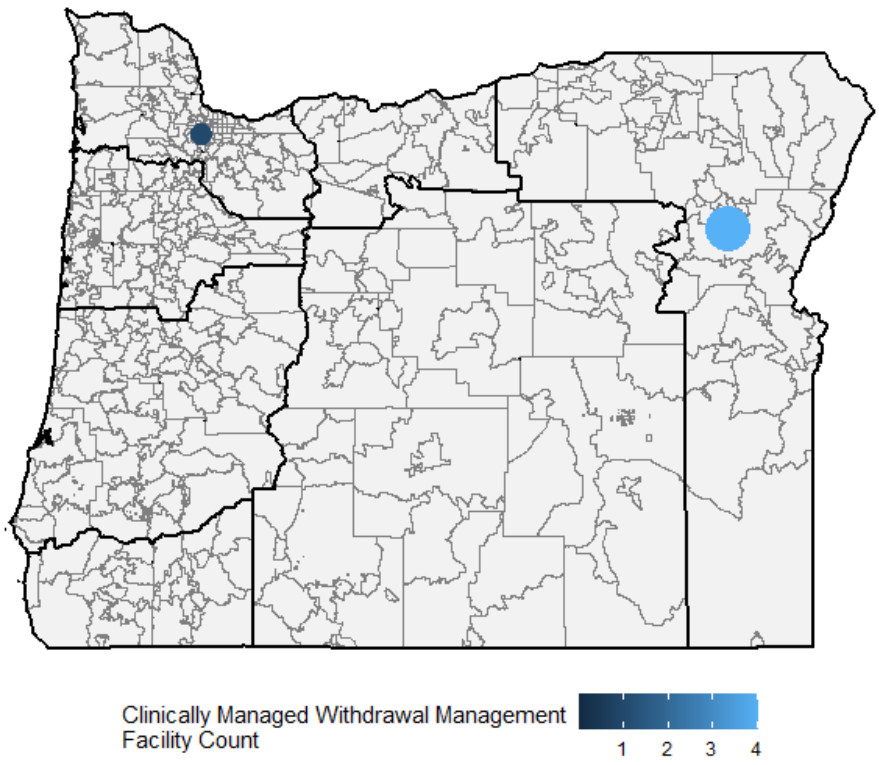

Figure 17. Clinically-Managed Withdrawal Management Facility Count Map

Medically-Monitored Withdrawal Management Facilities

SUD Withdrawal Management Medically Monitored Programs are substance use disorder treatment programs, within a residential substance use disorder treatment program, that are publicly or privately operated programs in a non-hospital setting, which provide assessment, treatment, rehabilitation, and twenty-four-hour observation and monitoring for individuals with substance use dependence. Medically Managed Withdrawal Management (ASAM Level 3.7-WM) means an inpatient setting which provides medically managed intensive inpatient treatment services. Such settings are also automatically certified for the provision of lower-level services.

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Number of Beds	135	43	55	24	0	36	44	337
Beds per 100,000 Population	6.14	5.86	11.74	7.74	0	10.32	24.55	7.87

Table 16. Medically-Monitored Withdrawal Management Bed Capacity

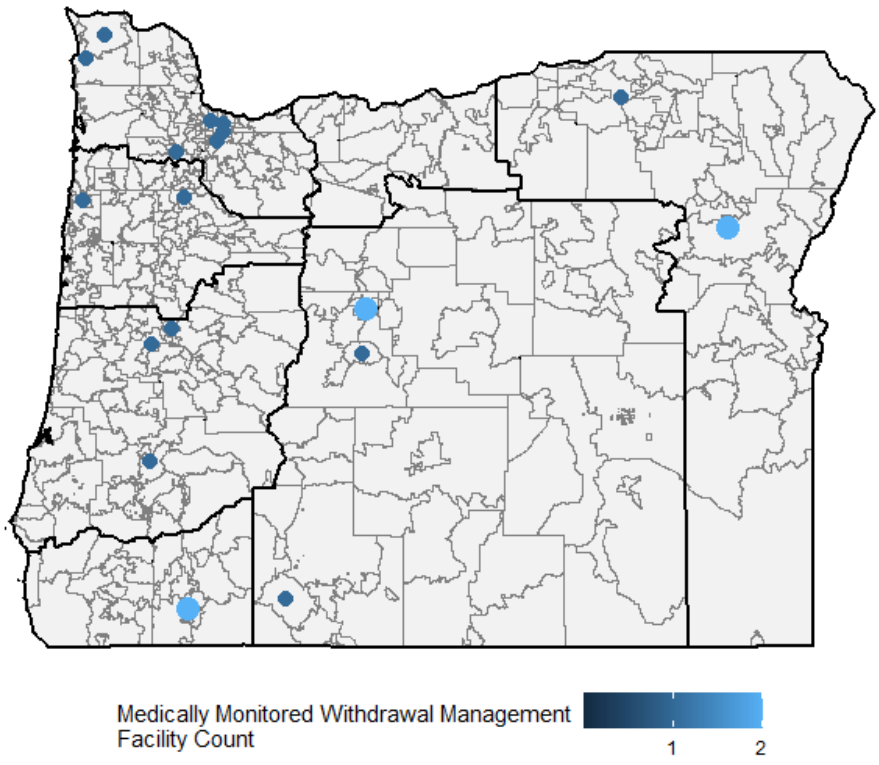

Figure 18. Medically-Monitored Withdrawal Management Facility Count Map

REGIONAL SUMMARY

The Regional Summary below shows all facility types and bed counts by Trauma System Area across Oregon:

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
State Hospitals	0	472	72	0	0	0	0	544
Acute Care Psychiatric Facility	84	25	0	0	0	0	0	109
Acute Care Psychiatric Unit in Hospital	191	34	48	24	0	15	0	312
Residential Treatment Facility (RTF)	283	80	59	26	12	26	43	529
Secure Residential Treatment Facility (SRTF)	147	106	131	72	0	48	42	546
Residential Treatment Home (RTH)	159	67	40	20	0	15	25	326
Adult Foster Home (AFH)	147	107	49	105	0	48	42	498
Residential SUD Facility	785	128	237	114	0	136	206	1,606
Clinically-Managed Withdrawal Management Facility	4	0	0	0	0	0	8	12
Medically-Monitored Withdrawal Management Facility	135	43	55	24	0	36	44	337
Total	**1,935**	**1,062**	**691**	**385**	**12**	**324**	**410**	**4,819**

Table 17. Regional Summary of Bed Capacity

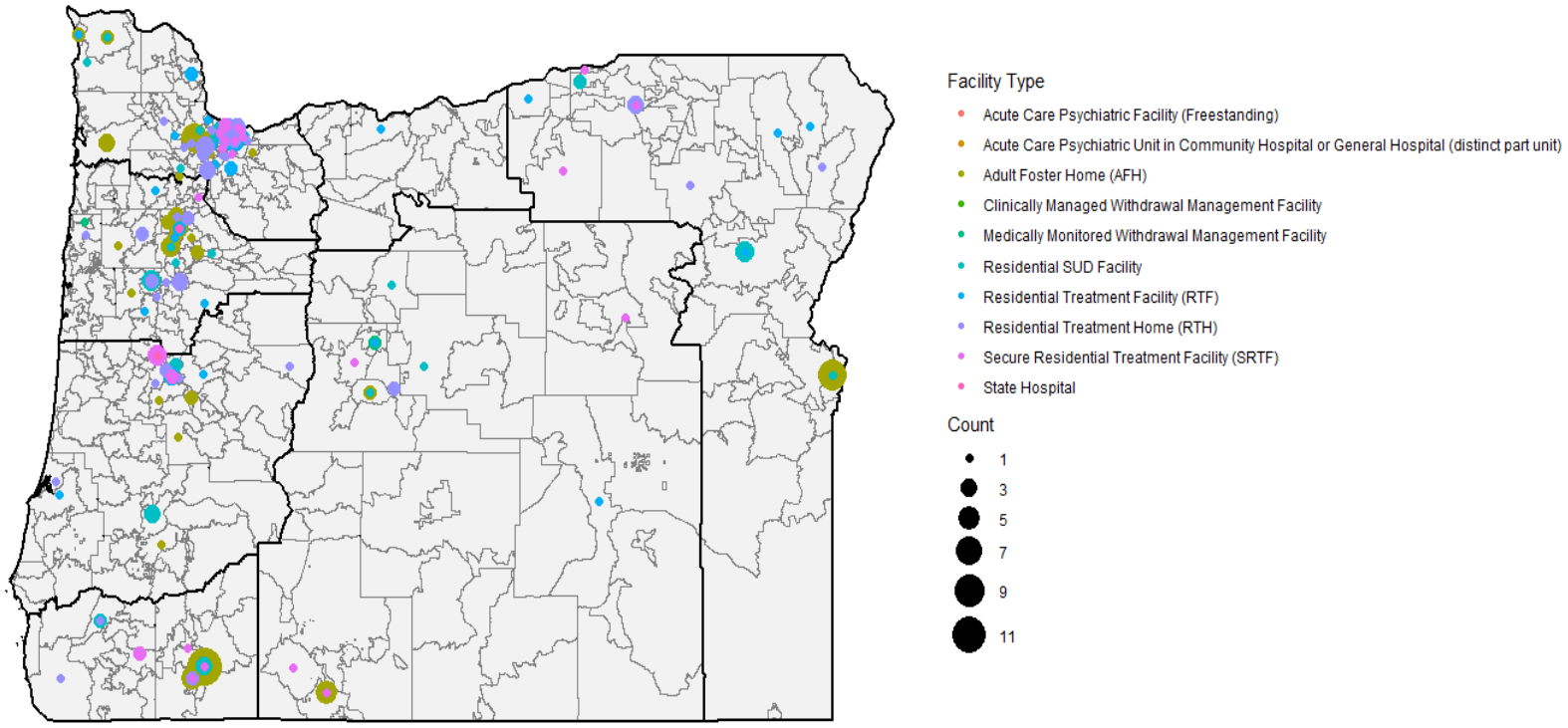

Figure 19. Regional Facility Count Map

ADDITIONAL CAPACITY IN PROGRESS (PENDING FACILITIES)

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

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

- New Construction
- Acquisition
- Renovation

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Residential Treatment Facility (RTF)	57	38	39	0	0	0	0	134
Secure Residential Treatment Facility (SRTF)	0	0	16	0	0	48	13	77
Residential Treatment Home (RTH)	10	20	30	20	0	0	0	80
Adult Foster Home (AFH)	0	0	5	0	0	0	0	5
Residential SUD Facility	44	0	0	0	0	0	0	44
Medically-Monitored Withdrawal Management	16	0	0	0	0	0	0	16
Total	127	58	90	20	0	48	13	356

Table 18. Facilities in Progress Bed Capacity

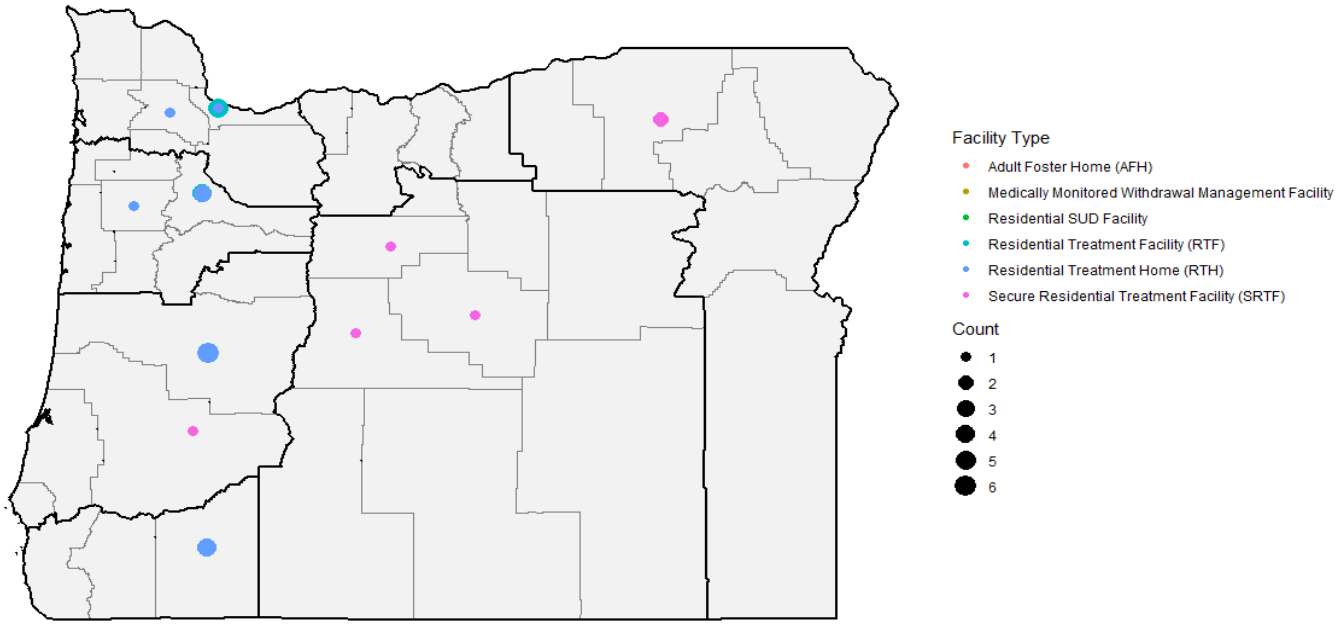

Figure 20. Facilities in Progress Facility Count Map

CURRENT AND PENDING CAPACITY

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

Trauma System Area		ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
State Hospitals	Beds	0	472	72	0	0	0	0	544
	Beds per 100k	0	64.28	15.37	0	0	0	0	12.71
Acute Care Psychiatric Facility	Beds	84	25	0	0	0	0	0	109
	Beds per 100k	3.82	3.40	0	0	0	0	0	2.55
Acute Care Psychiatric Unit in Hospital	Beds	191	34	48	24	0	15	0	312
	Beds per 100k	8.69	4.63	10.24	7.74	0	4.30	0	7.29
Residential Treatment Facility (RTF)	Beds	340	118	98	26	12	26	43	663
	Beds per 100k	15.47	16.07	20.92	8.38	28.80	7.45	24.00	15.49
Secure Residential Treatment Facility (SRTF)	Beds	147	106	147	72	0	96	55	623
	Beds per 100k	6.69	14.44	31.37	23.21	0	27.52	30.69	14.55
Residential Treatment Home (RTH)	Beds	169	87	70	40	0	15	25	406
	Beds per 100k	7.69	11.85	14.94	12.90	0	4.30	13.95	9.48
Adult Foster Home (AFH)	Beds	147	107	54	105	0	48	42	503
	Beds per 100k	6.69	14.57	11.52	33.85	0	13.76	23.44	11.75
Residential SUD Facility	Beds	829	128	237	114	0	136	206	1,650
	Beds per 100k	37.71	17.43	50.58	36.76	0	38.99	114.96	38.54
Clinically-Managed Withdrawal Management Facility	Beds	4	0	0	0	0	0	8	12
	Beds per 100k	0.18	0	0	0	0	0	4.46	0.28
Medically-Monitored Withdrawal Management Facility	Beds	151	43	55	24	0	36	44	353
	Beds per 100k	6.87	5.86	11.74	7.74	0	10.32	24.55	8.25
Total	**Beds**	**2,062**	**1,120**	**781**	**405**	**12**	**372**	**423**	**5,175**

Table 19. Current and Pending Bed Capacity

CRISIS FACILITY REVIEW

In addition to the licensed clinical facilities in scope, PCG also reviewed the Crisis facilities in Oregon. It is important to note that some of the crisis services in Oregon are not currently defined by State rules and do not have designated licensing and certification criteria at this time. The Health Systems Division is currently working on licensing criteria for the crisis facilities which will provide clarity on the types of services and the service delivery at the facilities that are offering the crisis services. The following information pertains to the crisis services and facilities in Oregon and was provided by the Oregon Health Authority:

Service or Facility Type	State Oversight	Services Provided
Psychiatric Emergency Services (PES)	Oregon Health Authority Health Systems Division: Behavioral Health Services – Chapter 309 Division 23 Oregon Secretary of State Administrative Rules Facilities providing PES must also meet standards for Regional Acute Care Psychiatric Facilities for Adults (OAR 309-032-0850 through 8070) and be approved as a hospital hold facility pursuant to OAR 309-033-0500 through 0550	Psychiatric Emergency Services are not distinct facilities – they are services provided in an emergency department of a hospital or satellite hospital for less than 23 hours. They may provide up to 23 hours of triage and assessment, observation and supervision, crisis stabilization, crisis intervention, crisis counseling, case management, medication management, safety planning, lethal means counseling, and mobilization of peer and family support and community resources.
Crisis Respite Services	Oregon Health Authority Health Systems Division: Behavioral Health Services – Chapter 309 Division 35 Oregon Secretary of State Administrative Rules	Crisis Respite Services are not distinct facilities. Crisis Respite Services are Medicaid reimbursable and are provided in Residential Treatment Facilities (RTFs) or Secure Residential Treatment Facilities (SRTF) for up to 30 days.
Crisis Receiving Centers	In Development – There is no facility type defined by rule.	Crisis Receiving Centers are not a defined facility type and are a future model of providing crisis services. According to the House Bill 2417 Report, Crisis Receiving Centers would provide crisis services for up to 23 hours and would be required to receive everyone who needs crisis services whether voluntary or involuntary and regardless of ability to pay. OHA HB 2417 Report

Service or Facility Type	State Oversight	Services Provided
Crisis Stabilization Centers	In Development – There is no facility type that is defined by rule.	Crisis Stabilization Centers are opening in Oregon, but they are not currently defined by rule. According to the HB 2417 Report, Crisis Stabilization Centers are often under the same roof as the 23-hour Crisis Receiving Center and are bedded units that range from 6-16 beds. They are staffed by licensed clinical staff as well as peer support specialists. Services are provided on a 24-hour basis to address immediate safety concerns and create a plan to integrate the individual back into the community. OHA HB 2417 Report
Peer Respite Centers	Oregon Health Authority Health Systems Division: Behavioral Health Services – Chapter 309 Division 20 Oregon Secretary of State Administrative Rules	Peer Respite Centers are not online in Oregon yet, but HB 2980 provided funding for 4 centers. Peer Respite Centers are peer run, voluntary, short-term, overnight programs that provide community-based, non-clinical support for those experiencing or at risk of experiencing an acute behavioral health crisis.

Table 20. Crisis Services Review

Given that the landscape of crisis services is under development with the rules being defined, PCG and OHA held nine (9) interviews with CMHPs providing crisis services in Oregon to learn more about the crisis services currently being offered and the plans to expand crisis services across the State. PCG and OHA collaborated to create a survey that was discussed and reviewed during these conversations. The survey aimed to understand the services being offered, the delivery model, the number of people served, the challenges and barriers, the staffing models, and the plans for expanding crisis services in their county. Conversations were held with the following groups:

- Benton County CMHP
- Lane County CMHP
- Adapt Oregon
- Polk County CMHP
- Deschutes County CMHP
- Marion County CMHP
- Clackamas County CMHP
- Washington County CMHP
- Multnomah County CMHP

PCG understands that the crisis services identified during these discussions may not represent the entirety of crisis offerings in the State. The crisis services identified during these discussions provide care for 23 hours or less or provide 24+ hour care based on their facility.

PCG is working with OHA to further identify where crisis services are being offered and will provide updates in the Final Report as necessary. The map below demonstrates where crisis services are being offered and where facilities are planning to offer services based on the conversations we had with the above groups:

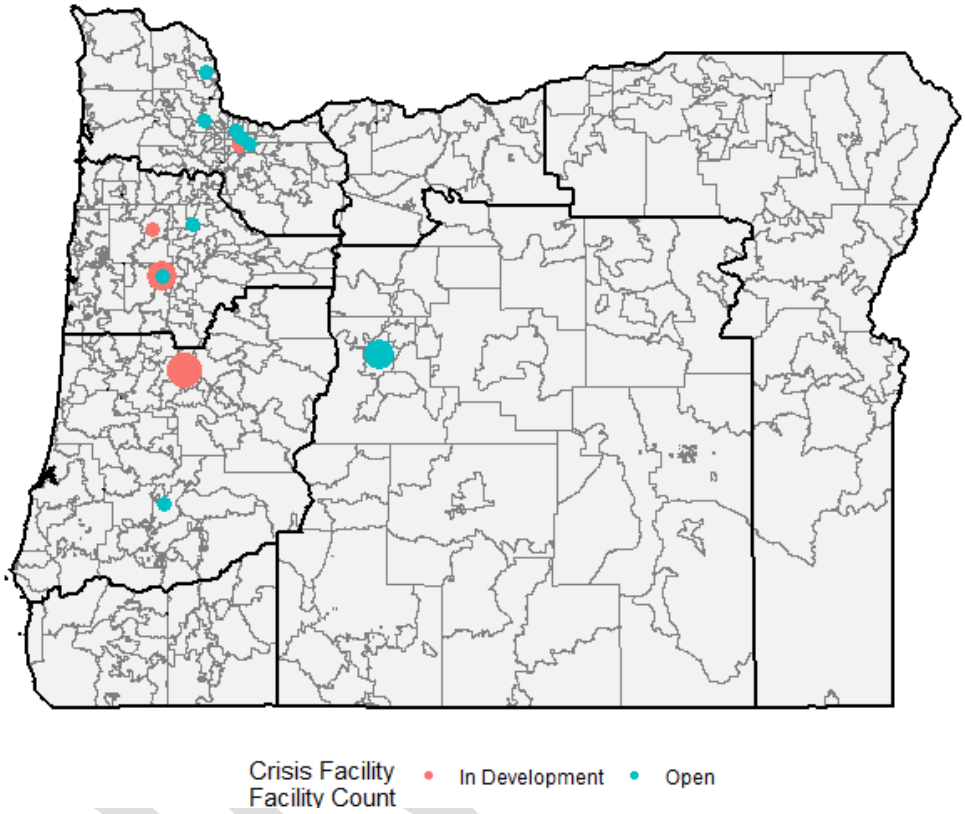

Figure 21. Crisis Facility Count Map

In addition to identifying the services provided, these discussions yielded important information about the barriers and challenges that are faced by the facilities that offer crisis services. Some key themes of the conversations are noted below:

- **Staffing:** Staffing was noted as a significant challenge for most of the programs that we spoke to. Hiring and retaining qualified staff has become increasingly difficult. Master's level clinician roles were noted as a position that has been challenging to fill with some facilities having several open positions that have been posted for long periods of time. These conversations also noted that retaining staff has been difficult due to alternative settings offering compensation that the crisis facilities cannot compete with. One of the facilities we spoke with noted that they often have limited hours on the weekend due to the staffing shortages and challenges that they face. Another facility noted that they have difficulty hiring and retaining staff for the night shift and have had to use staffing firms to bring in staff to fill these positions. The staffing shortages are leading to supervisors having to step in to provide services in other positions and leading to burnout amongst staff. Additionally, some facilities indicated that they must limit bed availability due to staff shortages.

- **Unavailability of beds at the next level of care:** During our conversations, it was noted that there can be a significant challenge finding a bed available for someone at another level of care. Some of the individuals we talked to noted that they had faced challenges discharging individuals from the crisis setting because there was a lack of available beds at another facility. Some individuals noted that residential is the most difficult facility to find with an open bed while others noted that withdrawal management is the most challenging to find for individuals who need it. Facilities noted that there are times when a bed is not available in a withdrawal management setting, so they refer the individuals to the emergency department. It was also identified that housing can be a barrier when discharging individuals from the crisis care setting – the facilities try to avoid sending someone back to the unhoused environment and have been working with community resources to prevent this.
- **Funding:** Funding was noted as a barrier for several of the facilities. It was mentioned that there is not adequate funding for some of the counties to provide mobile crisis services and to have mobile crisis teams that can cover the entire county. One facility noted that the cost to employ staff has risen substantially but there has been very limited state funding – they are relying on grant funding and, even with the grant funds, they are still operating with a funding gap.

The crisis facilities and services will continue to be reviewed and analyzed over the coming months to be included in the June 2024 Final Report.

COMMUNITY ENGAGEMENT

INTRODUCTION & METHODOLOGY

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

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

Review of Previous Community Engagement Initiatives

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

Identification of Community Partners

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

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

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

Development of Community Partner Engagement Matrix

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

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

Review of Community Partner Engagement Matrix

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

Stipend Distribution

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

Focus Groups/Discussions

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

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

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

It was important to emphasize an open line of communication between focus group organizers and participants, so participants felt comfortable continuing the conversation and sharing follow-up thoughts, if need be, and for the organizers to emphasize the participants' centrality to the project and the ability to keep in touch if more opportunities for community input arose in the future. Follow-up was indeed conducted by members of one of the focus groups to share further information and upcoming webinars for the PCG team to engage with continued learning opportunities. Furthermore, contact information was collected from each participant for stiped distribution and further communication, and the contact information of focus group organizers was also made available.

Tribal Discussion

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

1. What are the greatest behavioral health challenges and needs your tribal communities are facing?
2. What existing models of care should the State expand upon to better serve American Indian and Alaska Natives in Oregon?
3. What's working well about the State's government-to-government relationship with the Tribes, with respect to supporting and expanding behavioral health care? What could be improved?
4. Where do you believe State funding for behavioral health services should be prioritized or invested to address unmet need and improve the overall system?

Many important points were made during the discussion that aligned with the key themes that emerged during the community engagement period. However, what also arose was the need to integrate unique cultural approaches that may not be uniform across different tribes and across the State. Prioritizing the use of a culturally specific, tribal-based practices model in these communities is critical, as is consistency and relationship building with OHA. Many other key takeaways emerged from this discussion, and PCG will continue to explore these issues further in individual discussions with some of the tribes in the coming months.

Focus Group #1: OBBIAC

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

Focus Group #2: Caregivers with Lived Experience

The second focus group was held on October 24, 2023 via Microsoft Teams. This focus group included Caregivers with Lived Experience, and all six participants were parents of children with interaction with the behavioral or mental health systems within the State. The focus group was scheduled for two hours. This focus group was led by members of the PCG team; Phoebe Kelleher facilitated the conversation, and Kaitlyn Crone and Rhea Lieber supported note taking and monitoring of the meeting platform and the chat.

Stipends were sent to all participants on October 24, 2023. With a slightly larger group all sharing the identity of parents, the conversation flowed and there was a meaningful exchange of stories and ideas for improving Oregon's systems and resources.

Key Informant Interviews

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

- Rural & Urban CCO
- Rural & Urban Hospital
- Tribal*
- Public Safety
- Rural & Urban CMHP
- Housing
- Residential/LGBTQIA2S+
- Person with Lived Experience (PWLE)
- Peers

*The tribal interviews are currently being scheduled and are in progress.

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

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

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

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

#	Type	Meeting Date & Time (PT)
1	Residential/LGBTQIA2S+	9/13/23, 12-1pm
2	Housing*	10/5/23, 11-12pm
3	Rural Hospital*	10/5/23, 1-2pm
4	Public Safety	10/5/23, 3-4pm
5	Urban CCO	10/11/23, 3-4pm

6	Urban CCO	11/16/23, 2-3pm
7	Housing	10/12/23, 11-12pm
8	Rural CCO	10/19/23, 10-11am
9	Urban Hospital	10/25/23, 8-9am
10	PWLE #1	9/19/23, 11-12pm
11	PWLE #2	10/2/23, 1-2pm
12	PWLE #3	10/23/23, 12-1pm
13	PWLE/Peer #1	9/25/23, 1-2pm
14	PWLE/Peer #2*	10/5/23, 9-10am
15	PWLE/Peer #3	10/18/23, 12-1pm
16	PWLE/Peer #4	10/26/23, 1-2pm
17	PWLE/Peer #5	10/30/23, 10-11am

*Conducted in-person.

Table 21. Community Engagement Meetings

Like the focus groups, it was also important to emphasize an open line of communication after the key informant interview concluded. Participants were encouraged to save the email addresses for Ms. Kelleher and Ms. Lieber, who oversaw interview outreach and the sessions themselves. Follow-up was indeed conducted by a handful of key informant interview participants, so offering space to share more ideas or follow-up questions was important. Furthermore, stipends were distributed to Peer and PWLE interview participants.

Facility Visits

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

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

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

FEEDBACK ANALYSIS

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

During the upcoming analysis, multiple PCG staff members will review the data to identify common categories or themes across entries for each question. Once consensus is reached, numerical or alphabetical labels will be assigned to the categories and the team will apply these labels to each entry. The team will utilize the Excel 'Sort' function to group entries by the assigned categories, and in instances where inconsistencies arise, we will re-categorize entries or introduce new categories. This process will be repeated for each interview, resulting in an organized arrangement of categories based on the frequency of entries. From this process, we will be able to identify key themes and recommendations.

KEY INFORMANT INTERVIEW KEY THEMES

Common themes quickly emerged among the interview data collected, and similar themes arose across all respondent types. Although our study primarily focuses on identifying the capacity of residential behavioral health facilities, participants frequently addressed additional needs in behavioral health resources and how various points of care impact residential facilities. As a result, key themes not only centered on residential facilities but also extended across the entire behavioral health continuum. While many of these key themes fall outside the immediate scope of this study, their inclusion was integral to capture in order to inform further analysis of behavioral health needs across the continuum and to provide essential context to the behavioral health access experience. The first part of this subsection provides a narrative review of those common themes organized by interview topic. This is a brief overview of identified themes which will be further examined in the June 2024 Final Report after the feedback analysis, as outlined above, is completed.

Perspectives of People with Lived Experience (PWLE)

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

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

Staffing

Community partners report that the current operational challenges within various facilities stem from staffing shortages and difficulties in retaining qualified personnel. These issues have hindered the ability of these facilities to operate at full capacity and have led to negative experiences for individuals accessing behavioral health facility services. Community partners identified multiple factors that contribute to persistent staffing challenges. Some of these factors included:

- **Burnout and Safety:** Provider burnout has been a large contributor to staff turnover in recent years, especially following the COVID-19 Public Health Emergency (PHE). According to respondents, one of the main causes of this burnout is lack of safety and support in the work environment. The acuity of individuals accessing behavioral health and substance use services has sharply increased in recent years. Current facility capacity does not align with this level of acuity, causing individuals to be placed in facilities that are unable to meet their level of need. Some

participants also indicated that newly graduated providers entering the workforce are not properly trained in the increased acuity or complex needs of the populations served. Staff who operate in these facilities feel unprepared to serve the population and overwhelmed by the workload.

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

Facility Access, Availability, and Experience

- **Wait Times:** Wait times were reported as an issue when accessing all levels of care across the behavioral health continuum, but particularly when accessing residential services. Multiple community partners described a “bottle neck,” situation, where street outreach engagement can connect with individuals who are seeking treatment services, but there is a significant wait to access withdrawal management or detox care. Then, once individuals can access withdrawal management services, after discharge they are unable to access timely residential care. Extended wait times were also a notable issue when individuals sought access to residential care from hospital emergency departments. This often led to individuals spending multiple days or weeks in the emergency department while waiting for available placements.
- **SUD Level of Care Mismatch and Rising Acuity:** Community partners advised that there is a general lack of preparedness for the levels of care needed to meet the high acuity needs of patients in Oregon today. This mismatch between available levels of care for SUD and the actual required level of care carries significant consequences throughout the healthcare continuum. It is imperative to build out the correct levels of care for SUD that are in line with the acuity of the patient population with a specific focus on the effects of new drug use trends, a growth in co-occurring diagnoses and conditions, and the traumas associated with houselessness. A mismatch in levels of care also has trickle down effects that can lead to no one receiving adequate care at any level of the medical or mental health system. One such effect is workforce burnout – staff are being asked to treat at the wrong level of care just so patients can receive some form of treatment, however inadequate or inappropriate given patients’ unique needs. Staff are being asked to address increasingly complex and intense situations that are outside their training or available resources, which can lead to burnout, or even unsafe situations.
- **State Hospital Accessibility Issues:** Oregon’s public psychiatric hospitals have dedicated most of their capacity to individuals in the legal system, causing these facilities to greatly reduce admissions for civilly committed individuals. Community partners shared concerns that with this reduced capacity, there is nowhere to place individuals experiencing a mental health crisis. Often, these individuals must stay in the facilities’ emergency department, putting a strain on available resources.

- **Residential Experience:** Many of the people with lived experiences the PCG team met with during the community engagement period reflected on negative experiences in a residential treatment setting. Participants discussed how providers and staff are not trained to adequately serve patients with sensitivity, compassion, respect, and empathy, especially high acuity patients and those with SMI, due to a lack of understanding or education, or fatigue and burnout. This led to patients feeling unsafe and feeling as though they had nowhere to turn to access services after being discharged from a facility in which they experienced distress, trauma, or stigma. Compounded upon an existing shortage of residential treatment options, patients feeling further isolated from potential spaces to access care is a critical issue with both personal and systemic effects.

Funding and Facility Expansion Priorities

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

- **Substance Use Disorder (SUD) Continuum of Care:** To meet the rising acuity and complex needs of individuals accessing SUD services, community partners emphasized that the SUD continuum needs to be strengthened at all points of care, not just within residential facility capacity. Additionally, the participants pointed to the absence of residential facilities that can provide an intermediate level of care, such as partial hospitalization (PHP) and intensive outpatient programs (IOP). Such facilities play a critical role in the care continuum, supporting safe discharge from inpatient and acute care settings as well as preventing decompensation that leads to inpatient utilization. Priority facilities to be invested in and expanded according to participants include withdrawal management, sobering centers, day centers, strong step-down programs, Medication-Assisted Treatment (MAT), harm reduction and street outreach services, and community housing facilities.
- **Culturally Specific Services:** There is a need to expand culturally specific services and providers across the behavioral health continuum in Oregon. Challenges related to culture, language, and identities frequently amplify the symptoms of both mental and physical illnesses. Recent and historical encounters with oppression, discrimination, and severe trauma pose significant hurdles to involvement in behavioral healthcare systems. Participants with lived experience report feeling safer when providers share their identities. Community partners identified that culturally specific services should be expanded to meet the needs of populations included but not limited to Black, Asian, Hispanic, Native American, immigrants and refugees, and members of the LGBTQIA2S+ community, particularly transgender and gender nonconforming individuals.
- **Meeting Complex Needs:** In addition to culturally specific services, community partners identified populations that experience disproportionate unmet needs within the behavioral health system in Oregon, and services to target these populations should be expanded. This includes youth and families, individuals accessing services during pregnancy, individuals with physical disabilities, veterans, co-occurring disorders, and individuals experiencing homelessness.
- **Peer Workforce Expansion:** In addition to the above workforce considerations, community partners emphasized the crucial need to expand peer services in residential behavioral health and substance use disorder treatment settings. According to their feedback, having individuals with lived experiences in recovery as Peers creates trust, understanding, and hope in individual's experiences. Integrating Peer services was seen not only as an enhancement to overall care quality but also as a key component of a more inclusive and holistic treatment approach. Further considerations for the Peer workforce are also mentioned above in the Staffing themes.

- **Models for Rural Communities:** The diverse geographic landscape and unique social needs of rural areas require a tailored approach to treatment design and residential facility options. Oregon's rural communities often face distinct challenges, such as limited access to mental health resources, long travel distances, and a scarcity of specialized and culturally specific facilities. Recognizing and addressing these specific hurdles is essential to creating effective and accessible behavioral health care.

FOCUS GROUP KEY THEMES

Oregon Black Brown Indigenous Advocacy Coalition (OBBIAC)

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

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

- **Grants for Culturally-Specific Groups:** In order to bring culturally-specific groups and patients to the table, the State should offer grant opportunities that are targeted and limited, so not open to everyone, in order to increase cultural diversity and expand funding opportunities for organizations that will offer culturally-specific services.

Caregivers with Lived Experience

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

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

participants offered a few key ways the State could address issues of care coordination, such as: embed care coordination into every clinic, improve access to services outside of crisis situations, marry mental and physical health care and encourage these providers to collaborate, work with law enforcement and state agencies to track individuals in mental health crisis, and offer early intervention and wraparound services.

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

FORECASTING NEED AND COSTS FOR ADDITIONAL BEHAVIORAL HEALTH CAPACITY

This section provides initial draft estimates of forecasted capacity needs and costs to expand behavioral health facilities in Oregon. These estimates will be the foundation and will be further explored and refined in the coming months. The June 2024 Final Report will include PCG's final projections for forecasted bed needs and funding needs to expand behavioral health capacity in Oregon.

BEHAVIORAL HEALTH CAPACITY NEEDS

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

Work Stream	Process
Quantitative Data Analysis	• Confirmed the data points required with OHA to accurately describe current adult behavioral health and SUD facilities and bed types by region. • Reviewed data points from the State and community partners. • Processed data received and conducted follow-up with identified sources as needed. • Completed Provider Survey • Incorporated additional data from the following sources into the analysis: o National Association of State Mental Health Program Directors o Substance Abuse and Mental Health Services Administration (SAMHSA) American Psychological Association (APA)
Peer State Analysis	• Identified and confirmed five states for inclusion: Colorado, Kentucky, Massachusetts, Utah, and Washington. o Colorado, Utah, and Washington represent similar geographies o Kentucky represents a similar population o Massachusetts is a highly ranked state nationally for access to mental health care o Utah is similar statistically with prevalence of mental health and overdose statistics, as well as similar geographies and populations These states were used as benchmarks for community bed capacity based on data obtained from The National Association of State Mental Health Directors and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Table 22. Work Streams for Capacity Data Analysis

Current Capacity

This section provides the total bed counts and beds per one hundred thousand population for the facilities by Trauma Service Area. To determine capacity, PCG gathered and analyzed all available Oregon bed source data and conducted a provider survey to estimate that the State of Oregon has 965 adult inpatient mental health beds (22.54 per 100,000 population). Of those 965 beds, 544 were inpatient beds at the state hospital level (12.71 per 100,000 population), and 421 adult inpatient beds at the acute level in freestanding, general, or community hospitals (9.83 per 100,000 population).

At the community residential level, we estimated Oregon currently has a total of 3,505 adult residential beds (81.87 per 100,000 population), including mental health residential facilities, mental health treatment homes, secure residential treatment facilities and SUD residential. Of those beds, 1,353 are adult mental health residential beds (31.61 per 100,000 population), 546 are adult secure mental health residential facilities (12.75 per 100,000 population) and 1606 are SUD residential (37.52 per 100,000 population).

Within the Withdrawal Management treatment beds, we estimated Oregon currently has 349 beds, comprising 337 Medically Monitored beds (equivalent to 7.87 per 100,000 population) and 12 Clinically Monitored beds (equivalent to 0.28 per 100,000 population).

Facility Type	Current Capacity	Beds Per 100k population
State Psychiatric Hospital	544	12.71
Acute Care Inpatient Psychiatric Beds	421	9.83
Mental Health Residential (RTF & RTH only)	855	19.97
Mental Health Residential (AFH only)	498	11.63
Secure Residential Treatment Facility (SRTF only)	546	12.75
SUD Residential	1,606	37.52
Withdrawal Management, Medically Monitored	337	7.87
Withdrawal Management, Clinically Monitored	12	0.28
Total	4,819	112.57

Table 23. Current Facility Capacity

Additional Capacity in Progress

Apart from the existing community capacity in Oregon, several facilities are currently under construction, expanding their capacity and contributing to the overall bed capacity within the state. Table 24 below shows the bed counts for facilities in progress and the projected capacity by the third quarter of 2025. PCG determined a timeline of third quarter 2025 for beds to be online and accessible, by reviewing anticipated completion project data submitted requesting state funding through the SDOH 5202, 5024 and Measure 110 funding opportunities.

To determine pending capacity, PCG examined data from the State of Oregon's grant funding initiatives for SDOH 5202, 5204, and Measure 110 to ascertain the quantity of new mental health residential beds in development to enhance bed capacity within the State. Through our analysis, PCG determined

approximately 356 new mental health residential and withdrawal management beds would be available or an additional 8.31 beds per 100,000 population. Of note, this project did not include capacity planning needs at the state or acute psychiatric hospital level, although PCG does provide a very limited capacity analysis at the community hospital bed level in this report.

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025
State Psychiatric Hospital	544	Unknown	544
Acute Care Inpatient Psychiatric Beds	421	Unknown	421
Mental Health Residential (RTF & RTH only)	855	214	1,069
Mental Health Residential (AFH only)	498	5	503
Secure Residential Treatment Facility (SRTF only)	546	77	623
SUD Residential	1,606	44	1,650
Withdrawal Management, Medically Monitored	337	16	353
Withdrawal Management, Clinically Monitored	12	0	12
Totals	4,819	356	5,175

Table 24. Additional Capacity in Progress

Methodology for Defining Capacity Needs

To establish a benchmark for the targeted number of residential beds needed in Oregon per capita, we completed a peer state comparison using data from Colorado, Kentucky, Massachusetts, Utah, and Washington. Bed data was extracted from the Substance Abuse and Mental Health Services Administration (SAMHSA), 2020 National Mental Health Services Survey (N-MHSS). Although various factors may have evolved since then, including the repercussions of the COVID-19 pandemic, PCG utilized this report as a reference point for data calculations. The report includes the number of beds per state for 24-hour residential facilities and we used population data from the United States Census Bureau from 2020. For comparison purposes, we calculated the number of beds per 100,000 population and then averaged the peer state ratios to calculate our target beds per 100,000 population as shown in Table 25.

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

***Table 25.* Calculating the Peer State Average for Residential Beds**

Acute Care Psychiatric Inpatient Beds

Through PCG's analysis of all data sources, we have estimated 421 (9.83 beds per 100,000 population) acute care inpatient psychiatric beds are currently available in Oregon. This includes Freestanding Inpatient Psychiatric Unit and Distinct Units in a General or Acute Care Hospital; however, this does not include "scatter beds", which are beds in a general medical unit of a hospital used to place psychiatric inpatients in. In addition, the total does not include state psychiatric hospital beds.

Acute care inpatient psychiatric beds are usually for those who need intensive psychiatric inpatient level of care to manage an illness in an emergency or acute situation, but not requiring the highest level of intensity services provided by a state psychiatric hospital. According to a report published in the International Journal of Environmental Research and Public Health titled "*Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model,"* the overall rate of psychiatric beds needed per 100,000 population, was 34.9. This figure is validated by another report entitled, "*Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process,"* citing 30 to 60 beds per 100,000. To conduct a brief analysis of current capacity and needs within Oregon, PCG used 34.9 beds per 100,000 to estimate 1,494 inpatient acute psychiatric beds are needed in the State of Oregon. Consequently, employing this methodology suggests that Oregon's capacity in acute care inpatient psychiatric beds could increase by an additional 1,073 beds.

To further analyze the gap between the State of Oregon's acute inpatient psychiatric beds and the above needed projection, PCG combined the existing psychiatric inpatient acute care beds of 421 with the current state psychiatric hospital beds of 544, resulting in a total of 965 inpatient psychiatric beds, equivalent to 22.54 beds per 100,000 population. With both numbers added together, Oregon's beds per 100,000 population is below the 34.9 beds per 100,000 population benchmarks by 12.36 beds per 100,000 population or 529 beds. Table 26 shows peer state beds per 100,000 population according to a 2021 report titled *"Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model."* When reviewing peer states, utilizing the lowest beds per 100,000 from Utah and Washington, the average is 26.59 beds per 100,000 population, which is higher than Oregon's 22.54, by 4.05 or 173 beds.

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

Table 26. Peer State Population and Inpatient Psychiatric Beds Per 100,000 Population

Although this study did not encompass a comprehensive analysis of acute care psychiatric beds, or state psychiatric hospital beds for that matter, PCG recognizes the necessity for a full continuum of care within a geographic region to facilitate psychiatric treatment and enhance accessibility, thereby mitigating challenges and bottlenecks to access care throughout the continuum. PCG would recommend further comprehensive analysis of acute care inpatient psychiatric beds and investigation into how the State could support non-for-profit or for-profit hospitals in developing additional capacity for a minimum of 173 beds, a median of 529 beds, and up to a maximum of 1,073 beds. Furthermore, the inclusion of crisis facilities in the final report numbers may result in variations, potentially mitigating some of the required inpatient beds. This could have a notable effect on the overall demand for hospital beds in the state, thanks to the supplementary support available within the community.

Mental Health Residential Treatment Facilities and Homes

Mental Health Residential, includes both Residential Treatment Facilities (RTF) and Mental Health Treatment Homes (RTH), which are unlocked and provide community residential treatment for longer term care of adults with a mental health diagnosis. Adult Foster Homes were not included in the capacity needs assessment as these were not noted as high priority in our discussions. As shown in Table 27, Oregon has a total of 855 mental health residential beds currently in the state, of which 529 (12.36 beds per 100,000 population) are classified as RTFs and 326 (7.62 beds per 100,000 populations) are classified as RTHs. Mental Health Residential Beds of this type equate to 19.97 beds per 100,000 population.

Trauma System Area	ATAB 1	ATAB 2	ATAB 3	ATAB 5	ATAB 6	ATAB 7	ATAB 9	Total
Combined Number of Beds	442	147	99	46	12	41	68	855
Combined Beds per 100,000 Population	20.11	20.02	21.13	14.83	28.80	11.75	37.95	19.97

Table 27. Combined Residential Treatment Facilities and Homes Bed Current Capacity

Mental Health Residential Facilities and Homes Capacity Needs Assessment

PCG analyzed data from the State of Oregon's grant funding initiatives for SDOH 5202, 5204 and Measure 110 to determine the number of new mental health residential beds coming online. Through our analysis, PCG determined 214 new mental health residential beds are coming online by the third quarter of 2025. With the current bed capacity of 855 plus the addition of 214 beds, we are projecting a total of 1,069 beds to support Community Mental Health Residential needs by the third quarter of 2025.

Utilizing peer states' average of 18.54 beds per 100,000, Oregon would need 794 residential beds to support this type of service and care. Currently, Oregon has a capacity of 855 beds or 19.97 beds per 100,000 population statewide. When combining additional capacity of 214 new beds by the third quarter 2025, Oregon will have a projection of 1,069 beds or 24.97 beds per 100,000 population. When comparing Oregon to peer states average, Oregon's beds per 100,000 projections of 24.97 exceeds beds per 100,000 population of the comparison states by 6.43, thereby indicating residential beds for Mental Health Facilities and Residential Homes meet or exceed needed capacity by this method.

To further analyze if the above-described method determined if bed capacity was met or exceeded, PCG analyzed data from The National Association of State Mental Health Directors Report, "*Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022,"* for the number of patients per 100,000 in a 24-Hour Residential Treatment Facility of each reporting year from 2010 through 2020. On April 30th for each year reported, PCG can determine that the projected bed capacity of 1,069 or 24.97 beds per 100,000 does support the number of individuals in residential care treatment for the State in 2018 (22.36 per 100,000 population) and 2020 (17.31 per 100,000 population). Of note, in 2020, there is a decline in the number of patients per 100,000 reported; however, this would reflect the impact of the COVID-19 pandemic on health care.

However, if you average each year together for Oregon, the average number of patients in a 24-hour residential facility over the ten-year reporting period is 26.71 residents per 100,000 on a given date, indicating that 1.74 additional beds per 100,000 or 74 additional beds would be needed to support residential treatment services. If you remove the high and low variables reporting individuals per 100,000 in a 24-hour residential setting on that given date, the average is 24.43 per 100,000, placing Oregon within capacity of the projected beds within the State by the end of 2025. The current recommendation of meeting or slightly exceeding capacity needs by the end of 2025 with new additional capacity would be validated by

this methodology; however, incorporating an additional 74 beds would enhance capacity to address the needs of residents in Oregon and growth in population.

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

Table 28. Average Patients in Residential Facility

PCG would be remiss if, however, we did not acknowledge an opportunity in the 24-hour residential space, in which a clear need was identified during our data collection and interviews. During PCG's interviews with providers and government stakeholders, the difficulty of placing individuals with mental health diagnosis and concomitant medical needs requiring longer term care, especially the elderly, in 24-hour residential facilities emerged as a key theme. While the data does not account for different types of needs within adult residential beds, the State of Oregon would benefit from completing an additional study focusing on geriatric mental health treatment and continuum of care and services, further defining if there is a need for increasing services and funding for this specialized population. In the event that the State of Oregon would like to add beds to the 24-hour residential facility continuum, PCG would recommend adding beds dedicated to this specialty population or other "hard to place" populations. Specifically, placing individuals within this population subset can be challenging due to the unique needs of the patients and the shortage of residential treatment homes and facilities capable of addressing both mental and physical requirements. Consequently, there is an increased likelihood of patients being "boarded" in facilities or emergency rooms until suitable placement becomes available.

Secure Residential Treatment Facilities (SRTF)

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

Secure Residential Mental Health Treatment Facilities are locked facilities, providing longer term care for individuals with a mental health diagnosis and usually for those with a criminal history or ordered to a locked community facility. The current estimate suggests that Oregon currently has a total of 546 beds in secure residential mental health treatment facilities, equivalent to 12.75 beds per 100,000 population in the state.

Capacity Needs Assessment

PCG analyzed data from the State of Oregon's grant funding initiatives for SDOH 5202, 5204 and Measure 110 to determine the number of new Secure Residential Treatment Facility (SRTF) beds coming online. Through our analysis, PCG determined 77 new SRTF beds are coming online by the third quarter of 2025. With the current bed capacity of 546 plus the addition of 77 beds, we are projecting 623 beds to support Secure Residential Treatment Facility needs by the third quarter of 2025.

Utilizing the peer states average of 18.54 beds per 100,000, Oregon would need 794 secure residential beds to support this type of service and care. Currently, Oregon has a capacity of 546 beds with an additional capacity of 77 new beds coming online by the third quarter 2025. At that time, Oregon will have a projection of 623 beds or 14.55 beds per 100,000 population, thereby requiring an additional 171 SRTF beds to meet or exceed needed capacity by this method.

To further analyze if the above-described method did determine if bed capacity was not met, PCG analyzed data from The National Association of State Mental Health Directors Report, "*Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970-2022,"* for the number of patients per 100,000 in a 24-Hour Residential Treatment Facility of each reporting year from 2010 through 2020. On April 30th for each year reported, PCG can determine that the projected bed capacity of 623 or 14.55 beds per 100,000 does not support the number of individuals in secure residential care treatment for 2018 (22.36 per 100,000 population) and 2020 (17.31 per 100,000 population), thus indicating the capacity need is not met. Of note,

in 2020, there is a decline in the number of patients per 100,000 reported; however, this would reflect the impact of the COVID-19 pandemic on health care.

However, with Secure Residential Treatment Facilities more exclusively providing care and treatment to individuals requiring a locked community facility, such as forensic status individuals, the trends according to The National Association of State Mental Health Directors report indicates a decline of 9% in forensic population in state psychiatric hospitals. While the report does not specifically account for different levels of care within community residential treatment options, PCG would recommend convening a provider advisory group to determine the most appropriate use of the additional 171 residential beds identified through the capacity analysis for Secure Residential Treatment Facilities. While Mental Health Residential Treatment Facilities and Homes indicated capacity was met or could use an additional 74 beds, the opportunity exists to utilize some, or all the identified SRTF additional beds needed in that space as well.

Substance Use Disorder Residential Capacity

Residential Substance Use Disorder treatment provides assessment, treatment, rehabilitation, and 24-hour observation and monitoring for individuals with substance use dependence, consistent with Level III of ASAM. Through our analysis, we identified Oregon has 1,606 Substance Used Disorder (SUD) Residential Treatment Beds (37.52 per 100,000 population).

Substance Used Disorder (SUD) Residential Treatment Capacity Needs Assessment

To determine SUD Residential capacity needs, PCG analyzed data from the State of Oregon's grant funding initiatives for SDOH 5202, 5204 and Measure 110 to determine the number of new SUD Treatment Facility beds currently pending in the state. Through our analysis, PCG determined 44 new SUD residential beds will be available by the third quarter of 2025. With the current bed capacity of 1,606 beds plus the addition of 44 beds in progress, we are projecting a total of 1,650 beds (38.54 per 100,000 population) to support SUD Residential needs by mid-year 2025.

To evaluate SUD residential capacity needs, PCG utilized three resources to further evaluate the capacity needs for the state. First, a report from the Rand Corporation titled "*Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California*," which cited that a reference benchmark for adult SUD treatment beds needed were about 42.7 to 46.2 beds per 100,000 adults after literature research. Using the average of the quoted beds per 100,000 population of 44.45, PCG estimated that the State of Oregon is 6.93 beds per 100,000 population or 297 beds short to support the needs in the State. The second source in our analysis utilized the OHA/BH rapid assessment for 2024 Governor's Budget, which called for an additional 1,200 beds. Utilizing this data source, the projection for additional bed need in Oregon would be 1,156 (26.96 beds per 100,000 population). Although these two sources of comparison provide an estimation of need in Oregon's SUD residential bed capacity, they vary vastly and do not paint a clear picture of what a more precise analysis could provide.

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

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

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

Table 29 defines the NSDUH boundaries used to define regions for the CAST model, initial assessment, and re-assessment.

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

Table 29. NSDUH Boundaries for CAST Model

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

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

Considering the outlined variables, assumptions, and detailed data inputs, the projections for SUD residential treatment bed requirements for the entire State indicated a need for 3,775 beds in the updated forecast. Therefore, with the current bed capacity of 1,606, the State of Oregon would need an additional 2,169 SUD residential treatment beds to support this service and demand from this method. Currently, the State of Oregon has 37.52 beds per 100,000 population and if the state would increase the SUD residential treatment beds by 2,169 over a period of time. This would inflate Oregon's bed per 100,000 population to 78.84, thus increasing by 41.32 beds per 100,000 population.

While PCG identified the CAST model to be the most precise in reflecting the additional bed capacity need within the State, we also understand that a significant capital investment within the infrastructure would be needed to increase the total beds. Therefore, the recommendation would be to create a five-year plan, thereby increasing the State's SUD residential treatment bed capacity to a minimum of 1,156 and a maximum of 2,169 beds to meet the anticipated demand.

Table 30 identifies the breakdown of beds by NSDUH region and the projected bed need to support the demand for SUD residential treatment by region.

Region	Current Bed Capacity	Calculated Bed Demand	Number of Additional Beds Needed to Support Demand
Region 1	545	745	200
Region 2	91	896	805
Region 3	457	1,175	718
Region 4	236	519	283
Region 5	71	222	151
Region 6	206	217	11
Statewide	1,606	3,775	2,169

Table 30. Capacity and Demand

Withdrawal Management Capacity

Through our analysis, we identified that Oregon has a total of 349 Withdrawal Management Beds (8.15 beds per 100,000 population). Within the total 349 beds, 337 (7.87 per 100,000 population) are designated as Medically Managed Withdrawal treatment beds and 12 (0.28 per 100,000 population) beds are classified as Clinically Managed Withdrawal treatment beds. Medically and Clinically Managed treatment differ by the setting, management, and monitoring of individuals going through withdrawal or detoxification treatment and under the type of treatment guidance provided by medically or clinically trained personnel. Medically monitored is an inpatient setting that provides medically managed intensive inpatient treatment services requiring 24-hour nursing care and under the guidance of a physician and classified as ASAM Level 3.7. Clinically Managed Withdrawal Management is provided in a setting which is residential in nature, delivering clinically managed services directed by non-physician addiction specialist rather than medical or nursing personnel and classified as ASAM Level 3.2. Medically Managed is considered the higher level of care of the two care delivery models, therefore allowing either Clinically or Medically Managed treatment to occur in this setting versus Clinical Management which can only provide Clinically Managed treatment or lower.

Withdrawal Management Capacity Needs Assessment

To determine Withdrawal Management capacity needs, PCG analyzed data from the State of Oregon's grant funding initiatives for SDOH 5202, 5204 and Measure 110 to determine the number of new Withdrawal Management beds in development currently within the state. Through our analysis, PCG determined that 16 new Medically Managed Withdrawal Management beds will be available by the third quarter of 2025. With the current bed capacity of 349 plus the addition of 16 beds in progress, we are projecting a total of 365 beds (8.53 beds per 100,000 population) to support Withdrawal Management needs by mid-year 2025.

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

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

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

Table 31 defines the NSDUH boundaries used to define regions for the CAST model re-assessment.

Regions	Counties
Region 1	Multnomah
Region 2	Clackamas, Washington
Region 3	Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, Yamhill
Region 4	Coos, Curry, Douglas, Jackson, Josephine, Klamath
Region 5	Crook, Deschutes, Jefferson

Region 6	Baker, Gilliam, Grant, Harney, Hood River, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, Wheeler

Table 31. NSDUH Regions for CAST Reassessment

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

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

With the variables, assumptions, and detailed data inputs described above, the projections for Withdrawal Management bed needs for the State indicated that 888 beds (20.74 beds per 100,000 population) were needed in the updated forecast. Therefore, with the projected bed capacity of 365, the State of Oregon would need an additional 523 (12.22 beds per 100,000 population) Withdrawal Management beds to support this service and demand.

Table 32 identifies the breakdown of beds by NSDUH regions and the projected bed need to support the demand for withdrawal treatment beds by region.

Region	Current Bed Capacity	Calculated Bed Demand	Number of Additional Beds Needed to Support Demand
Region 1	84	175	91
Region 2	27	211	184
Region 3	111	276	165
Region 4	55	122	67
Region 5	20	52	32
Region 6	52	51	-1
Statewide	349	888	539

Table 32. Capacity and Demand

Summary

After initial analysis of current, pending, and projected forecasted needs, PCG has identified areas and initial bed capacity needs by service and facility type for community based behavioral health care including mental health residential, SUD residential treatment, and Withdrawal Management services. While the projection for additional capacity varies by the methodology utilized, below are initial projected needs and total percentage increases in the facility and services to increase capacity within Oregon.

Facility Type	Current Capacity	Pending Capacity	Total Projected Capacity by 3rd Qtr 2025	Projected Additional Capacity Needed	Total Number of Beds (Current + Pending + Needed)	% Increase
Acute Care Inpatient Psychiatric Beds	421	Unknown	421	529	950	125.65%
Mental Health Residential (RTF & RTH only)	855	214	1,069	74*	1,143	6.92%
Secure Residential Treatment Facility (SRTF only)	546	77	623	171	794	27.45%
SUD Residential	1,606	44	1,650	1,662**	3,312	100.72%
Withdrawal Management	349	16	365	523	888	143.29%
Totals	3,777	351	4,128	2,959	7,087	71.68%

*Given the estimated need ranged from 0-74, PCG used 74 for this analysis

**Given the estimated need ranged from 1,156 to 2,169, PCG used 1,662 for this analysis which is the average of the estimated range.

Table 33. Needed Capacity Analysis

FORECASTED COSTS FOR ADDITIONAL CAPACITY

This section represents initial estimates for the forecasted costs to expand behavioral health capacity in Oregon for the facilities within our project scope. These estimates will be further refined and analyzed in our subsequent June 2024 Final Report.

PCG has determined an average cost per bed to build facilities based on available Oregon-specific data provided by the Oregon Health Authority Social Determinants of Health. PCG will continue to collect and analyze data to further provide estimates of building costs for new behavioral health facilities.

Mental Health Residential

PCG obtained preliminary estimates of new facility construction costs provided by the Oregon Health Authority's Office of Social Determinants of Health. The dataset from SDOH included sixteen records categorized with the following facility categories:

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

Based on this data, construction development costs for new residential facilities range from $515,658 to $12,494,000 with an average cost of $4,294,638. On a per-bed basis, this comes out to a cost range of $85,943 to $780,875 with an average cost of $314,927.80 per bed for mental health residential facilities.

The cost of the one Residential Treatment Home is $652,500 for the five-bed facility, or $130,500 per bed. For Residential Treatment Facilities, the costs range from $1,789,000 to $6,155,500 with an average cost of $3,466,138 per facility. The per-bed cost of these facilities ranges from $121,869 to $384,718.80 with an average of $249,558.40 per bed. For Secure Residential Treatment Facilities, the total cost range is $515,658 to $12,494,000 with an average cost of $5,761,802 per facility. The per-bed cost of SRTFs ranges from $85,943 to $780,875 with an average cost of $415,982.50 per bed in these facilities.

Considering the restricted number of data points and the substantial ranges, particularly for Secure Residential Treatment Facilities, these figures are subject to change as more data on facility costs becomes available. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operations.

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
Residential Treatment Home	N/A	N/A	652,500	$130,500
Residential Treatment Facility	$1,789,000	$6,155,500	$3,466,138	$249,558.40
Secure Residential Treatment Facility	$515,658	$12,494,000	$5,761,802	$415,982.50
Adult Mental Health Residential	$515,658	$12,494,000	$4,294,638	$314,928.80

Table 34. Mental Health Residential Estimated Costs

Residential SUD and Withdrawal Management Facilities

PCG received copies of proposals, specs, and costs submitted to Oregon Health Authority for expanding capacity by building new facilities in Residential Substance Use Disorder and Withdrawal Management Treatment Facilities. The dataset from OHA included three records for these facilities which are categorized as Residential Substance Use Disorder and Withdrawal Management Facilities to determine cost per bed.

Based on this data, construction development costs for new residential substance use disorder and withdrawal management facilities ranges from $5,500,000 to $8,000,000 with an average cost of $6,533,333 per facility. On a per-bed basis, this comes out to a cost range of $105,172.41 to $550,000 with an average cost of $285,057.47 per bed for residential SUD and withdrawal management facilities.

Considering the restricted number of data points and the substantial ranges, these figures are subject to change as more data on facility costs becomes available. It is essential to recognize that these numbers solely encompass capital expenses and do not encompass other costs like staffing or operations.

Facility Type	Minimum Estimate	Maximum Estimate	Average Total Development Cost	Average Cost per Bed
SUD Residential & Withdrawal Management Facility	$5,500,000	$8,000,000	$6,533,333.33	$285,057.47

Table 35. Residential SUD and Withdrawal Management Facility Estimated Costs

Capital Building Cost Estimate Examples

The below table represents the average number of beds per facility type from the SDOH data for mental health residential as well as the Licensing and Certification Data for Substance Use Disorder and Withdrawal Management facilities. The cost per bed numbers below are reflected as whole numbers in this analysis. This table provides a high-level projection of the average costs associated with building new facilities based on average bed size to meet the demands of Oregonians.

Facility Type	Cost per bed	Average Number of Beds	Capital Cost Per Facility
Residential Treatment Home	$130,500	5	$652,500
Residential Treatment Facility	$249,558	15	$3,743,376
Secure Residential Treatment Facility	$415,982	13	$5,407,772
Residential SUD Facility	$193,390	27	$5,221,551
Withdrawal Management	$193,390	13	$2,514,080

Table 36. Capital Cost per Facility

Forecasted Capacity Need Investment Costs

As noted throughout the report, the projected and forecasted capacity needs and costs included present our initial estimations. Further refinement and analysis will be completed throughout this project and included in our June 2024 Final Report.

To calculate the total projected investment costs for the capacity needs in Oregon, PCG utilized the projected capacity needs identified earlier in the report and the cost per bed derived from our above analysis. This resulted in a total projected investment cost for capital funds for each of the facility types in the analysis. In our analysis of projected capacity need, the total capacity needs for Mental Health Residential (RTF & RTH only) yielded a need of 0-74 beds. For the Cost Estimation, we allocated those 74 beds evenly across Residential Treatment Homes and Residential Treatment Facilities. For the Residential SUD facility capacity need, our calculation of bed needs was between 1,156 and 2,169 beds. For the Cost Estimation, PCG took the average of this range and used 1,662.

Table 37 below provides the Total Projected Investment Costs for each facility type with a grand total cost of expanding capacity in Residential Treatment Homes, Residential Treatment Facilities, Secure Residential Treatment Facilities, Residential SUD Facilities, and Withdrawal Management Facilities of $507,752,218. This number reflects the initial maximum estimate and will be further refined and analyzed for the June 2024 Final Report.

Facility Type	Projected Capacity Needed	Cost per bed	Total Projected Investment Costs
Residential Treatment Home	37	$130,500	$4,828,500
Residential Treatment Facility	37	$249,558	$9,233,646
Secure Residential Treatment Facility	171	$415,982	$71,132,922
Residential SUD Facility	1,662	$193,390	$321,414,180
Withdrawal Management	523	$193,390	$101,142,970
Totals	**2,430**	**$236,564***	**$507,752,218**

*Represents the average cost per bed

Table 37. Forecasted Need and Costs

RECOMMENDATIONS

The recommendations included in this section are preliminary. The final recommendations will be included in the June 2024 Final Report.

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

CARE MODEL AND STRATEGY

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

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

WORKFORCE DEVELOPMENT

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

ADDITIONAL FACILITIES

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

- Expand Mental Health Residential Treatment for those with medical comorbidities
- Expand Mental Health Residential Treatment Home and Secure Residential Treatment Facility capacity
- Expand capacity for Substance Use Disorder Residential Treatment
- Expand capacity for Withdrawal Management facilities

- Support additional acute care inpatient psychiatric beds by working with non-profit and for-profit entities to develop capacity to optimal levels of care to meet the demand
- Develop Crisis Center Models

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

AWARENESS, EDUCATION AND ENGAGEMENT

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

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

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

AREAS FOR FURTHER ANALYSIS

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

- **Youth Population**: Our study currently focuses on the adult population. A similar analysis of current capacity and capacity needs for the child and youth population would provide beneficial information when considering funding priorities.
- **Geriatric Population**: While the data does not account for different types of needs within adult residential beds, the State of Oregon would benefit from completing an additional study focusing on geriatric mental health treatment and continuum of care and services, further defining if there is a need for increasing services and funding for this specialized population.
- **Complex Needs**: An additional analysis and study of the services and capacity of behavioral health facilities to adequately care for those with complex needs would be a critical component in further analyzing the continuum of care. It was noted during Community Engagement how challenging it can be for people to find beds when they have both physical health and behavioral health needs.
- **Staffing and Workforce**: A thorough analysis of the staffing challenges and workforce development barriers to providing services at behavioral health facilities could offer important insights into the feasibility of new facility construction.

- **Crisis Facilities**: A thorough review of the crisis facilities and services in coordination with the Oregon Health Authority as they develop the rules would provide valuable information on the entire continuum of care and where additional supports are needed.
- **Quality of Care:** Quality of care was mentioned throughout Community Engagement as an area that could be further explored. Understanding the type of care being provided at the facilities is crucial, as well as understanding the culturally appropriate care available and the areas for expansion.