Mink-Bowman Evaluation of Aid and Assist (A&A) and Guilty Except for Insanity (GEI) Community-based Behavioral Health Services Funding

DOCUMENT PREPARED BY PUBLIC CONSULTING GROUP AT THE DIRECTION OF DEBRA A. PINALS, M.D., COURT MONITOR, MINK-BOWMAN ON BEHALF OF THE HONORABLE JUDGE ADRIENNE NELSON

REPORT PER FEDERAL ORDER

October 2026

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

EXECUTIVE SUMMARY **3**

BACKGROUND AND SCOPE **6**

Data Collection, Validation, & Methodological Considerations 10

ALLOCATIONS AND EXPENDITURES FOR COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES **15**

Overview: How Oregon Funds Community-Based Behavioral health Services 15

Allocations and Expenditures for Community-Based Behavioral Health Capacity 16

Allocations and Expenditures for Community-Based Behavioral Health Services 29

OHA Allocations and Expenditures for Services Directly Serving A&A and GEI Populations 31

Projected Allocations and Expenditures for Community-Based Services 38

DETAILED FINDINGS & RECOMMENDATIONS **41**

Key Findings 41

Recommendations 43

EXECUTIVE SUMMARY

Pursuant to a June 2025 federal court order by the Honorable Adrienne Nelson in the *Mink-Bowman* case, the Oregon Health Authority (OHA) engaged Public Consulting Group LLC (PCG) to evaluate how the state has allocated and expended funding to expand community-based behavioral health services for individuals who are unable to Aid and Assist in their case (individuals found unable to A&A) and individuals who are found Guilty Except for Insanity (individuals found GEI). As part of the court's order, this work was conducted under the direction of Debra A. Pinals, M.D., *Mink-Bowman* Court Monitor.

Under the *Mink-Bowman* rulings, individuals ordered for competency restoration at Oregon State Hospital (OSH) through the A&A process must be admitted for A&A restoration within seven days of the court order. While this admission timeframe does not apply to individuals found GEI, as an offshoot of the Bowman litigation and the consolidation of the cases under one federal judge, OSH manages both populations through coordinated admission processes and seeks timely access to OSH consistent with applicable statutes, court orders, and operational capacity.

As a result of prior ongoing non-compliance with the seven-day admission requirement, PCG was engaged to analyze aspects of the Oregon behavioral health system to address the court's questions. PCG's initial evaluation examined fiscal year 2022-2025 (FY22-25) data provided by OHA, including information on funding, service utilization, community-based capacity, service needs, and costs, to address the questions posed by the court. However, due to limitations and gaps in the available data provided by OHA, this evaluation only addresses the first question posed by the court regarding how funds were expended to increase the supply of behavioral health services in the community. All analyses, findings, and interpretations were developed with the input and guidance of Dr. Pinals and reflect the data available from OHA for review.

QUESTIONS POSED BY THE COURT:

1. HOW HAS THE STATE SPENT FUNDING DEDICATED TO INCREASING THE SUPPLY OF BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY?

The State of Oregon has made substantial investments to expand behavioral health infrastructure and community-based behavioral health services. Available data indicate that these investments generally tracked increasing community-based behavioral health populations and contributed to expanded community-based capacity. However, as discussed in the Data Collection, Validation, & Methodological Considerations section of this report, many infrastructure investments remain under development, and existing data are insufficient to fully assess service adequacy, funding sufficiency, and unmet need, especially with regard to the A&A and GEI populations (also known as "forensic populations"). Continued investment in community-based capacity, coupled with improved data collection and system monitoring, will be critical to meeting potential future demand and informing policy decisions related to Oregon's forensic behavioral health system.

KEY FINDINGS

- **Oregon has made substantial investments in community-based forensic behavioral health services, and the Oregon forensic behavioral health population continues to have evolving needs.** State investments in community-based behavioral health infrastructure, community restoration, and related supports increased significantly during the review period. Funding generally aligned with the intended purposes of legislative appropriations and supported Oregon's efforts to expand community-based care for individuals found unable to A&A and individuals found GEI.
- **Growth in community restoration services reflects major legal, policy, and operational changes.** Community restoration became an increasingly important component of Oregon's forensic continuum, with the number of individuals receiving community restoration services more

than doubling during the study period. This growth occurred alongside federal court orders, legislative actions, expanded community-based capacity, and efforts to reduce reliance on OSH and local jails. As many of these factors have driven recent growth and may influence changes over time, future demand remains uncertain.

- **Existing data systems can track funding but cannot fully demonstrate service impact.** Available financial and administrative data generally identify where funds were allocated and expended. However, they do not consistently demonstrate how those investments translated into services, capacity, access, outcomes, or unmet need. As a result, important questions regarding service adequacy, workforce needs, and remaining system gaps cannot be fully answered using currently available information.
- **Fragmented data governance limits statewide planning, accountability, and oversight.** Information related to forensic populations, expenditures, utilization, and outcomes is distributed across multiple agencies, organizational units, and data systems. The absence of a centralized reporting and accountability framework makes it difficult to monitor system utilization, evaluate investments, forecast future needs, and respond efficiently to legislative, operational, and court information requests.
- **The ultimate impact of recent investments has not yet been fully realized.** Many infrastructure investments remain under development and may require several years before their full effects are reflected in available capacity and service delivery. Continued monitoring will be necessary to determine whether these investments improve access to care and produce intended outcomes for forensic populations and what additional investments will be needed.

RECOMMENDATIONS

- **Establish centralized leadership and accountability within the OHA Behavioral Health Division (BHD) for forensic behavioral health oversight.** Develop a leadership and accountability structure within OHA BHD that is responsible for forensic behavioral health planning, data governance, financial oversight, forecasting, performance monitoring, and reporting across agencies and programs within the State. This should not be a standalone unit, but an integrated component within Oregon's broader behavioral health system to avoid siloing of data and forensic populations. Accomplishing this could include but is not limited to re-evaluating current structures, leveraging existing resources, or seeking alternative resources.
- **Create a comprehensive forensic behavioral health reporting and monitoring framework.** Develop a recurring statewide reporting process that tracks funding, expenditures, population trends, service utilization, capacity, outcomes, and unmet need to support court and Psychiatric Security Review Board (PSRB) oversight, legislative decision-making, and long-term planning.
- **Strengthen data governance, reporting, and financial accountability.** Standardize definitions, reporting methodologies, reconciliation processes, and data collection practices to improve transparency and ensure consistent monitoring of forensic behavioral health investments and outcomes.
- **Monitor emerging service delivery trends and future capacity needs.** Continue tracking community restoration utilization, infrastructure investments, workforce capacity, and other factors that may affect future demand for services, particularly as legal requirements, funding structures, and system conditions evolve.

2. WHAT LEVELS OF CARE ARE STILL LACKING AND WHERE?

The analysis could not fully address the court's second question regarding which levels of care remain insufficient within Oregon's behavioral health continuum and where those gaps exist. While available data helped identify patterns in expenditures and capacity growth, the data were not sufficient to determine whether current service availability aligns with the needs of individuals found unable to A&A or individuals found GEI across different regions and levels of care.

Addressing this question will require additional data collection from and coordination with OHA to understand where capacity remains insufficient and what barriers continue to limit access to appropriate care. In accordance with Judge Nelson's September 18, 2026, Court Order, PCG will work with OHA to conduct a second phase of analysis focused on identifying remaining service gaps, evaluating system capacity, and assessing whether existing resources are sufficient to meet the needs of Oregon's forensic populations.

- **Conduct a subsequent study assessing what levels of community-based behavioral health care are still lacking and where, specifically for the forensic population.** Subject to data availability and court-mandated timelines, undertake a second phase of analysis involving additional data collection to identify what levels of care are lacking and where for individuals found unable to A&A and individuals found GEI.

BACKGROUND AND SCOPE

HISTORICAL CONTEXT

In 2002, Oregon Advocacy Center (now Disability Rights Oregon) filed a lawsuit (Oregon Advocacy Center v. Mink)[1] challenging prolonged jail wait times for individuals found unable to A&A. The Ninth Circuit affirmed the district court's ruling that OSH (which falls within OHA) must admit individuals found unable to A&A within seven days of receiving a court order. Despite this ruling, there have been periods of compliance and non-compliance, and by spring 2019, average wait times had grown to approximately 26 days, prompting renewed court intervention in June 2019. The onset of the COVID-19 pandemic in March 2020 caused significant disruptions in provision of care and facility admission and transition capacity throughout the state, all of which was exacerbated by rising demand for these services.

Later in 2021, a lawsuit was filed on behalf of individuals found GEI; the plaintiffs alleged substantive due process violations after waiting in jail for six-to-eight months for admission to OSH.[2] The state argued that compliance with A&A admission requirements under *Mink* constrained the state's ability to timely admit individuals found GEI. The court rejected this argument, finding that the *Mink* ruling did not govern the admission priority between individuals found unable to A&A and individuals found GEI. The *Mink* and *Bowman* cases were then consolidated,[3] and the parties agreed that individuals found GEI would not remain in jail longer than four months before admission to OSH.[4] These developments effectively expanded the population that OSH was required to serve within defined timeframes and further heightened the need for sufficient inpatient, community-based, and step-down capacity across the forensic behavioral health continuum.

In December 2021, Dr. Pinals was appointed as the court's Neutral Expert and subsequently recommended combining GEI and A&A admissions into a single managed admission list, a practice that was adopted and implemented. The managed admission process was intended to improve coordination of forensic admission and patient flow across populations by prioritizing admission based on clinical need and available capacity rather than solely by legal status.

In September 2022, a federal court order (known as the Mosman order) required OSH to limit how long individuals found unable to A&A can remain at OSH for competency restoration, setting shorter than statutory maximum durations based on charge severity.[5] Specifically, restoration was capped at 90 days (or the maximum sentence) for misdemeanors, six months for most felonies, and up to one year for certain serious violent felonies.[6] Because this order pertained only to the duration of OSH-based restoration services, the number of individuals discharged from OSH to community restoration has increased over time. As a result, more individuals found unable to A&A transitioned from OSH into community-based restoration services, shifting a growing share of restoration services from the state hospital to community-based settings. This shift likely increased demand for community-based services and supports needed to successfully serve individuals outside the inpatient setting. Concurrently, Oregon has placed greater emphasis on serving individuals in the most appropriate and least restrictive settings, including community restoration programs.

---

[1] *Oregon Advocacy Center v. Mink*, 322 F.3d 1101 (9th Cir. 2003).
[2] *Disability Rights Oregon v. Bowman*, No. 3:21-cv-01637 (D. Or.).
[3] *Oregon Advocacy Center v. Mink* and *Disability Rights Oregon v. Bowman*, Order Consolidating Cases (D. Or.).
[4] Debra Pinals, *Report of the Mink/Bowman Neutral Expert* (U.S. District Court for the District of Oregon, 2022).
[5] Michael Mosman, *Order Regarding Competency Restoration Timelines* (D. Or., 2022).
[6] Prior to June 1, 2026, there were also 30-day extensions for discharge planning and renewable 180-day extensions for violent felonies. On June 1, 2026, a federal court order changed these extensions, limiting the 180-day extension for violent felonies to a one-time option and stopping the 30-day extension option for discharge planning.

In 2024, the state moved toward compliance with the *Mink* case permanent injunction for admission within seven days, meeting court-ordered timelines for several months before again falling out of compliance, prompting the plaintiffs to file motions for contempt and court-ordered remedies.

In June 2024, PCG, at the direction of Governor Kotek and OHA, completed a statewide assessment of adult behavioral health facility capacity in Oregon. The assessment examined the availability of mental health residential treatment, substance use disorder residential treatment, and withdrawal management beds in order to identify existing capacity and unmet need across the state. The assessment provided a comprehensive inventory of behavioral health bed capacity but was limited to evaluating bed supply. It did not examine specific drivers of utilization by patient populations, utilization patterns, patient flow, or population-specific service needs and therefore was not intended to assess the suitability of available capacity for GEI, competency restoration, or other specific behavioral health populations. The assessment is referenced here as prior statewide capacity analysis and should not be interpreted as identifying facility or bed types that are appropriate for, or intended to serve, the population examined in this current evaluation.

In June 2025, the court found the defendants in contempt and ordered OHA and OSH to follow several recommendations from Dr. Pinals' 11th Neutral Expert Report,[7] imposed daily fines for A&A admission delays beyond seven days, and converted Dr. Pinals' role from Neutral Expert to Court Monitor. The defendants appealed components of the court's ruling, and the 9th Circuit heard arguments to review those appeals in September 2026. With regard to fines, there have been arguments in court about how they should be calculated, but to date, fines dollars have not been utilized in part related to the ongoing appeal.[8] Collectively, the court's actions sought to improve timely access to OSH restoration services and thereby encourage continued development of a forensic behavioral health continuum capable of serving individuals in the community.

Pursuant to a June 2025 federal court order, OHA was required to hire a contractor "to be chosen and overseen by Dr. Pinals, to [1] review how the State has spent funding dedicated to increasing the supply of behavioral health services in the community; [and 2] identify what levels of care are still lacking and where; and provide this information in a public report to the court."[9] PCG was selected by OHA and Dr. Pinals to conduct this evaluation.

In July 2025, certain provisions of Oregon's House Bill (HB) 2005 went into effect, modifying the state's competency restoration statutes for individuals found unable to A&A in the community.[10] The legislation established restoration and commitment time limits that vary based on the severity of the underlying charge and, in part, parallel the time limits already applicable to hospital-based restoration. Prior to HB 2005, community restoration was not subject to statutory time limits, and some defendants remained in community restoration services for extended periods, including multiple years for lower-level offenses. HB 2005 also introduced certain options for extensions to community restoration timeframes and included a sunset provision to allow for future reassessment.[11] HB 2005 may have significant implications for future community restoration caseloads. By establishing restoration and commitment time limits based on charge severity, the legislation may reduce the average length of stay in community restoration, depending on how extensions are utilized, particularly for individuals charged with lower-level offenses. The law may also increase turnover within community restoration programs, creating more regular movement into and out of restoration services and potentially improving access for newly referred individuals. Because the legislation

[7] Debra Pinals, *11th Neutral Expert Report in the Mink/Bowman Litigation* (U.S. District Court for the District of Oregon, 2025).
[8] Pinals, *Report of the Mink/Bowman Neutral Expert*.
[9] *Oregon Advocacy Center et al. v. Mink et al.*, No. 3:02-cv-00339, Order (D. Or., June 2025).
[10] Per Section 47(1), Section 44-46 went into effect September 29, 2025; per Section 66, Sections 2-6, 8-13, 15-37, 41, 51-57 went into effect January 1, 2026; per Section 42, Section 42 went into effect January 1, 2026; per Section 68, all other sections are effective upon signature.
[11] Oregon Legislative Assembly, *House Bill 2005, 2025 Reg. Sess. (2025)*.

is relatively recent, it remains to be seen how HB 2005 will ultimately affect restoration duration, outcomes, program utilization, and overall community restoration caseloads over time.

Because HB 2005 was enacted after most of the period examined in this report, its effects are not reflected in the historical caseload or expenditure data presented herein. Future monitoring will be necessary to determine whether the legislation affects restoration lengths of stay, community restoration census levels, service demand, expenditures, and patient flow across Oregon's forensic behavioral health system.

Also in July 2025, the federal budget reconciliation law commonly referred to as the "One Big Beautiful Bill Act" (otherwise known as H.R. 1) was enacted, introducing significant changes to Medicaid that will be phased in over the coming years.[12] Changes under H.R. 1, including new work requirements for many adult enrollees, more frequent eligibility verification, and reductions in retroactive coverage. Policy leaders have indicated that this may result in coverage losses for some Oregonians, including individuals found unable to A&A and individuals found GEI. As a result, OHA may need to cover additional expenses through County Financial Assistance Agreements (CFAAs) for previously Medicaid-enrolled individuals. To the extent Medicaid enrollment declines among forensic populations, a larger share of treatment, housing, and support service costs may shift to state and local funding sources, potentially increasing reliance on CFAA-funded services.

In December 2025, OHA published a phase II report prepared by Optumas pursuant to HB 4092 (2024) to assess expenditures for behavioral health services provided by Oregon Local Mental Health Authorities (LMHA's) and Community Mental Health Programs (CMHPs).[13] The analysis in the Optumas report builds on work initiated in Fall of 2024, focusing on services supported through CFAA funding, which analyzed historical CMHP cost data, CFAA funding information and Medicaid payments for FY22-24. The outcome highlighted funding expenditures reported by CMHPs for services rendered. While the Optumas report is another report with financial analysis data, it is separate and distinct from this report, although both reports relied upon some of the same underlying data sources for analysis.

On June 1, 2026, Federal District Court Judge Adrienne Nelson further limited admissions to OSH for specific lower level charged defendants who would have otherwise been admitted to OSH and changed extension options that were previously in place, limiting the 180-day extension for violent felonies to a one-time option and stopping the 30-day extension option for discharge planning.[14] The June 2026 federal court order may further shift competency restoration activities from hospital-based to community-based settings by limiting OSH admissions for certain lower-level defendants. To the extent this occurs, future demand for community restoration and related community-based supports may increase. By limiting certain OSH restoration extensions and narrowing eligibility for OSH admission, the order may also accelerate movement through the forensic continuum while increasing demand for community treatment, housing, and other supports needed to serve individuals outside of inpatient settings. Taken together, HB 2005 and the June 2026 federal court order create competing pressures within Oregon's forensic system. While HB 2005 may reduce the length of time individuals remain in community restoration by establishing restoration and commitment time limits, the court order may simultaneously increase the number of individuals requiring community-based restoration and support services by further limiting admissions to OSH. As a result, community programs may experience greater turnover while also serving a larger and potentially more complex population. As noted, HB 2005 also permits extensions of restoration periods for a variety of reasons, and the use of these extensions remains to be seen but could further impact utilization overall.

According to OHA, following the latest federal court order, as of June 13, 2026, OSH was admitting in-custody individuals found unable to A&A for treatment within the required seven-day timeframe, except in cases involving the late receipt of court orders.

---

[12] United States Congress, *Pub. L. No. 119-21* (2025).
[13] Optumas, *Expenditures Associated with Behavioral Health Services through Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) – House Bill 4092 – Phase Two* (2025).
[14] *Disability Rights Oregon v. Hathi*, No. 3:02-cv-00339-AN (lead), No. 3:21-cv-01637-AN (consolidated) (D. Or., June 1, 2026).

On September 8, 2026, OHA requested that the court halt contempt fines. Some of the issues pertaining to the contempt order are currently under appeal. After a status hearing on September 15, 2026, the court permitted PCG and OHA to focus this initial report on the first question posed by the court, and required the report to be submitted by October 30, 2026.

Collectively, these legal, policy, operational, and financing changes have significantly reshaped Oregon's forensic behavioral health system over the period examined in this report. Many of the most significant reforms, including HB 2005, federal Medicaid policy changes, and the June 2026 federal court order, occurred near or after the end of much of the historical period analyzed as part of this report. Consequently, historical expenditure and population trends may not fully predict future service demand, funding needs, or community restoration utilization, underscoring the importance of ongoing monitoring and periodic reassessment of Oregon's forensic behavioral health system.

This report focuses specifically on findings through OHA data regarding individuals ordered for competency restoration through the A&A process and on individuals found GEI who are under the jurisdiction of PSRB between FY22 and FY25. The report does not specifically evaluate individuals classified as Extremely Dangerous Persons under PSRB jurisdiction, nor does it examine forensic evaluations as a community service. Using data provided by OHA, the report assesses the allocation and expenditure of funds intended to support community-based behavioral health services for the A&A and GEI populations and offers considerations and recommendations for future planning.

PROJECT SCOPE AND PURPOSE

This report analyzes fiscal data from FY22-25 using information provided by OHA between October 2025 and September 2026 in order to answer the first question posed by the court. Due to the limitations of the data available and provided at the time this report was drafted, the second question posed by the court will be answered in a subsequent report using additional data collected from OHA and community-based behavioral health providers.

To align with the state's funding structure and budgeting cycles, all analyses and findings are presented according to Oregon's fiscal year, which runs from July 1 through June 30. The fiscal years and corresponding timeframes used in this report are listed below:

- FY22: July 1, 2021 – June 30, 2022
- FY23: July 1, 2022 – June 30, 2023
- FY24: July 1, 2023 – June 30, 2024
- FY25: July 1, 2024 – June 30, 2025
- FY26: July 1, 2025 – June 30, 2026
- FY27: July 1, 2026 – June 30, 2027
- FY28: July 1, 2027 – June 30, 2028
- FY29: July 1, 2028 – June 30, 2029

Additionally, some of the analyses are based on Oregon's biennium budgeting cycle structure. The budget period spans two fiscal years, referred to as a biennium, beginning on July 1 of an odd-numbered year and ending on June 30 of the following odd-numbered year. For instance, the period from July 1, 2023, through June 30, 2025, constitutes a single biennium.

- FY21-23: July 1, 2021 – June 30, 2023
- FY23-25: July 1, 2023 – June 30, 2025
- FY25-27: July 1, 2025 – June 30, 2027
- FY27-29: July 1, 2027 – June 30, 2029

ACRONYM DICTIONARY

The chart below provides an overview of acronyms and defined terms used throughout this report.

FIGURE 1. ACRONYM DICTIONARY

Acronym	Term
A&A	Aid and Assist
AFH	Adult Foster Home(s)
AOCMHP	Association of Oregon Community Mental Health Programs.
ARPA	American Rescue Plan Act
ATRP	Addictions Treatment Recovery and Prevention
BHD	Behavioral Health Division
BHI	Behavioral Health Investments
CCBHC	Certified Community Behavioral Health Clinic(s)
CCO	Coordinated Care Organization
CFAA	County Financial Assistance Agreement(s)
CMHP	Community Mental Health Program
CPRTF/YAT	Certified Psychiatric Residential Treatment Facility/Young Adult in Transition
FY	Fiscal Year
GEI	Guilty Except for Insanity
NM	Not Enrolled in Medicaid
OHA	Oregon Health Authority
OSH	Oregon State Hospital
PCG	Public Consulting Group LLC
PSRB	Psychiatric Security Review Board
RTF	Residential Treatment Facility(ies)
RTH	Residential Treatment Home(s)
SE	Service Element(s)
SFMA	Statewide Financial Management Application
SMI	Serious Mental Illness
SPMI	Serious and Persistent Mental Illness
SRTF	Secure Residential Treatment Facility(ies)
SUD	Substance Use Disorder
SUD RES	Substance Use Disorder Residential Treatment

DATA COLLECTION, VALIDATION, & METHODOLOGICAL CONSIDERATIONS

PCG collaborated closely with OHA and multiple state agencies throughout this evaluation to identify, request, obtain, and validate the data necessary to complete the analysis under the direction of Dr. Pinals. This effort included ongoing coordination with OHA leadership and program staff, formal data requests, and iterative discussions to clarify data definitions, reporting methodologies, data sources, and known limitations. Through this collaborative process, PCG, Dr. Pinals, OHA, and related state agencies and departments worked to ensure that the analyses presented in this report were informed by the most accurate and comprehensive information available within the project's timeframe. Given the limited scope of this report, the data informing this analysis were provided by the following entities:

- Oregon Health Authority (OHA), Behavioral Health Division (BHD), Program Team
- Oregon Health Authority (OHA), Behavioral Health Division (BHD), Budget Unit
- Oregon Health Authority (OHA), Behavioral Health Investments (BHI) Team
- Integrated Client Services (ICS) data warehouse in the Office of Forecasting, Research, and Analysis

PCG initially completed its data analyses and provided the preliminary findings to OHA for review on March 31, 2026. OHA subsequently conducted a detailed review of the data and analyses, validating portions of the information, identifying necessary corrections to the data, and providing feedback. Using the data that had been reviewed and confirmed by OHA, PCG prepared a comprehensive draft report including findings

and recommendations, which was subsequently reviewed by Dr. Pinals and submitted to OHA on July 1, 2026.

Following its review of the draft report, OHA provided additional feedback, contextual information, and questions related to certain data elements that had previously been reviewed and approved. Through subsequent discussions and further examination of the underlying data, it became apparent that some datasets and analytical assumptions required refinement. For example, certain Service Elements that had initially been identified as directly serving individuals found unable to A&A and individuals found GEI were later determined to support broader behavioral health populations. These collaborative discussions ultimately strengthened the analysis by improving the understanding of how funds were allocated and expended across different populations. These discussions also identified that additional sources would be needed to help answer the court's second question in the order that generated this consultation.

OHA DATA SOURCES AND RECONCILIATION CHALLENGES

During this review, PCG evaluated allocation and expenditure information from multiple OHA sources, including data maintained by the BHD Program Team and the BHD Budget Unit. As noted by OHA, the Budget Unit relies primarily on accounting codes, provider names, contract numbers, funding types, and related information maintained within the Statewide Financial Management Application (SFMA) to identify expenditures associated with A&A and GEI services for legislative reporting purposes.[15] The state's accounting system functions primarily as a financial management and transaction-tracking system that supports broader budgeting, funding, and reporting activities. Although effective for monitoring expenditures, it is not designed to consistently identify the specific populations served, services provided, or programmatic purpose of every transaction. Consequently, expenditures associated with the populations examined in this evaluation potentially may be under- or over-represented when identified solely through accounting codes and available financial records.[16]

By contrast, BHD Program Team staff responsible for contract management and program oversight have access to additional information sources, including invoices, provider reports, contract tracking, and program-specific documentation that provide greater visibility into how funds were allocated and expended. Consequently, expenditure and allocation amounts reported by the Program Team may differ from those reported by the Budget Unit.

Because these datasets are not routinely reconciled against one another, some discrepancies are expected. During the course of this analysis, PCG identified material differences between the two data sources, including missing GEI-related allocation and expenditure information in the FY21-23 Budget Unit data and differences in how certain expenditures were categorized. Following discussions with OHA and additional review of the underlying information, PCG determined that the BHD Program Team data represented the most complete and appropriate source for addressing the questions posed by the court. Accordingly, unless otherwise noted, the analyses presented in this report rely on data provided by the BHD Program Team.

The analyses presented in this report reflect the information available to PCG at the time of analysis and report preparation. During its review of the July 2026 draft report, OHA noted that it was continuing to reconcile and refine allocation and expenditure data for FY19 through FY25. As a result, certain allocation, expenditure, or funding attribution figures presented in this report should be considered point-in-time estimates based on the best available information provided during the study period. Future reconciliation activities may alter the historical financial data used in this analysis, which would likely impact the findings, and potentially the recommendations, included in this report.

More broadly, these findings highlight the fragmented nature of community-based forensic behavioral health data in Oregon. No single agency or organizational unit maintains a complete record of funding,

[15] Alex Medina, letter to Public Consulting Group, January 27, 2026, unpublished correspondence.
[16] Medina, letter to Public Consulting Group.

expenditures, service utilization, capacity, and outcomes across forensic behavioral health populations. Rather, this information is distributed across budget, contracting, programmatic, claims, court, hospital, and provider systems. As a result, significant effort was required to compile, validate, and reconcile the information included in this report.

BEHAVIORAL HEALTH INVESTMENTS DATA CONSIDERATIONS

The OHA Behavioral Health Investments (BHI) team administers state-funded behavioral health infrastructure investments, aligning legislative appropriations with community-identified needs to expand treatment and housing capacity through grants that support the development, acquisition, renovation, and expansion of behavioral health facilities and housing across Oregon.

Interpretation of the BHI data requires an understanding that legislatively appropriated amounts do not always correspond directly to the dollars ultimately available for behavioral health investment projects. As noted by OHA, administrative costs, Tribal set-asides established through Tribal consultation, and statutory requirements may reduce or redirect the amount ultimately available for investment.

Additionally, some appropriations authorized uses beyond capital development. For example, HB 5202 permitted CMHPs to use funding for a variety of behavioral health purposes, including short- and long-term rental assistance, service delivery, and operational supports. Consequently, appropriated amounts identified in statute should not necessarily be interpreted as direct investments in capital development or bed creation.

The relationship between allocated funding, expenditures, and beds brought online is further complicated by the long timelines associated with behavioral health infrastructure projects. Property acquisition, zoning and permitting requirements, construction delays, inflationary pressures, licensing and certification activities, and workforce challenges can all affect project implementation and occupancy timelines. According to OHA, behavioral health development projects typically require between two and six years to complete.[17]

As a result, expenditures often occur well before new beds become operational, meaning that bed counts observed during a given biennium may understate the ultimate impact of investments made during that period. For this reason, appropriations, allocations, commitments, expenditures, and operational beds should be viewed as distinct measures representing different stages of a multi-year implementation process rather than directly comparable indicators within a single reporting period.

Throughout project development, the BHI team works closely with grantees to monitor progress, provide technical assistance, support regular required grantee reporting, and connect providers with other OHA functions, including Licensing and Certification and Workforce Incentives teams, to support successful transition from construction to operational readiness.[18] Consequently, many of the investments analyzed in this report are expected to continue generating additional treatment capacity beyond the study period.

COMMUNITY ENGAGEMENT

Highlighting the significance of community input is crucial for providing context to the quantitative data gathered for this evaluation. A core component of this analysis involved consultation with a diverse group of community members who provide services to, or are directly involved with, the A&A and GEI populations within Oregon's behavioral health and criminal court systems.

The community input process was designed to uncover obstacles within the forensic behavioral health system, such as issues with its structure, barriers to accessing services, and limitations in capacity. It also sought ideas from community members who work in or are affected by the forensic behavioral health clinical

[17] Maritza Herrera, *Behavioral Health Investments New Construction and Renovation Timeline Factsheet*, provided to Public Consulting Group, October 2, 2026, unpublished correspondence.
[18] Elizabeth Sells, email message to Public Consulting Group, October 1, 2026.

and legal systems, aiming to discover opportunities for transforming the system or making further investments.

PCG sought to engage community members that represent or engage with the A&A and GEI populations across Oregon's behavioral health system at a variety of stages in the forensic process, including individuals with lived experience in the forensic judicial process. PCG compiled a comprehensive community input matrix comprising individuals and groups with deep operational knowledge of A&A and GEI populations, including their intersection with community-based services. The roster was developed with oversight from the Court Monitor, Dr. Pinals, and refined with input from OHA behavioral health team leadership to include representation across system roles and geographies. The final list of participants was approved by both Dr. Pinals and OHA.

PCG engaged with over 50 individuals reflecting the following categories:

- Advocates and Representatives/Organizations
- CMHPs
- Rural CMHPs
- State PSRB Staff
- Public Safety/Law Enforcement
- District Attorneys
- State/County Leadership
- Behavioral Health Coordinated Care Organization (CCO)
- Plaintiffs
- People with Lived Experience
- Providers

As part of the community engagement process, PCG conducted in-person visits to behavioral health facilities, including OSH, two Secure Residential Treatment Facilities (SRTFs), as well as a Permanent Supportive Housing site to gain a comprehensive understanding of the system and their operations. These visits provided an opportunity to observe the facilities firsthand, review the physical environment, and learn about the daily activities and services offered to individuals with complex needs, including those found unable to A&A and those found GEI. By conducting these visits, the project team gained a deeper understanding of the operational realities, service delivery models, and barriers affecting timely care.

While the scope of this report was subsequently limited to the first question posed by the court on how the state has spent funding dedicated to increasing the supply of behavioral health services in the community, the context provided by community members provided a valuable foundation for understanding the forensic behavioral health system in the state and may be utilized in subsequent analyses if applicable.

SERVICE UTILIZATION AND ANALYTICAL LIMITATIONS

The scope of this assessment is subject to several additional limitations that affect the interpretation of findings.

First, expenditure data were generally available only at the biennium and Service Element levels. Oregon's Service Element framework provides a standardized structure for categorizing, tracking, and funding behavioral health services across the continuum of care. Service Elements identify the type of service being supported and facilitate reporting, reimbursement, and funding allocation across providers and programs statewide. However, Service Elements primarily function as funding and reporting categories against which expenditures are charged and do not necessarily represent actual units of service delivered. As a result, allocation and expenditure data provide insight into where funding was directed but do not contain sufficient detail to evaluate service utilization, service intensity, or costs at the individual level.

Second, PCG conducted a comprehensive review of Medicaid claims data provided by OHA to evaluate services received by A&A and GEI populations. To better understand how funding is translated into service delivery, PCG requested data on services provided outside of Medicaid. However, data on non-Medicaid-

funded services were not available for analysis. As a result, findings related to service utilization were limited primarily to Medicaid-funded services and did not reflect the full scope of community-based behavioral health services supported through state General Funds, county funding, grants, or other non-Medicaid funding sources. This limitation restricted the ability to assess how all state investments translated into service utilization across the populations examined in this evaluation. Consequently, the findings from that particular analysis have been excluded from this report and its applicability will be considered for inclusion in any future reports.

Third, OHA's CFAA Service Element structure changed effective January 1, 2026. While this change does not affect the analyses presented in this report, it may limit the comparability of future analyses with the historical findings presented herein. Beginning in 2026, and in part related to recommendations made by Dr. Pinals, OHA implemented a revised CFAA framework that significantly restructured how community behavioral health funds are organized, allocated, and reported, as well as how data are collected. Under the revised model, funding is prioritized to support specific populations and services including services not reimbursed by Medicaid, and those for A&A, PSRB, and civil commitment populations, before being directed to other behavioral health service needs.[19] The revised CFAA also replaced numerous prescriptive Service Elements with broader Core Service Areas, providing LMHAs and CMHPs greater flexibility in designing services that meet local needs. As a result, funding, expenditure, and utilization data reported after January 1, 2026, may not align directly with the Service Element categories used in this analysis. Changes in service definitions, funding structures, reporting requirements, and local implementation approaches may make it difficult to distinguish whether observed differences over time reflect actual changes in service demand, utilization, expenditures, or outcomes, versus changes in how services are categorized, funded, and reported.

While the revised framework is intended to improve flexibility, accountability, and alignment with Oregon's broader behavioral health system goals, it also presents a fundamental shift in how services and funding are defined, managed, and reported. Under the previous CFAA structure, funding was allocated across numerous Service Elements, which often limited visibility into spending across broader service categories. The revised framework addresses these challenges by requiring CMHPs to develop budgets within Core Service Areas, track expenditures against those budgets, and prioritize spending for mandated populations, including A&A, PSRB, and civil commitment populations. In addition, OHA developed a crosswalk between the historical Service Elements and the new Core Service Areas through the Phase 2 Cost Study to support continuity in reporting and analysis.[20] While establishing this crosswalk is a critical foundation for longitudinal analysis, its effectiveness will depend on sustained and consistent implementation of the revised framework, clear guidance regarding service categorization, and ongoing maintenance of reliable financial and utilization records. Over time, these efforts will be necessary to ensure that changes in reported expenditures, utilization, and outcomes can be interpreted with confidence and appropriately distinguished from changes in reporting methodology. As a result, the revised reporting structure may provide more meaningful insight into how behavioral health funds are allocated and expended across service systems. However, because service definitions, funding structures, reporting requirements, and local implementation approaches changed substantially beginning in 2026, caution should be exercised when comparing future data to the historical findings presented in this report. Even with a crosswalk in place, observed differences over time may reflect both actual changes in service demand, utilization, expenditures, and outcomes, as well as changes in how services are categorized and reported under the new framework.

---

[19] Priority populations as of October 2026 are designated as follows: Priority 1, A&A, PSRB/JPSRB, Civil Commitment; Priority 2, individuals eligible for diversion from the criminal/legal system because of a behavioral health disorder; Priority 3, other individuals who are at risk of hospitalization or removal from their homes (if under 18); individuals who need behavioral health treatment but do not require hospitalization; and Priority 4, all other individuals who have or are at risk of developing a behavioral health disorder. OHA may modify these priorities moving forward.

[20] Optumas, *Expenditures Associated with Behavioral Health Services through Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) – House Bill 4092 – Phase Two*.

Fourth, the duration and complexity of the data collection process itself reflects the fragmented nature of Oregon's forensic behavioral health data systems in addition to the disconnect between forensic requirements and the rest of the behavioral health system. More than a year of data requests, validation activities, discussions, and analytical refinement were required to assemble the information necessary to address the court's questions. This reflects the reality that responsibility for monitoring forensic populations is distributed across multiple agencies and programs and that information may not always be available in a centralized or real-time format.

Finally, this assessment did not include original data collection from providers, individuals receiving services, family members, or other individuals, other than qualitative data collected during the community engagement process described above. Therefore, findings are based exclusively on administrative, financial, and programmatic data provided by OHA and partner agencies.

Collectively, these limitations constrained the extent to which available data could support definitive conclusions regarding service utilization patterns, provider expenditures, funding adequacy, unmet need, and remaining system gaps. Although the analyses presented in this report provide important insights into how behavioral health funds were allocated and expended, a more complete assessment of how funding translates into service delivery would likely require future additional data collection of provider-level utilization, capacity, workforce, and expenditures to support A&A and GEI populations. Such information would strengthen the state's ability to evaluate funding adequacy, identify remaining service gaps, and support long-term planning for Oregon's forensic and community-based behavioral health systems.

Recognizing these limitations, PCG has recommended conducting a subsequent phase of this work to include additional data collection from OHA and community-based providers to supplement the administrative data analyzed in this report. This was reviewed in the federal court hearing on September 15, 2026, with Judge Nelson. That effort would be intended to more directly address the court's second question by examining how allocated funds are translated into service delivery, the adequacy of available resources to meet service needs, and the extent to which unmet need, capacity constraints, or other system gaps continue to exist for A&A and GEI populations.

ALLOCATIONS AND EXPENDITURES FOR COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

OVERVIEW: HOW OREGON FUNDS COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

The Oregon Legislature supports community-based behavioral health services through biennial appropriations to OHA and, at times, through targeted House and Senate bills that fund specific priorities, such as residential treatment capacity, substance use disorder services, or specialized programs. Legislative funding consists of state General Funds and other revenue sources, including alcohol, marijuana, and tobacco taxes and settlement funds. OHA receives additional resources with federal funding, including Substance Use Prevention, Treatment, Recovery Services (SUPTRS) and Community Mental Health Services block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), State Opioid Response funding, Projects for Assistance in Transition from Homelessness (PATH) funding, and Temporary Assistance for Needy Families (TANF) block grant dollars. During the FY21-23 and FY23-25 biennia, OHA allocated short-term federal funds from the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, and the American Rescue Plan Act (ARPA) of 2021.

Funding is generally distributed through grants, contracts, and other funding mechanisms to support behavioral health services delivered throughout the state. Historically, OHA organized legislative appropriations into Service Elements, which reflected categories of services rather than specific populations. Because Oregon's funding structure has been primarily service-based rather than population-

based, most appropriations support the community behavioral health system broadly and cannot be readily traced to specific populations that use the service, including specific populations identified by their legal status at a point in time in the criminal system processes. Individuals found unable to A&A, individuals found GEI, and other behavioral health populations frequently access services financed through the same funding streams, including residential treatment, supportive housing, and other community-based supports.

There are, however, notable exceptions. Service Elements 4 and 30 provide dedicated funding for A&A and GEI-related unique activities, including community restoration, supervision, monitoring, case management, and other forensic supports. Unlike broader behavioral health appropriations, these funding streams are specifically designated for A&A and GEI purposes. Treatment services utilized by A&A and GEI individuals, however, are generally financed through the same county-administered behavioral health funding and Medicaid reimbursement mechanisms available to the broader behavioral health population.

OHA distributes community behavioral health funding through grants and some contracts with a variety of provider types, including CMHPs and LMHAs, community-based providers, federally recognized tribes, SRTFs, and Residential Treatment Facilities and Homes (RTFs/RTHs). CMHPs also provide services reimbursed separately through Medicaid fee-for-service claims or Coordinated Care Organization (CCO) arrangements, including capitated and value-based payment models. Given CCOs' central role in administering Oregon Health Plan Medicaid benefits and coordinating behavioral health services within that funding stream, their impact on access, outcomes, and system performance for A&A and GEI populations represents an important area for future study.[21]

Overall, Oregon's funding model reflects a legislative approach focused on financing services and system capacity rather than appropriating separate treatment funding streams for individual populations. As a result, while certain appropriations can be directly linked to A&A and GEI activities, most behavioral health funding supports a broad range of individuals receiving care within the community behavioral health system.

ALLOCATIONS AND EXPENDITURES FOR COMMUNITY-BASED BEHAVIORAL HEALTH CAPACITY

Since 2021, the Oregon Legislature has enacted a series of initiatives aimed at expanding behavioral health infrastructure across the state. OHA's BHI team administers these funds, aligning legislative appropriations with community-identified priorities to increase behavioral health treatment and housing capacity. Through capital investment grants, BHI supports the development, acquisition, renovation, and expansion of behavioral health facilities and housing throughout Oregon.

These investments primarily support facilities and programs serving individuals with Serious Mental Illness (SMI) and substance use disorders (SUD). Individuals found GEI and unable to A&A are among the people who experience serious mental health and/or substance use treatment needs. Consequently, while BHI funding is not specifically designated for A&A or GEI populations, these investments benefit such individuals by increasing access to treatment, housing, and recovery supports.

BHI funding supports a range of community-based residential treatment and housing settings. Licensed project types include SRTFs, RTFs, RTHs, Substance Use Disorder Residential Treatment (SUD Res), Withdrawal Management programs, and Adult Foster Homes (AFHs). Non-licensed project types include supportive housing, transitional housing, recovery housing, and re-entry programs. Collectively, these investments are intended to strengthen Oregon's behavioral health infrastructure and expand capacity to serve individuals with complex behavioral health needs in community-based settings, including A&A and GEI populations.

[21] As of October 2026, implementation of HB 4092 is underway. This legislation requires OHA to conduct a study to determine the funding required for each CMHP to provide the services and provide the functions required by law.

Key Fiscal and Programmatic Definitions

Because BHI investments frequently span multiple years and funding sources, several fiscal and programmatic terms are used throughout this analysis. Key definitions[22] are provided below to support interpretation of the findings and funding data presented in this section.

- **Encumbered Funds:** BHI funds that have been legally committed through a grant agreement. Because BHI projects often span multiple years and biennia, encumbrances ensure funding remains available until a project is completed, amended, or closed.
- **Funding Expended**: Payments made to grant recipients as project work progresses. Expenditures reflect the portion of committed funding that has been disbursed during the reporting period.
- **Capacity Preservation Project**: A capital investment focused on maintaining an existing behavioral health facility or housing asset through renovations, repairs, or modernization. These projects preserve safety, functionality, and regulatory compliance and may include limited capacity expansion within an existing facility footprint.
- **Cost Overrun**: A situation in which project costs exceed the original approved budget and grant Not-to-Exceed amount. When funding is available, supplemental preservation grants may be awarded to cover unforeseen expenses and support project completion.
- **Carryforward and Carryover Funds**: Carryforward and carryover funds refer to unspent appropriations that remain available beyond the original biennium through legislative authorization. While the terms are sometimes used interchangeably, both mechanisms allow funding to continue supporting multi-year capital projects that would otherwise lose access to unspent appropriations.
- **Ongoing Budget**: Recurring funding appropriated by the Legislature for each biennium to support continuing agency operations and programs.
- **One-Time Budget**: Funding appropriated for a specific purpose or period, typically within a single biennium. Unless otherwise authorized, unspent one-time funds generally are not available for future use.

The subsequent section includes an overview of the pieces of legislation between FY21-23 and FY23-25 that allocated money to OHA for investment in additional behavioral health capacity.

House Bill 5024[23]

As noted by OHA, during the FY21-23 biennium, the Oregon Legislature passed HB 5024, allocating $130 million ($65 million from the General Fund and $65 million from one-time ARPA dollars) to OHA for the expansion of community-based licensed residential facilities and homes and supportive housing settings for individuals with Serious and Persistent Mental Illness (SPMI) requiring a higher level of care.[24]

Although the Legislature allocated $130 million to OHA, approximately $33.7 million was redirected to initiatives outside of behavioral health infrastructure investments. These included the Certified Psychiatric Residential Treatment Facility/Young Adult in Transition (CPRTF/YAT) carve-out and a Tribal set-aside. The Tribal set-aside reflects OHA's commitment to supporting Oregon's federally recognized Tribes through dedicated capital funding for the development, expansion, and modernization of Tribal behavioral health facilities, ensuring access to culturally responsive behavioral health services.[25]

Figure 2 below shows how the remaining non-re-directed allocated funds from HB 5024 were committed to licensed capacity projects, non-licensed capacity projects, and preservation and non-capacity awards, as well as the extent to which these committed funds were expended between FY21-23 and FY23-25.

[22] Elizabeth Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026),* Microsoft Excel spreadsheet, September 30, 2026.
[23] Oregon Legislative Assembly, *House Bill 5024,* 2021 Reg. Sess. (2021).
[24] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[25] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*

FIGURE 2. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA HB 5024 FOR BEHAVIORAL HEALTH INVESTMENTS, FY21-23, FY23-25

Use	Amount	Project Type	Amount
FY21-23 Allocated	$130,000,000	BHI	$130,000,000
Funding Re-Directed from Allocation	($33,750,384)	Less CPRTF/YAT Carve-Out	($12,250,384)
		Less Tribal Set-Asides	($21,500,000)
FY21-23 Available to BHI	**$96,249,616**	**BHI**	**$96,249,616**
FY21-23 Encumbered Awards	$101,852,159	Licensed Capacity Projects	$69,269,671
		Non-Licensed Capacity Projects	$32,582,488
		Less Preservation/Non-Capacity Awards	($7,916,586)
		Projects Creating New Capacity	**$93,935,573**
FY23-25 Encumbered Awards*	$9,400,000	Licensed Capacity Projects	$5,400,000
		Non-Licensed Capacity Projects	$4,000,000
		Less Preservation/Non-Capacity Awards	($641,304)
		Projects Creating New Capacity	**$8,758,696**
Total Encumbered, FY21-23 – FY23-25	**$111,252,159**	**Total Encumbered for New Capacity**	**$102,694,269**
FY21-23 Expenditures	$15,809,082	All Projects	$15,809,082
FY23-25 Expenditures	$57,713,432	All Projects	$57,713,432
Total Expended, FY21-23 – FY23-25	**$73,522,514**	**Total Expended for All Projects, FY21-23 – FY23-25**	**$73,522,514**

Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

**BHI over-encumbered based on what was available from HB 5024. This overage will be paid with additional continuing service level General Fund dollars in subsequent years.*

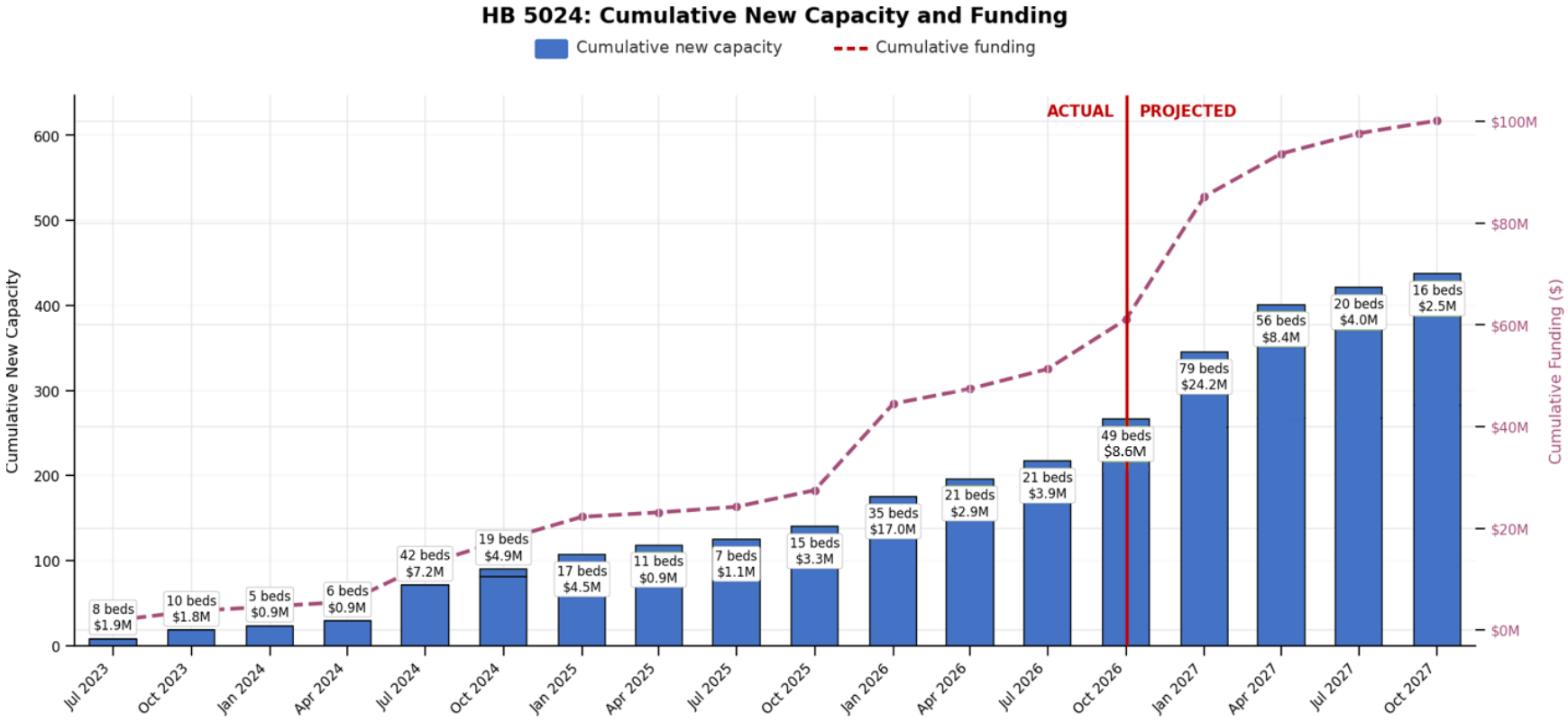
Although BHI had approximately $96.2 million available after re-directing some of the funds allocated under HB 5024, it ultimately committed approximately $111.3 million in awards, resulting in an over-encumbrance of roughly $15 million, which was expected to be covered through additional continuing service-level General Fund appropriations. While $111.3 million was encumbered, only about $102.7M directly supported expansion and preservation of residential treatment capacity. Of this, $73,522,514 was expended during the FY21-23 and FY23-25 biennia. Overall, these expenditures resulted in the creation of eight new licensed RTF beds in Jackson County between FY21-23 and FY23-25, with more in development and anticipated to open. In addition to expanding licensed RTF capacity, these investments support further growth in subsequent years.

Figure 2 above does not fully illustrate the inherent lag between initial capital investment and the creation of new behavioral health capacity. As discussed previously, behavioral health infrastructure projects typically require two to six years to progress from funding award to operational readiness. Consequently, expenditures often occur well before beds become available for service delivery. The process begins with a feasibility phase, during which organizations define the service model, conduct cost and funding analyses, evaluate regulatory requirements, and establish key decision points to determine whether the project should move forward. Once feasibility is established, organizations often pursue grant development and execution activities, including responding to OHA funding opportunities, developing required application materials, and completing legal and financial reviews.[26]

[26] Herrera, *Behavioral Health Investments New Construction and Renovation Timeline Factsheet.*

As a result, expenditure data alone may understate the long-term impact of behavioral health infrastructure investments. Funding allocated under HB 5024 in FY21-23 continues to generate new capacity beyond the study period: In addition to the 8 beds already operational, an additional 258 new beds have been created as of September 2026, with an additional 171 beds projected to become operational by the end of calendar year 2027, as Figure 3 below illustrates.

FIGURE 3. STATEWIDE BEHAVIORAL HEALTH CAPACITY EXPANSION ACHIEVED AND TO BE ACHIEVED THROUGH HB 5024 INVESTMENTS



Sources: Oregon Health Authority, Behavioral Health Division: Behavioral Health Investments Team. (2026, October 1). *Behavioral Health Investments Team data for OHA investments for the expansion of mental health and SUD residential licensed and non-licensed bed capacity; State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.*

House Bill 5202[27]

As noted by OHA, during the FY21-23 biennium, Oregon Legislature passed HB 5202, allocating $100 million from the General Fund to OHA and granted to CMHPs to increase behavioral health housing capacity and treatment options. Each county was awarded an amount determined by a funding formula based on geographic information produced by the Association of Oregon Community Mental Health Programs (AOCMHP).[28]

Unlike funds allocated under HB 5024, OHA did not re-direct any funds allocated under HB 5202. As such, the full $100 million was available for BHI. Figure 4 below demonstrates how these allocated funds were committed to licensed capacity projects, non-licensed capacity projects, and non-capacity awards, as well as the extent to which these committed funds were expended between FY21-23 and FY23-25.

FIGURE 4. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA HB 5202 FOR BEHAVIORAL HEALTH INVESTMENTS, FY21-23, FY23-25

Use	Amount	Category	Amount
FY21-23 Allocated	$100,000,000	BHI	$100,000,000
Funding Re-Directed from Allocation	N/A	N/A	N/A
FY21-23 Available to BHI	**$100,000,000**	**BHI**	**$100,000,000**
FY21-23 Encumbered Awards	$63,676,420	Licensed Capacity Projects	$14,649,881
		Non-Licensed Capacity Projects	$49,026,539
		Less Non-Capacity Awards*	($36,323,580)
		Projects Creating New Capacity	**$63,676,420**
FY23-25 Encumbered Awards	N/A	N/A	N/A
Total Encumbered, FY21-23 – FY23-25	**$63,676,420**	**Total Encumbered for New Capacity**	**$63,676,420**
FY21-23 Expenditures	$100,000,000	All Projects	$100,000,000
FY23-25 Expenditures	N/A	N/A	N/A
Total Expended, FY21-23 – FY23-25	**$100,000,000**	**Total Expended for All Projects, FY21-23 – FY23-25**	**$100,000,000**

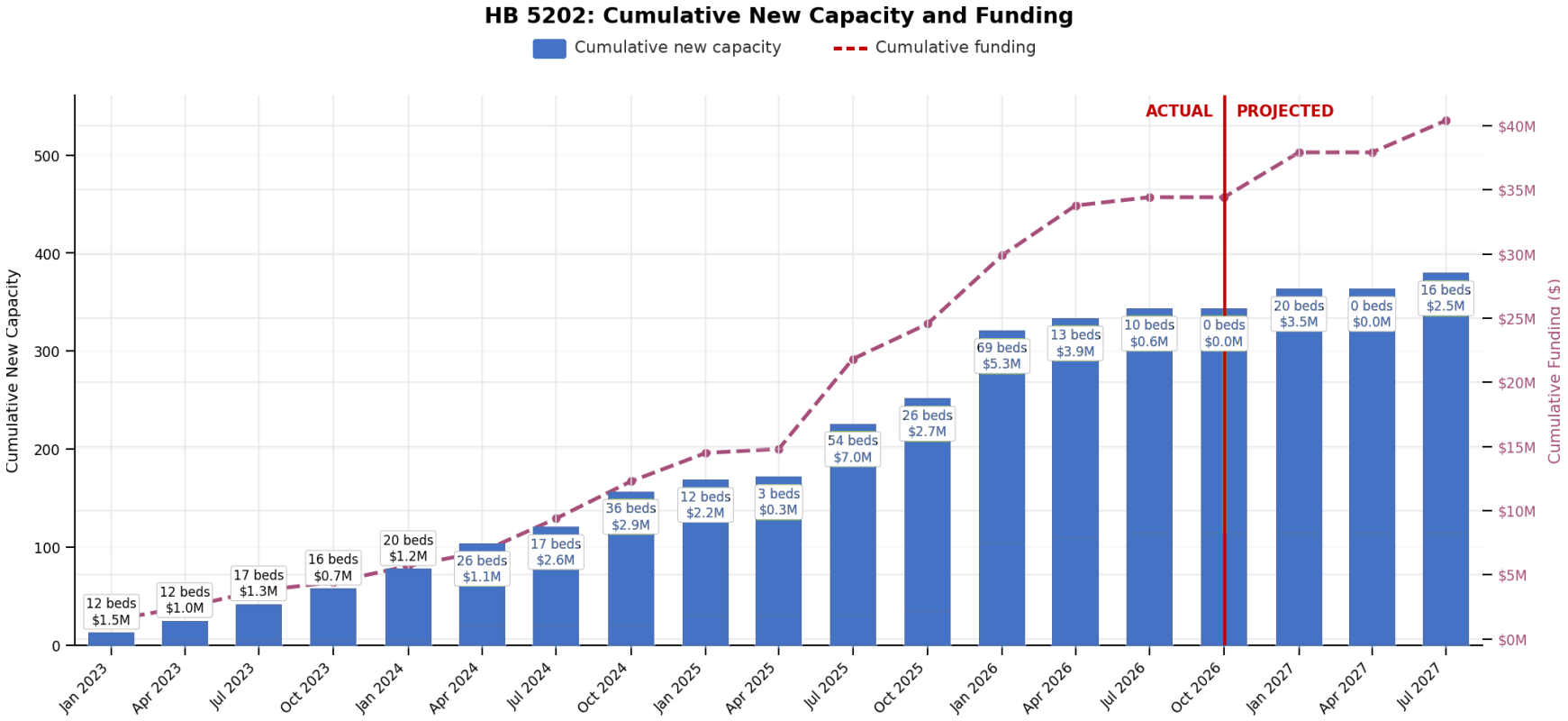
Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

Although the full $100 million appropriated through HB 5202 was both encumbered and expended in FY21-23, not all funding was used for licensed or non-licensed capacity development projects. Of the total, $14.6 million supported licensed facilities and $49 million supported non-licensed facilities, for a combined total of approximately $63.7 million in capacity-related investments. The remaining $36.3 million was used for other allowable grant purposes, including service and operational needs, short- and long-term housing supports, and administrative costs.[29] As a result, facility-related investments account for only a portion of the total HB 5202 funding expended. The $63.7 million expended in FY21-23 resulted in the creation of 19 new transitional housing beds in Umatilla County, four supportive housing beds in Josephine County, and 13 recovery housing beds in Multnomah County. Although the funds were expended during FY21-23, the resulting capacity gains continue to emerge as projects progress through development and implementation.

[27] Oregon Legislative Assembly, *House Bill 5202, 2021 3d Spec. Sess. (2021)*.
[28] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026)*.
[29] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026)*.

Figure 5 below demonstrates that, like HB 5024, the outcomes associated with HB 5202 investments materialize over several years. As of September 2026, HB 5202 investments had supported the addition of 343 new beds, with an additional 36 beds projected to come online by August 2027.

FIGURE 5. STATEWIDE BEHAVIORAL HEALTH CAPACITY EXPANSION ACHIEVED AND TO BE ACHIEVED THROUGH HB 5202 INVESTMENTS



Sources: Oregon Health Authority, Behavioral Health Division: Behavioral Health Investments Team. (2026, October 1). *Behavioral Health Investments Team data for OHA investments for the expansion of mental health and SUD residential licensed and non-licensed bed capacity; State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.*

House Bill 2316[30]

As noted by OHA, during the FY21-23 biennium, the Oregon Legislature passed HB 2316, allocating $20 million from net proceeds of lottery bonds to OHA to support the development of community-based housing, including licensed residential treatment facilities, for individuals with mental illness and SUD. The amended expenditure deadline approved by the Department of Administrative Services is May 9, 2028.[31]

FIGURE 6. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA HB 2316 FOR BEHAVIORAL HEALTH INVESTMENTS, FY21-23, FY23-25

Use	Amount	Category	Amount
FY21-23 Allocated	$20,000,000	BHI	$20,000,000
Funding Re-Directed from Allocations	N/A	N/A	N/A
Net Available to BHI	**$20,000,000**	**BHI**	**$20,000,000**
FY21-23 Encumbered Awards	$0	N/A	N/A
FY23-25 Encumbered Awards	$0	N/A	N/A
Total Encumbered, FY21-23 – FY23-25	**$0**	**Total Projects Creating New Capacity**	**$0**
FY21-23 Expenditures	$0	N/A	N/A
FY23-25 Expenditures	$0	N/A	N/A
Total Expended, FY21-23 – FY23-25	**$0**	**Total Expended for All Projects, FY21-23 – FY23-25**	**$0**

Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

As with HB 5202, OHA did not redirect any funds allocated under HB 2316; therefore, the full $20 million allocation remained available for BHI investments. Figure 6 shows that, because the expenditure deadline was extended through May 2028, none of these funds were committed or expended on licensed capacity projects, non-licensed capacity projects, or non-capacity awards during FY21-23 or FY23-25. However, project development is underway, and some HB 2316-funded projects are expected to continue through the FY27-29 biennium.[32] In addition, $10.0 million has been encumbered in FY25-27, which falls outside the scope of this report. As a result, the outcomes associated with these investments have not yet been fully realized. New projected bed capacity is expected to result from HB 2316-funded projects in future years, including 76 projected new beds by November 2028.

[30] Oregon Legislative Assembly, *House Bill 2316*, 2021 Reg. Sess. *(2021)*.
[31] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026)*.
[32] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026)*.

Senate Bill 1530[33]

As noted by OHA, during the FY23-25 biennium, the Oregon Legislature passed SB 1530, allocating $18 million from the General Fund to OHA and granted to organizations identified in the bill to support the development of SUD Recovery Housing and services throughout the state.[34]

Of the $18 million allocated, $1.3 million was re-directed to the Addictions Treatment Recovery and Prevention (ATRP) Team for service and operation contracts, leaving roughly $16.7 million for BHI. Figure 7 below illustrates how these allocated funds were committed to non-licensed capacity projects, rental subsidies, and preservation projects, as well as the extent to which these committed funds were expended between FY21-23 and FY23-25.

FIGURE 7. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA SB 1530 FOR BEHAVIORAL HEALTH INVESTMENTS, FY23-25

Use	Amount	Category	Amount
FY23-25 Allocated	$18,000,000	BHI	$20,000,000
Funding Re-Directed from Allocations	($1,281,100)	ATRP Team for service and/or operational contracts	($1,281,100)
Net Available to BHI	**$16,718,900**	**BHI**	**$16,718,900**
FY23-25 Encumbered Awards	$16,114,045	Non-Licensed Capacity Projects	$10,888,744
		Less Rental Subsidy	($260,000)
		Less Non-Utilized Funding*	($344,855)
		Less Preservation/TBD Awards	($5,225,301)
		Total New Capacity Awards	**$10,888,744**
Total Encumbered, FY23-25	**$16,114,045**	**Total Projects Creating New Capacity**	**$10,888,744**
FY21-23 Expenditures	$16,114,045	All Projects	$16,114,045
Total Expended, FY23-25	**$16,114,045**	**Total Expended for All Projects, FY23-25**	**$16,114,045**

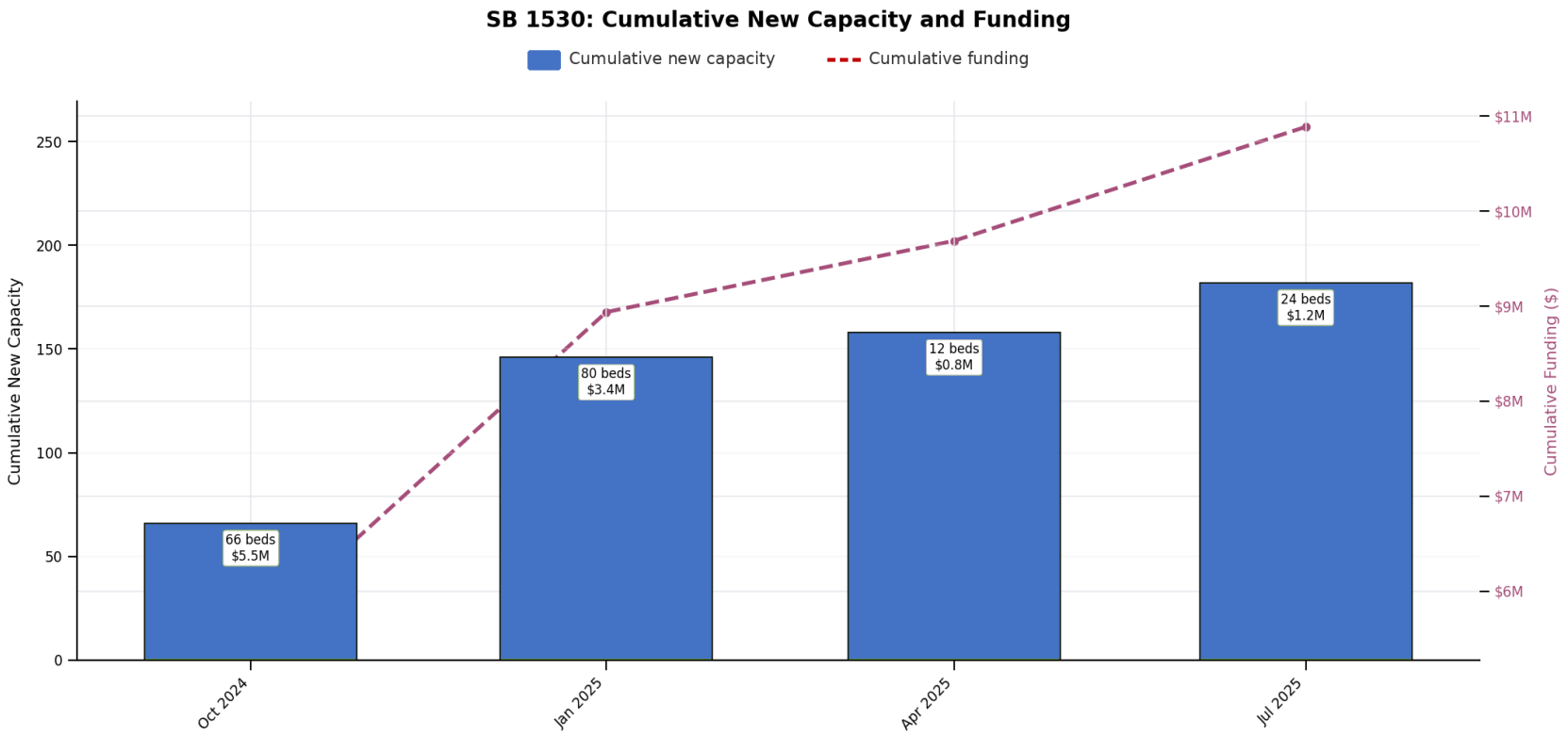
Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

*Note that $344,855 was not able to be utilized by the organization that the funding was identified for in SB 1530. As a result, no grant was developed for this portion of the funding.

Although the full $16.1 million was expended in FY23-25, only $10.9 million was invested in the creation of new bed capacity. These investments supported the construction of 182 new recovery home beds across Clackamas, Columbia, Deschutes, Marion, Multnomah, Tillamook, and Washington counties during the biennium. They also preserved 68 existing recovery home beds across Clackamas, Multnomah, Wasco, and Washington counties.[35] Unlike many of the capital investments discussed previously, there was significantly less time between the expenditure of funds and the realization of new capacity. As shown in Figure 8 below, most bed additions occurred within the same biennium in which funding was expended, with 182 beds becoming available as of August 2025 and no additional projected new bed construction, illustrating the variability in project development and implementation timelines.

[33] Oregon Legislative Assembly, *Senate Bill 1530,* 2024 Reg. Sess. (2024).
[34] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[35] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*

FIGURE 8. STATEWIDE BEHAVIORAL HEALTH CAPACITY EXPANSION ACHIEVED THROUGH SB 1530 INVESTMENTS



Sources: Oregon Health Authority, Behavioral Health Division: Behavioral Health Investments Team. (2026, October 1). *Behavioral Health Investments Team data for OHA investments for the expansion of mental health and SUD residential licensed and non-licensed bed capacity; State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.*

Senate Bill 5525[36]

As noted by OHA, during the FY23-25 biennium, the Oregon Legislature passed SB 5525, allocating $15 million from the General Fund to OHA to increase the availability of facilities for children and adults with SUD.[37] OHA redirected $1.5 of the $15 million allocated, leaving $13.5 million for BHI. Figure 9 below demonstrates how much of these funds were encumbered and expended in FY23-25 for all projects.

FIGURE 9. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA SB 5525 FOR BEHAVIORAL HEALTH INVESTMENTS, FY23-25

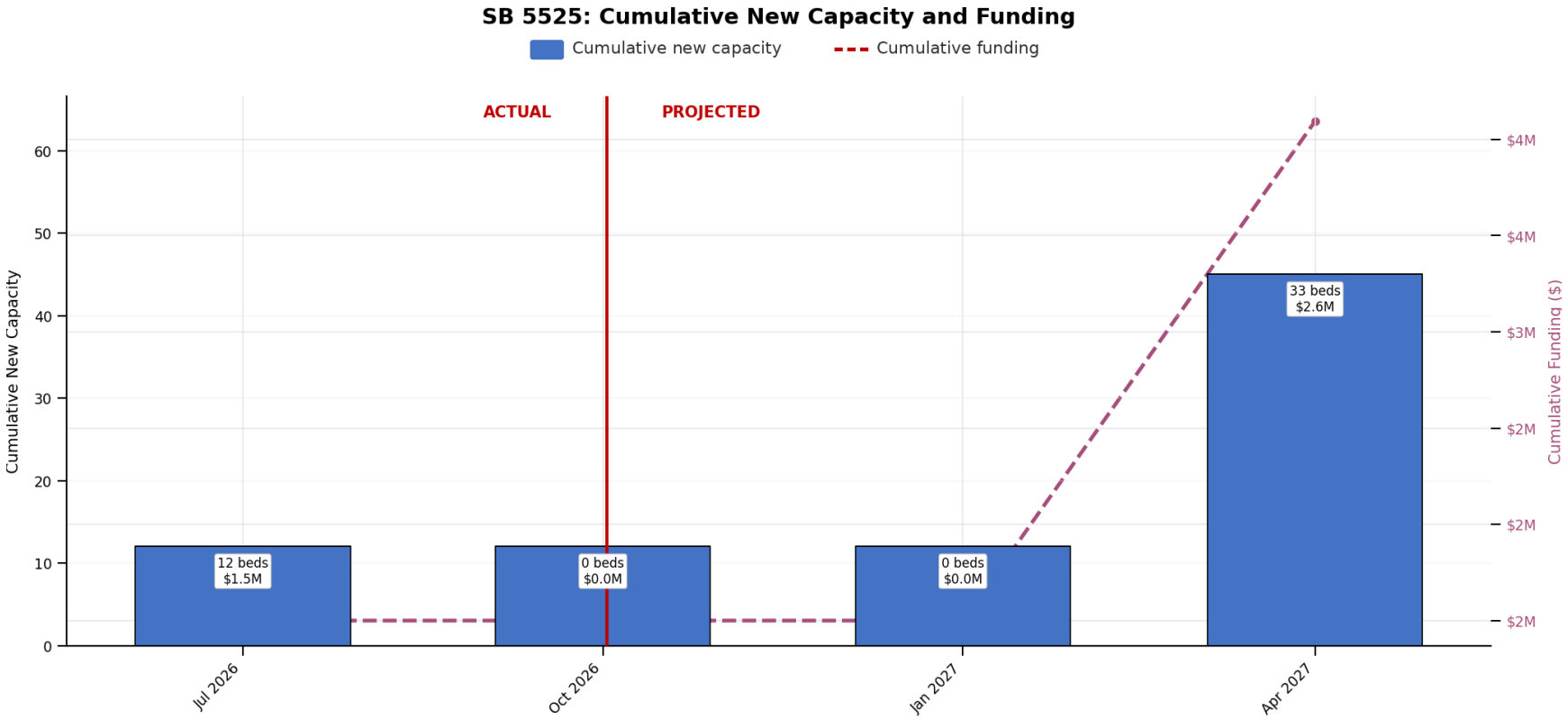
Use	Amount	Category	Amount
FY23-25 Allocated	$15,000,000	BHI	$15,000,000
Funding Re-Directed from Allocations	($1,500,000)	Tribal Set Aside	($1,500,000)
Net Available to BHI	**$13,500,000**	**BHI**	**$13,500,000**
FY23-25 Encumbered Awards	$6,100,000	New Capacity Projects	$5,093,827.87
		Less Youth SUD	($7,400,000)
		Less Gap Funding	($506,172.13)
		Less Preservation Awards	($500,000)
		Total New Capacity Awards	**$5,093,827.87**
Total Encumbered, FY23-25	**$6,100,000**	**Total Projects Creating New Capacity**	**$5,093,827.87**
FY23-25 Expenditures	$12,259,204	All Projects	$12,259,204
Total Expended, FY23-25	**$12,259,204**	**Total Expended for All Projects, FY23-25**	**$12,259,204**

Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

Although $13.5 million was available for BHI, $7.4 million was allocated to youth SUD capacity projects and an additional $1.0 million was committed to gap funding and preservation awards, leaving approximately $5.1 million available for new bed capacity projects. While these funds did not result in any new beds coming online during FY23-25, the BHI team has indicated that these funds supported gap funding activities and capacity development efforts that will yield results in future biennia.[38] BHI anticipates that all projects funded through SB 5525 will be completed and all remaining funds fully expended during the 2025-27 biennium. As a result, no SB 5525 funding is expected to carry forward into the FY27-29 biennium.[39] Figure 10 below illustrates that an additional 12 beds have become operational since the close of FY23-25, as well as the 33 additional beds projected to become operational through May 2027.

[36] Oregon Legislative Assembly, *Senate Bill 5525,* 2023 Reg. Sess. (2023).
[37] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[38] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[39] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*

FIGURE 10. STATEWIDE BEHAVIORAL HEALTH CAPACITY EXPANSION ACHIEVED AND TO BE ACHIEVED THROUGH SB 5525 INVESTMENTS



Sources: Oregon Health Authority, Behavioral Health Division: Behavioral Health Investments Team. (2026, October 1). *Behavioral Health Investments Team data for OHA investments for the expansion of mental health and SUD residential licensed and non-licensed bed capacity; State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.*

House Bill 5030[40]

As noted by OHA, during the FY23-25 biennium, the Oregon Legislature enacted HB 5030, allocating $50 million in lottery bond funding to OHA to increase community acute psychiatric facility capacity and support access to behavioral health services for individuals discharging from acute psychiatric facilities.[41] The appropriation was distributed in two phases, with $25 million becoming available in May 2024 and an additional $25 million in March 2025. Because both allocations carry three-year expenditure periods, funded projects are expected to be implemented over several years. Funds awarded under Lottery Revenue Bond 2024A must be expended by May 1, 2027, while funds awarded under Lottery Revenue Bonds 2025A must be expended by May 6, 2028.[42] Consequently, the capacity and service impacts associated with HB 5030 are expected to materialize gradually as projects advance toward completion.

Of the $50 million allocated, OHA redirected $5 million for a Tribal set aside, leaving $45 million available for BHI. Figure 11 below illustrates the extent to which these funds were encumbered and expended in FY23-25.

FIGURE 11. TOTAL FUNDING ENCUMBERED AND EXPENDED VIA HB 5030 FOR BEHAVIORAL HEALTH INVESTMENTS, FY23-25

Use	Amount	Category	Amount
FY23-25 Allocated	$50,000,000	BHI	$50,000,000
Funding Re-Directed from Allocations	($5,000,000)	Tribal Set Aside	($5,000,000)
Net Available to BHI	**$45,000,000**	**BHI**	**$45,000,000**
FY23-25 Encumbered Awards	$35,465,570*	New Capacity Projects	$34,974,366
		Less Preservation Projects	($491,204)
		Total New Capacity Awards	**$34,974,366**
Total Encumbered, FY23-25	**$35,465,570**	**Total Projects Creating New Capacity**	**$34,974,366**
FY23-25 Expenditures	$12,410,056	All Projects	$12,410,056
Total Expended, FY23-25	**$12,410,056**	**Total Expended for All Projects, FY23-25**	**$12,410,056**

Source: Oregon Health Authority, Behavioral Health Division, State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.

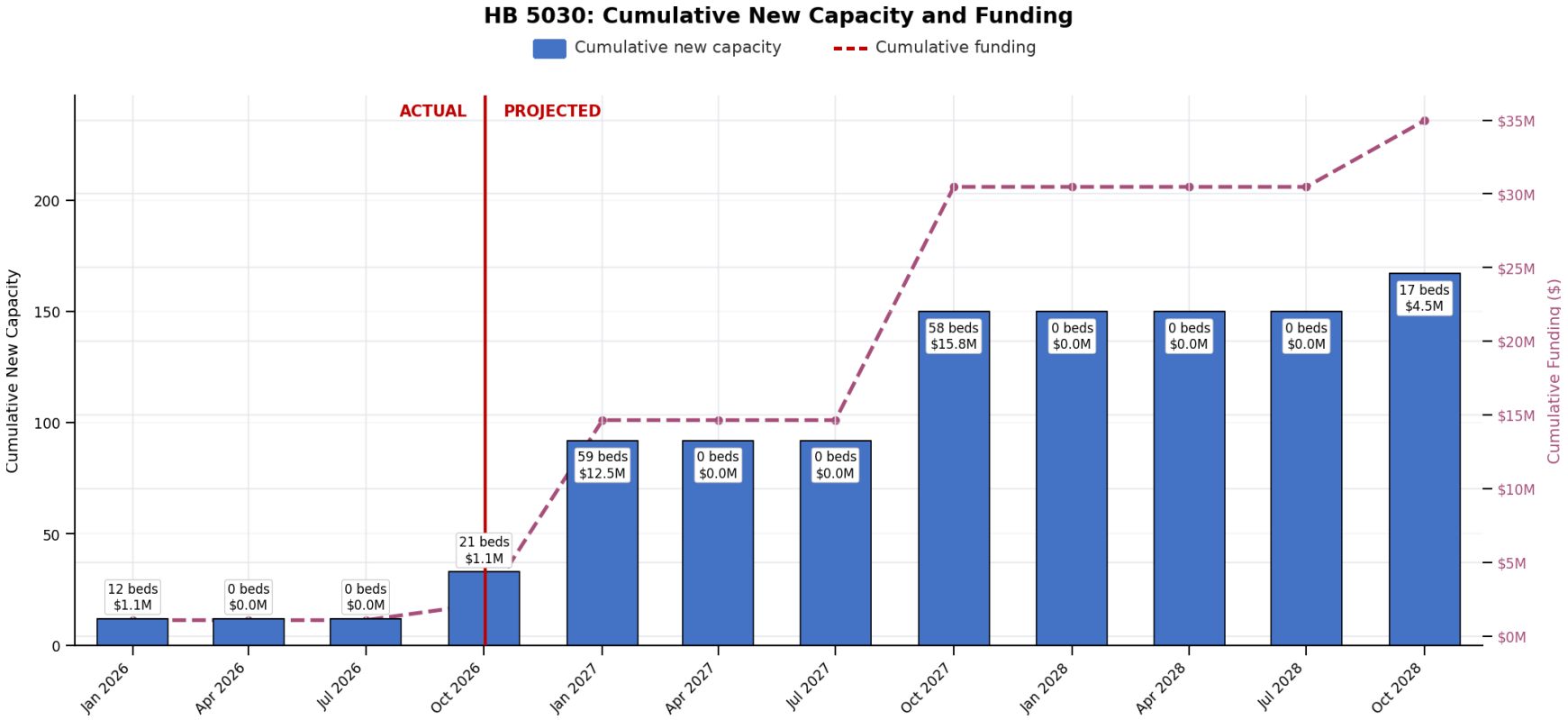
**BHI has continued to add new grants with the remaining funding and plans to have this funding fully expended prior to the appropriation expiring.*

Of the $45 million available, approximately $35.5 million was encumbered, including nearly $35 million for new capacity projects. As of the end of FY23-25, $12.4 million had been expended across funded projects. Consistent with other behavioral health infrastructure investments examined in this report, the benefits of HB 5030 funding are expected to materialize over multiple years due to the time required to develop new facilities and bring beds online. While these expenditures did not result in any new bed capacity becoming operational during FY23-25, the associated projects continued to advance through planning, permitting, construction, and implementation. As Figure 12 illustrates, 33 beds have come online as of September 2026, demonstrating the difference between investment and capacity realization. Because funding remains available through the expenditure deadline of May 6, 2028, and several projects are not scheduled for completion until 2028, a substantial portion of HB 5030 funds will be expended in subsequent biennia.[43]

[40] Oregon Legislative Assembly, *House Bill 5030*, 2023 Reg. Sess. (2023).
[41] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[42] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*
[43] Sells, *OR Bed Funding Final 05.11.2026 (updated 09.30.2026).*

Consequently, the majority of the capacity gains associated with these investments are expected to occur after FY23-25, with an additional 134 beds projected to come online by the end of calendar year 2028.

FIGURE 12. STATEWIDE BEHAVIORAL HEALTH CAPACITY EXPANSION ACHIEVED AND TO BE ACHIEVED THROUGH HB 5030 INVESTMENTS



Sources: Oregon Health Authority, Behavioral Health Division: Behavioral Health Investments Team. (2026, October 1). *Behavioral Health Investments Team data for OHA investments for the expansion of mental health and SUD residential licensed and non-licensed bed capacity; State of Oregon's Statewide Financial Management Application. (2026, October 1). Behavioral Health Investments Team data for mental health and SUD residential licensed and non-licensed expenditure of capital costs.*

Across the FY21-23 and FY23-25 biennia, the Oregon Legislature allocated a total of $333 million through the behavioral health infrastructure initiatives described above. Of these funds, OHA committed approximately $233 million, including $217 million specifically dedicated to new capacity projects. Across all projects, roughly $214 million was expended during the two biennia. These investments supported the creation of 226 new beds and the preservation of 68 existing beds during the reporting period.

While new bed construction has lagged expenditures due to the lengthy planning, permitting, financing, and construction timelines associated with behavioral health infrastructure projects, the majority of allocated funds have been committed, ensuring they remain reserved for their intended purpose of expanding and preserving treatment capacity. In addition, the Declarations of Restrictive Covenants (DRCs) in place during the study period helped protect these public investments by requiring funded properties to remain dedicated to approved behavioral health uses for a specified period. Generally, DRCs applied to projects receiving $250,000 or more for property acquisition, construction, or renovation and required continued use for behavioral health purposes for 20 years.[44]

As of September 2026, a total of 836 beds funded through these initiatives had become operational, with an additional 450 beds projected to come online over the next several biennia. Importantly, all beds reflected in this analysis remain operational. These findings underscore that the full impact of recent behavioral health infrastructure investments has not yet been realized, as many funded projects remain under development and are expected to generate additional capacity in future years. Expenditures associated with these investments should be viewed within the context of a multi-year implementation horizon, where funding is often expended years before the resulting treatment capacity becomes available.

Although these investments were not specifically targeted to individuals found unable to A&A or individuals found GEI, and the direct impact of these investments on these populations cannot be quantified at this time, individuals within both groups benefit from the expanded behavioral health infrastructure and service capacity created through these initiatives. By increasing residential, treatment, and recovery support capacity across the behavioral health continuum, these investments create additional opportunities for appropriate placement, stabilization, and step-down care. In turn, expanded system capacity may help alleviate discharge bottlenecks and capacity constraints at OSH, supporting more timely transitions to community-based settings for individuals involved in the forensic behavioral health system.

ALLOCATIONS AND EXPENDITURES FOR COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES

As previously described, OHA distributes community behavioral health funding through grants and contracts with a range of provider types, including CMHPs/LMHAs, community-based providers, federally recognized tribes, and a variety of providers of residential services (e.g., SRTFs, and RTFs/RTHs). Figure 13 below presents the state and federal funds allocated by the Oregon Legislature and OHA through these grants and contracts during the FY21-23 and FY23-25 biennia.

Allocated and expended amounts were compiled by the OHA BHD Program Team through a review of contracted Part A funds and invoiced Part C funds for each biennium. Part A funds are distributed to providers in substantially equal monthly payments, while Part C funds are reimbursed based on provider-submitted invoices approved by OHA. Although each applicable Service Element includes a not-to-exceed funding amount, Part C expenditures are incurred only as needed. Historical invoice records were used by OHA to identify and quantify Part C expenditures.

[44] Sells, *email message to Public Consulting Group*.

FIGURE 13. TOTAL OHA BHD FEDERAL FUND AND STATE BUDGET ALLOCATIONS AND EXPENDITURES FOR ALL COMMUNITY-BASED BEHAVIORAL SERVICES, FY21-23, FY23-25

	FY21-23	FY23-25	Amount Change	Percent Change
Total Funds Allocated	$470,698,224.63	$567,714,357.52	$97,016,132.89	20.61%
Total Funds Expended	$477,921,734.02	$592,053,622.96	$114,131,888.94	23.88%
Amount Difference, Allocated vs. Expended Funds	$7,223,509.39	$24,339,265.44	N/A	N/A
Percent Difference, Allocated vs. Expended Funds	1.53%	4.29%	N/A	N/A

Source: Oregon Health Authority, Behavioral Health Division, Rbase Access Tables, (2026, January 27), (2026, February 3).

In total, nearly $471 million was allocated for community-based behavioral health service delivery during the FY21-23 biennium, compared to almost $568 million in FY23-25, representing an approximately 21% increase in allocated funding. Community-based behavioral health service providers expended roughly $478 million in FY21-23 and just over $592 million in FY23-25, reflecting substantial growth in spending alongside increased appropriations.

Overall, expenditures for community-based behavioral health services increased by approximately 24% between the FY21-23 and FY23-25 biennia, outpacing the growth in allocated funding. Most expenditures were supported by state General Fund appropriations, supplemented by federal funds, Other Funds, and Lottery Funds. While expenditures of federal funds and Other Funds declined between biennia, expenditures supported by state General Fund and Lottery Funds increased, suggesting a greater reliance on state resources to support community behavioral health services in FY23-25.

Total expenditures slightly exceeded allocated funding in both biennia. In FY21-23, expenditures were approximately $7.2 million (1.5%) greater than allocated funding, while expenditures in FY23-25 exceeded allocations by roughly $24.3 million (4.3%). This pattern suggests that actual spending generally tracked appropriated amounts but exceeded allocated funding to a greater degree in FY23-25.

The substantial increase in both allocated and expended funds during the FY23-25 biennium was driven in large part by the availability of one-time federal funding associated with the COVID-19 public health emergency and recovery efforts. While these investments contributed to notable growth in funding levels during the period examined, some funding streams may not represent ongoing sources of support and therefore should be interpreted with caution when assessing long-term funding trends.

For context, these allocations and expenditures supported a large and growing statewide behavioral health population, which averaged approximately 78,214 individuals during FY21-23 and 93,568 individuals during FY23-25, representing a 19.6% increase in the total population served. This growth may mirror the roughly 20% increase in allocated funding between biennia and may help explain the corresponding 24% increase in expenditures. However, the relationship between funding and population served should be interpreted very cautiously. The population figures include both Medicaid-enrolled and non-Medicaid individuals and all adults receiving behavioral health services in Oregon, including services in the community, state hospital and residential regardless of payment source. As a result, the funding described above supports only a subset of the individuals included in these population totals. In addition, these counts represent unduplicated individuals receiving services during a specified period rather than a static group of individuals. Because individuals may enter, exit, or transition between levels of care, service settings, and funding sources over time, both the population served and the associated payer mix are dynamic. Changes in

enrollment, eligibility, coverage, and service utilization may result in individuals being supported by different payers at different points in time, making payer distribution inherently fluid rather than fixed.

Importantly, not all funding designated for community-based behavioral health services can be directly attributed to services provided to individuals in the A&A or GEI populations. Many funded programs serve broader behavioral health populations and have multiple intended purposes. To better understand the funding specifically associated with serving individuals found unable to A&A and individuals found GEI, PCG conducted a focused review of Service Elements 4 and 30 as described in greater detail below.[45]

OHA ALLOCATIONS AND EXPENDITURES FOR SERVICES DIRECTLY SERVING A&A AND GEI POPULATIONS

In addition to funding sources specifically designated for A&A and GEI populations, Oregon maintains broader funding pools that support community-based behavioral health services for a wide range of individuals. These funding sources are not allocated to specific populations and therefore cannot be disaggregated to determine the portion expended on individuals found unable to A&A or individuals found GEI. For example, invoiceable residential service funding is managed by counties and used to support residential treatment and related services that are generally not reimbursable through Medicaid. Because these funds are available to support eligible community behavioral health needs across populations, total expenditures cannot be directly attributed to any single group. While OHA incorporated population-specific expenditure information from underlying invoice documentation into expenditure summaries, PCG did not analyze these invoice expenditures as measures of A&A- or GEI-specific spending because the underlying funding streams support multiple populations.

By contrast, Service Elements 4 and 30 represent funding that has been explicitly appropriated by the Legislature to support individuals involved in the forensic behavioral health system. These funding streams are dedicated exclusively to community-based services for A&A and GEI populations, including community restoration, monitoring, supervision, and related supports. Importantly, these funds are not intended to finance behavioral health treatment services. Rather, treatment services are typically funded through other Service Elements within the CFAA, Medicaid reimbursement, and other community behavioral health funding sources.

As a result, while many state-funded behavioral health programs serve both forensic and non-forensic populations, Service Elements 4 and 30 provide the clearest view of legislative investments specifically targeted to supporting individuals found unable to A&A and individuals found GEI in community settings. The analysis that follows therefore focuses on these Service Elements to better understand funding levels and expenditures directly associated with these populations.

- **Aid & Assist Client Services (MHS 04):** Services include but are not limited to discharge planning, treatment designed to restore capacity, placement in appropriate community-based care, monitoring and coordination of services, and periodic assessment of the individual's capacity. Services are provided to individuals found unable to A&A as a condition of their court-ordered release and are intended to assist individuals in gaining or regaining their capacity to stand trial in the most integrated, least restrictive setting possible in the community. The goal of these services is to divert individuals from receiving restoration treatment at OSH into community restoration services to the greatest extent possible.

[45] Effective January 1, 2026, the CFAA was overhauled, and there is now only one service element, prioritization of mandatory populations, and funding/services are described in detail in local plans/budgets. In effect, this means that there is currently no specific amount allocated for individuals found unable to A&A and individuals found GEI. However, LMHAs/CMPHs are expected to delineate their projected expenditures by population (e.g., A&A, PSRB, Civil Commitment) within their budgets and delineate their actual expenditures the same way in their annual expenditure reports. The new CFAA gives the LMHAs/CMHPs the flexibility to allocate CFAA funds as necessary to meet the needs of the priority populations. It is also important to note that some services are directly invoiced.

- **Monitoring, Security, and Supervision Services for Individuals under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board (PSRB) (MHS 30):** Services include treatment, supervision, counseling, medication, skills training, and other supports and are delivered to individuals who are placed in their identified service area by Order of Evaluation or Conditional Release Order as designated by OHA.[46]

Figure 14 below provides OHA allocations for Service Elements 4 and 30 during the FY21-23 and FY23-25 biennia.

FIGURE 14. OHA BHD FEDERAL FUND AND STATE BUDGET ALLOCATIONS FOR SERVICE ELEMENTS 4 AND 30, FY21-23, FY23-25

Service Element	FY21-FY23	FY23-FY25	Amount Change	Percent Change
Aid & Assist Client Services (MHS 04)	$9,188,084.82	$38,621,446.25	$29,433,361.43	320.34%
Monitoring Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB (MHS 30)	$9,858,866.14	$10,171,473.07	$312,606.93	3.17%
Total	**$19,046,950.96**	**$48,792,919.32**	**$29,745,968.36**	**156.17%**

Source: Oregon Health Authority, Behavioral Health Division, Rbase Access Tables, (2026, January 27).

In FY21–23, just over $19 million was allocated across these Service Elements, representing roughly four percent of all funds allocated for community-based behavioral health services during the biennium. Allocations increased significantly in FY23–25, reaching nearly $49 million, or nearly nine percent of all funds allocated for that biennium. This increase indicates that Service Elements 4 and 30 became a substantially larger component of Oregon's community-based behavioral health investment strategy over time.

Between FY21–23 and FY23–25, total funding for these Service Elements increased by 156%, with notable variation between the two. Aid & Assist Client Services experienced dramatic growth, with funding increasing by 320%, while Monitoring Security and Supervision Services for Individuals under the Jurisdiction of the PSRB saw a modest funding increase of three percent. The substantial growth in Service Element 4 allocations coincided with broader policy, legal, and operational changes affecting Oregon's forensic behavioral health system, including increased reliance on community-based restoration services and legislative investments intended to expand community capacity. These changes are discussed further in relation to the population trends presented in Figure 17.

In FY21–23, all funding allocated to Service Elements 4 and 30 was supported by state General Fund dollars. In FY23–25, Monitoring, Security, and Supervision Services for individuals under the jurisdiction of the PSRB continued to be funded entirely through the state General Fund. Funding for A&A Client Services was similarly dominated by the General Fund, which accounted for 99.5% of allocations, with the remaining 0.4% funded through federal funds and 0.1% through Other Funds. Overall, these findings indicate that Oregon's investments in these Service Elements continue to rely almost exclusively on state resources. This reliance is not unexpected, as these Service Elements primarily support court-ordered restoration processes and PSRB oversight responsibilities, including supervision, monitoring, and public safety functions, rather than direct clinical treatment. As a result, services may have limited reimbursement via federal Medicaid matching funds, although the extent to which certain service components could qualify for Medicaid reimbursement warrants further review.

[46] Some of these services overlap with what could be reimbursable through Medicaid, but providers can only bill against one funding source. Examining when CFAA and when Medicaid is used is needed to ensure maximizing federal matching funds when possible.

Although allocation amounts indicate intended investments, expenditure data provides a more complete understanding of actual spending. Figure 15 below summarizes expenditures for OHA-funded Service Elements 4 and 30 during the FY21–23 and FY23–25 biennia.

FIGURE 15. OHA BHD FEDERAL FUND AND STATE BUDGET EXPENDITURES FOR SERVICE ELEMENTS 4 AND 30, FY21-23, FY23-25

Service Element	FY21-23	FY23-25	Amount Change	Percent Change
Aid & Assist Client Services (MHS 04)	$9,099,030.51*	$40,161,879.09*	$31,062,848.58	341.39%
Monitoring Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB (MHS 30)	$9,144,891.45**	$10,328,805.98**	$1,183,914.53	12.95%
Total	**$18,243,921.96**	**$50,490,685.07**	**$32,246,763.11**	**176.75%**

Source: Oregon Health Authority, Behavioral Health Division, Rbase Access Tables, (2026, February 3).

**As noted by OHA, the $9,099,030.51 total includes a payment made for services provided in the FY19-21 biennium in the amount of $263,330.84 and does not include a payment for $352,385.73 which should have been paid in FY21-23 but was paid in FY23-25. Also note that the $40,161,879.09 amount includes a payment for $352,385.73 which was paid in FY23-25 but was for services provided in FY21-23.*

***As noted by OHA, the $9,144,891.45 reported for FY21-23 includes a payment of $1,756.02 which should have been paid in FY19-21. Also note that for FY23-25, the total amount expended was $10,171,473.07. A payment of $157,333.14 was made in FY23-25 but should have been for FY21-23.*

OHA expenditures for Service Elements that directly serve A&A and GEI populations totaled just over $18 million in FY21-23 and more than $50 million in FY23-25, representing a cumulative increase of 177% across the biennia. Expenditures in FY21-23 accounted for nearly four percent of total OHA expenditures on community-based behavioral health services, while expenditures in FY23-25 accounted for nearly nine percent, which is aligned with allocation patterns. Similar to allocation trends, these findings demonstrate that spending on Service Elements supporting A&A and GEI populations became a substantially larger component of Oregon's community-based behavioral health expenditures over time.

As observed with allocations, expenditure growth varied considerably across both Service Elements. Aid & Assist Client Services experienced the most significant increase, with expenditures increasing by 341% between FY21-23 and FY23-25. In comparison, expenditures for Monitoring Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB increased by 13%. While the overall growth in allocations reflects legislative awareness of the rapid expansion of the community-based A&A population, the corresponding increase in expenditures likely reflects increased use of Aid & Assist Client Services and relatively stable use of GEI-related services. Unlike the GEI population, which remained relatively stable in community settings, the number of individuals found A&A receiving community restoration services more than doubled (see Figure 17 below). Growth was particularly pronounced among individuals not enrolled in Medicaid, whose average daily community restoration population increased from 45 to 146 individuals. Consequently, the substantial increase in Service Element 4 expenditures appears consistent with the effort to build and sustain a rapidly expanding community restoration system while reducing reliance on OSH-based services. However, available data do not explain the factors contributing to the increase in the number of individuals considered not Medicaid-enrolled, nor do they indicate whether Medicaid coverage may be interrupted or not reflected in available records during transitions between jails, OSH, and other settings.

Notably, the relationship between population growth and expenditure growth does not appear to be linear. Although the number of individuals receiving community restoration services increased substantially during

the study period, expenditures grew at an even faster pace, suggesting that factors other than caseload growth alone may have influenced expenditures. Although Service Element expenditure data cannot be directly attributed to individuals or services, the simultaneous growth in both overall community restoration caseloads and the subset not enrolled in Medicaid suggests increasing demand for community-based supports during the study period.

In FY21–23, all expenditures across the two Service Elements were supported by state General Fund dollars. In FY23–25, this remained true for Monitoring Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB, where 100% of expenditures were funded by the state General Fund. For A&A Client Services, approximately 99% of expenditures were funded by state General Fund dollars, with approximately 0.8% supported by federal funds and 0.01% by Other Funds. As with allocations, these findings indicate that these Service Elements are funded almost entirely through state resources.

Comparing allocations and expenditures provides additional insight into how appropriated funds translated into Service Element spending and whether funding levels generally aligned with Service Element utilization during each biennium. Figure 16 below provides a comparison of allocations and expenditures on the Service Elements directly serving A&A and GEI populations.

FIGURE 16. OHA BHD ALLOCATIONS VS. EXPENDITURES FOR SERVICE ELEMENTS 4 AND 30, FY21-23, FY23-25

Service Element	FY21-23 Allocated	FY21-23 Expended	Percent Difference	FY 23-25 Allocated	FY23-25 Expended	Percent Difference
Aid & Assist Client Services (MHS 04)	$9,188,084.82	$9,099,030.51*	-0.97%	$38,621,446.25	$40,161,879.09	3.99%
Monitoring Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB (MHS 30)	$9,858,866.14	$9,144,891.45**	-7.24%	$10,171,473.07	$10,328,805.98	1.55%
Total	**$19,046,950.96**	**$18,243,921.96**	**-4.22%**	**$48,792,919.32**	**$50,490,685.07**	**3.47%**

Source: Oregon Health Authority, Behavioral Health Division, Rbase Access Tables, (2026, January 27), (2026, February 3).

**As noted by OHA, the $9,099,030.51 total includes a payment made for services provided in the FY19-21 biennium in the amount of $263,330.84 and does not include a payment for $352,385.73 which should have been paid in FY21-23 but was paid in FY23-25. Also note that the $40,161,879.09 amount includes a payment for $352,385.73 which was paid in FY23-25 but was for services provided in FY21-23.*

***As noted by OHA, the $9,144,891.45 reported for FY21-23 includes a payment of $1,756.02 which should have been paid in FY19-21. Also note that for FY23-25, the total amount expended was $10,171,473.07. A payment of $157,333.14 was made in FY23-25 but should have been for FY21-23.*

Overall, these allocation and expenditure data demonstrate that Oregon significantly increased allocations to expand community-based behavioral health services for individuals found unable to A&A and individuals found GEI between FY21-23 and FY23-25. While expenditures lagged allocations slightly in FY21-23, they exceeded allocated amounts in FY23-25.

In the FY21-23 biennium, total expenditures for Service Elements 4 and 30 were four percent lower than the allocated amount. However, in FY23-25, expenditures were three percent above the allocated amount. It is important to note that reported differences between allocations and expenditures should not necessarily be interpreted as evidence of over- or underspending. As reflected under Figure 16 above, a portion of

recorded expenditures in both biennia reflects timing differences between when services were delivered and when payments were ultimately processed. Consequently, biennium-level expenditure totals may not fully correspond to the service period for which the funding was intended, resulting in minor distortions when comparing allocations and expenditures across reporting periods.

In FY21-23, expenditures on both Service Elements were less than allocations, while in FY23-25, expenditures on both Service Elements were slightly over allocated amounts:

- Funds expended on A&A Client Services increased significantly between FY21-23 and FY23-25, rising from just over nine million spent in FY21-23 to just over $40 million spent in FY23-25, approximately a 341% increase. OHA was relatively aligned for this Service Element, underspending by roughly one percent in FY21-23 and overspending by about four percent in FY23-25.
- Funds expended on Monitoring, Security, and Supervision Services for Individuals under the Jurisdiction of the PSRB rose slightly from FY21-23 to FY23-25, increasing from just over nine million to just over $10 million, approximately a 13% increase. OHA spent roughly seven percent less than budgeted in FY21-23 and about two percent more than budgeted in FY23-25 on this Service Element.

AVERAGE DAILY POPULATION DATA

It is important to understand the numbers of individuals these Service Elements served and how these groups changed over time in comparison to allocated and expended amounts. Figure 17 below provides this breakdown.

FIGURE 17. AVERAGE DAILY POPULATIONS BY PROGRAM CATEGORY AND SETTING, FY21-23, FY23-25

	Average Daily Population, FY21-23	Average Daily Population, FY23-25
Total Adult Behavioral Health Population	78,214	93,568
PSRB (In OSH)	248	251
PSRB (Out of OSH)	403	375
Civilly Committed (In OSH)	15	37
Civilly Committed (Out of OSH)	776	773
Aid and Assist (In OSH)	398	397
Aid and Assist (Out of OSH – Community Restoration)	244	515
Mandated Caseloads not enrolled in Medicaid (NM)		
Aid and Assist (Community Restoration – Not Enrolled in Medicaid)	45	146
PSRB (Out of OSH – Not Enrolled in Medicaid)*	85	65
Civilly Committed (Out of OSH – Not Enrolled in Medicaid)	39	39

Source: Integrated Client Services (ICS) data warehouse in the Office of Forecasting, Research, and Analysis, AVATAR, MMIS, ROADS, PSRB, and CRAA.

**Note that this population will be referred to as the community-based GEI population not enrolled in Medicaid for purposes of this report.*

As this report focuses on forensic populations receiving services in community-based settings and the use of allocated funds to expand access to behavioral health services for these populations, the analysis excludes individuals receiving services in inpatient facilities. During FY21-23, an average of 403 individuals

found GEI were under the jurisdiction of PSRB and receiving services in the community. This population declined slightly to an average of 375 individuals in FY23-25. In contrast, the average number of individuals found unable to A&A who received community restoration services increased from 244 in FY21-23 to 515 in FY23-25, representing an 111% increase. Despite recent growth in community restoration caseloads, forensic populations remain a relatively small subset of Oregon's overall adult community behavioral health population. During FY23-25, the average daily population of individuals found unable to A&A receiving community restoration services (515) and individuals found GEI under PSRB jurisdiction receiving services in the community (375) together represented less than 1% of the state's average adult behavioral health population of 93,568 individuals.

This growth in community restoration caseloads likely reflects a combination of factors, including continued growth in the underlying A&A population, expanded availability of community restoration services, and policy and court-driven efforts to reduce reliance on OSH for restoration services. As legal and operational pressures increased to reduce wait times for restoration services and prioritize community-based treatment whenever clinically appropriate, a greater proportion of individuals found unable to A&A were served in community settings. These shifts help explain the significant increases observed in both Service Element 4 allocations and expenditures during the same period.

Because Medicaid is generally available for medically necessary services provided to individuals receiving community-based behavioral health forensic services, the analysis also examined the subset of individuals not enrolled in Medicaid who could potentially benefit from services funded through CFAA expenditures. Among individuals receiving community restoration services, 45 of the 244 individuals served during FY21-23 (18.4%) were not enrolled in Medicaid, compared to 146 of the 515 individuals served during FY23-25 (28.3%). This constituted a 224% increase in the not enrolled in Medicaid population receiving community restoration services between FY21-23 and FY23-25. In contrast, among individuals found GEI and receiving services in the community, 85 of the 403 individuals served during FY21-23 (21.1%) and 65 of the 375 individuals served during FY23-25 (17.3%) were not enrolled in Medicaid. This constituted a roughly 24% decrease in the not enrolled in Medicaid population receiving GEI services in the community between FY21-23 and FY23-25. These populations represent the subset of community restoration participants who may be more likely to rely on services and supports funded through CFAA resources because Medicaid reimbursement may not be available for all eligible services. However, expenditure data were not available at the individual level, and it was therefore not possible to determine the extent to which Service Element 4 and 30 expenditures directly supported these individuals during FY21-25.

Notably, while the proportion of community-based GEI clients not enrolled in Medicaid declined over the study period, both the number and proportion of A&A community restoration clients not enrolled in Medicaid increased substantially, resulting in a larger population that may require services and supports funded through CFAA resources. However, these findings should be interpreted with caution. The caseload data reflect average daily populations and do not capture individual-level fluctuations, service utilization patterns, or transitions in Medicaid eligibility or enrollment that may occur over time. In addition, because expenditure data were available only at the Service Element level, it was not possible to determine how CFAA expenditures were distributed across specific individuals or services, or the extent to which expenditures directly supported non-Medicaid enrolled A&A and GEI populations. Inspired by HB 4092 and as part of the CFAA restructuring, OHA is in the process of collecting provider-level data on a quarterly basis, which is expected to provide greater insight into how CFAA-funded resources are ultimately used, including the types and volume of services delivered, the number of unique individuals served, and the relationship between expenditures, service utilization, and client outcomes as documented by providers.

Viewed together, these findings suggest that OHA's increased CFAA investments in A&A services were responsive to major changes occurring within the forensic behavioral health system. However, the substantial growth in the number of individuals receiving community restoration services who were not enrolled in Medicaid remains an important area for further analysis, as available data do not explain the

factors driving this increase. As community restoration became an increasingly important component of Oregon's competency restoration continuum, allocations and expenditures generally increased alongside growth in community-based A&A caseloads. In contrast, allocations and expenditures supporting the GEI population remained comparatively stable, reflecting the relative stability of community-based GEI caseloads during the same period. These findings suggest that funding growth was concentrated in those areas experiencing the greatest system pressures and population growth, particularly the expansion of community restoration services intended to reduce reliance on OSH and improve access to competency restoration in community settings.

CMHP EXPENDITURE DATA

Because this report did not include claims data, service-level utilization data, or original provider data collection, the extent to which CFAA funds were ultimately used to support specific services, populations, or outcomes could not be directly assessed. To provide additional context, this report reviewed findings from an Optumas analysis of CMHP expenditure data.[47] The Optumas analysis included information submitted by CMHPs regarding expenditures, staffing, operating costs, and the use of CFAA funding by Service Element and fiscal year.

It is important to note that CMHPs represent only one segment of Oregon's community behavioral health system and are not representative of all community-based providers serving A&A and GEI populations. In addition, the Optumas analysis relied on self-reported information from CMHPs, and 32 of Oregon's 35 CMHPs submitted all or most of the data requested. Furthermore, CFAA funding is not intended to cover the full cost of services provided to A&A and GEI populations, and CMHPs rely on multiple funding sources, including Medicaid and other state and local resources. As a result, the findings may not fully capture statewide provider expenditures or funding utilization patterns.

Importantly, the figures presented below are not directly comparable to the statewide allocation and expenditure amounts presented earlier in this report. The statewide analyses examine total OHA allocations and expenditures across all community-based providers (including but not limited to CMHPs) for Service Elements 4 and 30, whereas the Optumas report reflects a subset of provider-reported expenditures and funding information from CMHPs. Accordingly, differences between the Optumas results and statewide allocation or expenditure totals should not be interpreted as discrepancies or reconciled across analyses. Instead, the Optumas data are presented as a provider-level illustration of how spending patterns changed over time relative to changes in community-based forensic populations. Although imperfect and incomplete, these data provide one of the few available sources of information regarding provider costs associated with serving A&A and GEI populations in community settings. As such, they are most useful for evaluating broad directional trends rather than drawing conclusions regarding total system costs, funding adequacy, or statewide expenditure amounts.

Figure 18 below examines CMHP-reported expenditures associated with A&A and GEI populations alongside reported CFAA funding for Service Elements 4 and 30.

FIGURE 18. CMHP EXPENDITURES ON A&A AND GEI POPULATIONS LESS CFAA FUNDING, FY22-24

	FY22	FY23	FY24	Amount Difference	Percent Difference
Aid & Assist					
CMHP Expense (Adjusted)	$9,435,377	$12,210,849	$18,347,786	$8,912,409	94%
CFAA Funding	$5,492,891	$3,564,492	$15,680,139	$10,187,248	185%
CMHP Expenses Not Covered by CFAA Funding	$3,942,486	$8,646,357	$2,667,647	-$1,274,839	-32%

[47] Optumas, *Expenditures Associated with Behavioral Health Services through Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) – House Bill 4092 – Phase Two*.

Percent CMHP Expenses Covered By CFAA Funding	58.2%	29.2%	85.5%	N/A	N/A
Guilty Except for Insanity*					
CMHP Expense (Adjusted)	$6,064,631	$5,669,551	$6,543,292	$478,661	8%
CFAA Funding	$3,696,952	$2,558,988	$3,043,199	-$653,753	-18%
CMHP Expenses Not Covered by CFAA Funding	$2,367,679	$3,110,563	$3,500,092	$1,132,413	48%
Percent CMHP Expenses Covered By CFAA Funding	61.0%	45.1%	46.5%	N/A	N/A

Source: Optumas. (2025). *HB 4092 (2024) Expenditures Associated with Behavioral Health Services through Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) – House Bill 4092 – Phase Two*.

**GEI CFAA funding has been allocated: 75% to Involuntary & Forensic and 25% to Invoiced Services & Support Activities.*

The Optumas data provide a useful illustration of how provider-reported expenditures changed over time relative to changes in community-based forensic populations. Broadly, provider-reported expenditure patterns moved in the same direction as changes in community-based forensic caseloads and statewide CFAA expenditures. For the A&A population, CMHP-reported expenditures increased substantially during the study period, consistent with the growth in community restoration caseloads and corresponding increases in statewide Service Element 4 allocations and expenditures. For the GEI population, provider-reported expenditures remained comparatively stable, generally aligning with the relatively steady community-based GEI population and the limited changes observed in Service Element 30 funding. Given the absence of claims, utilization, and comprehensive provider expenditure data, these findings should be viewed as contextual information supporting broader trends observed elsewhere in this report rather than a definitive assessment of provider costs, funding adequacy, or statewide expenditure patterns.

PROJECTED ALLOCATIONS AND EXPENDITURES FOR COMMUNITY-BASED SERVICES

This report is primarily retrospective in nature, focusing on how Oregon allocated and expended community-based behavioral health funding during the study period; however, understanding historical spending patterns alone provides only a partial picture of future needs. Examining historical caseload, allocation, and expenditure trends alongside projected community-based populations helps illustrate the potential fiscal and operational implications of continued growth in demand for services. Although future funding needs will be influenced by a variety of factors, including policy decisions, court orders, statutory requirements, provider reimbursement rates, service utilization patterns, and workforce availability, historical relationships between caseload growth and expenditures provide a useful basis for estimating future costs and identifying areas where capacity constraints may emerge. Importantly, recent federal court orders and state policy changes have altered how forensic populations move through Oregon's behavioral health system, increasing reliance on community-based services. As a result, future demand may be influenced not only by underlying population growth but also by legal and policy requirements that shift service delivery settings. Such analysis is particularly important given Oregon's ongoing efforts to expand community-based alternatives to institutional care, as growing community populations will likely require corresponding investments in provider capacity, housing, treatment services, supervision, and workforce infrastructure to maintain access and quality of care.

Unless otherwise noted, all forecasts and projections presented in this section were provided by OHA or derived from historical OHA expenditure and population data. These projections should not be interpreted as predictions of future demand or expenditures and do not account for several factors that may substantially alter future system needs, including implementation of HB 2005, federal Medicaid changes, modifications to federal court orders, diversion initiatives, changes in restoration practices, workforce conditions, or future legislative actions.

FIGURE 19. PROJECTED AVERAGE DAILY POPULATIONS BY PROGRAM CATEGORY AND SETTING, FY25-27, FY27-29

	Average Daily Population, FY25-27 (Forecast as of Fall 2026)	Average Daily Population, FY27-29 (Forecast as of Fall 2026)
Total Adult Behavioral Health Population	105,982	109,943
PSRB (In OSH)	266	277
PSRB (Out of OSH)	403	411
Civilly Committed (In OSH)	29	31
Civilly Committed (Out of OSH)	860	878
Aid and Assist (In OSH)	373	353
Aid and Assist (Out of OSH – Community Restoration)	689	836
Mandated Caseloads not enrolled in Medicaid (NM)		
Aid and Assist (Community Restoration – Not Enrolled in Medicaid)	204	251
PSRB (Out of OSH – Not Enrolled in Medicaid)*	91	103
Civilly Committed (Out of OSH – Not Enrolled in Medicaid)	42	44

Source: Integrated Client Services (ICS) data warehouse in the Office of Forecasting, Research, and Analysis, AVATAR, MMIS, ROADS, PSRB, and CRAA.

**Note that this population will be referred to as the community-based GEI population not enrolled in Medicaid for purposes of this report.*

Historical allocation, expenditure, and caseload trends suggest that assuming current legal, policy, and service utilization patterns remain generally consistent, community-based behavioral health funding needs will likely continue to grow over the next two biennia. Between FY21-23 and FY23-25, the total adult behavioral health statewide caseload increased from 78,214 to 93,568 individuals, an increase of approximately 20%. During the same period, allocated funding increased from approximately $471 million to $568 million (21%), while expenditures grew from roughly $478 million to $592 million (24%). Although these trends suggest that investments generally kept pace with increasing demand, available data do not establish a presumptive relationship between population growth and expenditures. In addition, total caseload data includes individuals served across community, residential, and inpatient settings and therefore is not a direct measure of community-based service demand.

Looking forward, the total adult behavioral health population is projected to increase to approximately 105,982 individuals in FY25-27 and 109,943 individuals in FY27-29 based on Fall 2026 projections from the Oregon Office of Forecasting, Research, and Analysis. While projections for community-only caseloads are not available, expenditures would likely continue to rise if community-based caseloads increase in line with overall population trends and historical spending patterns remain stable, and assuming other factors do not change.

Projected growth, however, is not expected to occur evenly across populations. Community restoration services for the A&A population are projected to experience substantial growth, with the average community-based population projected to increase from approximately 515 in FY23-25 to 689 in FY25-27 and 836 in FY27-29. Growth is particularly pronounced among individuals who are not enrolled in Medicaid,

with the average projected non-Medicaid enrolled A&A population increasing from 146 individuals in FY23-25 to 204 in FY25-27 and 251 in FY27-29.

Assuming historical funding patterns remained unchanged and spending continued to scale proportionally with the non-Medicaid A&A population, PCG estimated potential future funding needs by applying the projected growth rate of the non-Medicaid enrolled community-based A&A population to FY23-25 Service Element 4 allocations and expenditures. The projected non-Medicaid enrolled community-based A&A population increases from 146 individuals in FY23-25 to 204 in FY25-27 (39.7% growth) and 251 in FY27-29 (71.9% growth). Applying these growth factors to FY23-25 allocations ($38.6 million) and expenditures ($40.2 million) yields projected allocations of approximately $53.9 million and $66.4 million and projected expenditures of approximately $56.2 million and $69.1 million, respectively. Notably, these estimates are based on projected growth in the non-Medicaid enrolled community-based A&A population rather than total community restoration caseloads, reflecting the population most likely to rely on CFAA-funded services. As a result, future expenditure needs could grow faster than overall behavioral health caseloads if the share of non-Medicaid enrolled clients remains elevated. These estimates are also intended only to illustrate the potential resource implications of projected caseload growth under current assumptions and should not be interpreted as forecasts.

In contrast, demand for services provided to individuals found GEI has remained comparatively stable. The average GEI population residing outside of OSH was 375 individuals in FY23-25 and is projected to increase only modestly to 403 in FY25-27 and 411 in FY27-29. Although the non-Medicaid enrolled community-based GEI population is projected to increase from 65 individuals in FY23-25 to an average of 91 individuals in FY25-27 and 103 in FY27-29, overall GEI caseload growth remains limited.

If Service Element 30 funding were to continue scaling proportionally with the projected non-Medicaid enrolled community-based GEI population, PCG estimated potential future funding needs by applying the projected growth rate of the non-Medicaid enrolled community-based GEI population to FY23-25 Service Element 30 allocations and expenditures. The projected non-Medicaid GEI population increases from 65 individuals in FY23-25 to 91 in FY25-27 (40.0% growth) and 103 in FY27-29 (58.5% growth). Applying these growth factors to FY23-25 allocations ($10.2 million) and expenditures ($10.3 million) yields projected allocations of approximately $14.3 million and $16.2 million and projected expenditures of approximately $14.4 million and $16.3 million, respectively. As with A&A estimates, these figures are intended to illustrate the potential funding implications of projected caseload growth under current assumptions rather than forecast future expenditures.

Importantly, for both A&A and GEI populations, recent restructuring and reprioritization of CFAA Service elements limit the practical applicability of these illustrative projections.

Taken together, these trends suggest that under current assumptions and based on projections provided by OHA, much of the projected growth in community-based behavioral health expenditures over the next two biennia may be attributable to continued expansion of community restoration services for the A&A population rather than significant growth in GEI-related service demand. Actual future demand and expenditures may differ substantially from these projections due to changes in legal requirements, Medicaid funding, eligibility, and enrollment, as well as Medicaid utilization, diversion strategies, future legislative actions, or broader behavioral health system conditions. Modifications to federal court orders, implementation of HB 2005, changes in restoration practices, and shifts in behavioral health system capacity could also materially affect future service utilization and expenditure patterns. Conversely, expansion of diversion initiatives, Certified Community Behavioral Health Clinics (CCBHCs), crisis services, and other community-based interventions may reduce future forensic involvement and moderate projected growth trends. As a result, ongoing monitoring and reassessment of population trends, service utilization, and expenditure patterns will be critical to ensure future investments remain aligned with evolving system needs, policy priorities, and legal requirements.

DETAILED FINDINGS & RECOMMENDATIONS

Collectively, the findings indicate that Oregon has made substantial investments in community-based behavioral health infrastructure and services, including significant increases in funding directed toward individuals found unable to A&A and individuals found GEI. Although some behavioral health investments during this period were supported by one-time ARPA funding, Service Elements 4 and 30 were funded predominantly through General Fund resources, indicating that much of the growth in A&A and GEI service capacity reflects ongoing state investment rather than temporary federal funding. The analysis demonstrates that many appropriated funds were allocated, committed, and expended in a manner generally consistent with information provided by OHA regarding the purpose of those appropriations. Expenditure of allocated funds generally aligned with major legal, policy, and operational shifts occurring within Oregon's forensic behavioral health system, particularly the expansion of community restoration services. Importantly, the growth in community-based forensic services appears to be driven in part by federal court orders and related system changes intended to reduce restoration wait times, meet timeliness requirements, and reduce reliance on OSH and local jails. At the same time, the analysis identified significant limitations in the state's ability to comprehensively track how funds translate into services, capacity, and outcomes due to fragmented data systems, inconsistent reporting methodologies, and limited provider-level information. Further, because many behavioral health infrastructure and service investments require multiple years to achieve their intended impact, the full benefits of recent appropriations have not yet been realized. Taken together, these findings suggest that Oregon has made meaningful investments to increase community-based capacity and respond to changing legal and operational requirements, but continued improvements in data governance, reporting, and monitoring will be necessary to determine whether these investments are translating into improved access to community-based treatment and support services for individuals found unable to A&A and individuals found GEI.

KEY FINDINGS

1) **Oregon lacks a comprehensive forensic behavioral health reporting and accountability framework.** No single entity maintains a comprehensive record of funding, expenditures, utilization, capacity, outcomes, and unmet need for forensic A&A and GEI populations. Information necessary to answer the court's questions was distributed across multiple agencies, organizational units, and data systems, requiring substantial effort to compile, validate, and reconcile. While numerous studies and reports have examined different aspects of Oregon's forensic behavioral health system, differences in scope, methodology, timeframes, and data sources make it difficult to develop a consistent statewide understanding of investments, service delivery, and outcomes. The effort required to answer the court's questions also demonstrated that current data collection, reporting, and review processes are not sufficiently nimble to support timely system planning, resource allocation, and performance monitoring.
2) **Available financial and administrative data can demonstrate where funding was allocated and expended but cannot fully demonstrate how expenditures translated into services, capacity, access, or outcomes.** The data also do not provide a clear picture of the relative contributions of Medicaid-funded services administered through CCOs and CFAA-funded services administered through CMHPs. The available data generally supported analysis of allocations, expenditures, infrastructure investments, and population trends. However, they do not consistently identify services received, service intensity, individuals served, outcomes achieved, unmet need, or funding adequacy. As a result, while this report provides substantial insight into how funds were directed and spent, it cannot fully assess whether allocations and expenditures were sufficient to meet population needs and where remaining gaps persist.
3) **Financial and programmatic data limitations made it difficult to consistently attribute funding and expenditures to A&A and GEI populations.** Allocation and expenditure data were maintained across multiple teams within OHA and within different reporting systems that are not

regularly reconciled. Differences in methodologies, expenditure categorization, timing of payments, and Service Element attribution required extensive validation and reconciliation during this analysis. Additionally, several Service Elements initially identified as directly serving A&A and GEI populations were subsequently found to support broader behavioral health populations, requiring refinement of the analysis and interpretation of findings. The analysis also identified substantial growth in the number of individuals receiving community restoration services who were not enrolled in Medicaid, increasing from 45 individuals in FY21-23 to 146 individuals in FY23-25 (a 224% increase). However, available data could not determine whether this trend reflects changes in eligibility, enrollment disruptions, transitions between settings, data limitations, or other factors. As a result, the extent to which Medicaid financing may offset or supplement state-funded services could not be fully assessed. These findings highlight the need for standardized data governance, reporting, and reconciliation processes to support consistent monitoring and reporting of forensic behavioral health allocations and expenditures.

4) **Funding growth for forensic community-based services was concentrated in the rapidly expanding community-based A&A population and generally tracked changes in system demand, legal requirements, and state policy.** Between FY21-23 and FY23-25, allocations and expenditures for services directly supporting A&A and GEI populations increased substantially, becoming a larger share of Oregon's community behavioral health spending. Most of this growth was attributable to community restoration services for individuals found unable to A&A, while funding supporting GEI populations remained comparatively stable. These trends aligned with significant growth in community restoration caseloads and occurred alongside federal court orders, legislative investments, and broader efforts to reduce reliance on OSH and expand access to community-based restoration services.
5) **Community restoration has become an increasingly important component of Oregon's forensic behavioral health continuum.** The number of individuals receiving community restoration services more than doubled during the study period, including substantial growth among individuals not enrolled in Medicaid. In contrast, community-based GEI populations remained relatively stable. Growth in community restoration services likely reflects a combination of factors, including increased use of community restoration as an alternative to OSH, federal court orders designed to reduce restoration wait times and limit prolonged hospital-based restoration, expanded community-based capacity, and legislative and administrative efforts to support treatment in the least restrictive setting. These factors collectively contributed to a significant shift in how Oregon serves individuals found unable to A&A. Importantly, some of the factors contributing to recent growth in community restoration services stem from specific court orders, policy decisions, and operational conditions that may evolve over time. If future legal requirements, OSH admission practices, restoration timelines, or system capacity constraints change, demand for community restoration services may change as well. Consequently, recent growth trends should not necessarily be assumed to continue indefinitely. Ongoing monitoring of restoration populations, service utilization, and capacity needs will be important to determine whether future investments remain aligned with changing system demands. Future demand for forensic services remains highly uncertain because recent community-based caseload trends have been shaped by significant legal, policy, and operational changes that may not persist over time.
6) **The full impact of recent investments for forensic populations and for the behavioral health system as a whole has not yet been realized.** A central issue raised during this litigation and subsequent community engagement discussions was understanding how behavioral health funds appropriated by the Legislature were spent and what outcomes those investments produced. This analysis found that OHA largely committed and expended funds allocated for behavioral health infrastructure and community-based services for their intended purposes. However, many investments remain in various stages of implementation and have not yet fully materialized.

Behavioral health infrastructure projects frequently require two to six years to progress from award to occupancy, meaning expenditures often occur years before new treatment capacity becomes available. Similarly, investments in community-based services may require time to develop workforce capacity, provider infrastructure, and operational readiness before their full benefits can be realized. As a result, current capacity may understate the ultimate impact of recent investments. This distinction is particularly important when evaluating whether allocated funds have produced the intended results. Oregon's forensic behavioral health system also continues to evolve in response to changing legal, operational, and policy conditions. The Mink-Bowman case, subsequent court orders, increasing reliance on community restoration, and broader efforts to move individuals more quickly to clinically appropriate levels of care have altered service delivery locations and patterns over time. Consequently, by the time investments are fully implemented, system needs may differ from those that existed when funding was originally allocated, underscoring the importance of ongoing monitoring and reassessment of capacity needs and investment priorities.

7) **Consistent implementation of the revised CFAA framework to support future trend analysis is needed.** While OHA's Phase 2 Cost Study developed a crosswalk between historical Service Elements and the new Core Service Areas, maintaining meaningful longitudinal analyses will require consistent application of the revised framework, clear service categorization guidance, standardized reporting practices, and ongoing data quality oversight. These efforts will help ensure that future changes in expenditures, utilization, and outcomes can be distinguished from changes in reporting methodology and service classification, preserving the ability to assess trends over time.
8) **Additional data collection is necessary to fully answer the court's remaining question regarding service adequacy and system performance.** Current data are sufficient to evaluate funding allocations, expenditures, and certain population trends, but insufficient to determine funding adequacy, unmet need, workforce constraints, service utilization, or whether available resources are sufficient to meet the needs of A&A and GEI populations. Additional provider-level and service-level data collection would provide critical information regarding how state investments are translated into service delivery for forensic populations and where remaining system gaps exist.

RECOMMENDATIONS

While this report provides substantial information regarding how funds were allocated, committed, and expended, it also demonstrates that answering questions about access, capacity, service adequacy, outcomes, and future resource needs remains challenging due to fragmented data systems, changing program structures, and limited provider-level information. The recommendations that follow are designed to improve Oregon's ability to monitor and plan for the needs of forensic populations by strengthening data governance, reporting, accountability, and long-term system oversight. Collectively, these recommendations aim to support ongoing court monitoring, improve legislative and operational decision-making, and provide a clearer understanding of whether investments in community-based behavioral health services are improving access and outcomes for individuals found unable to A&A and individuals found GEI.

1) **Establish Centralized Leadership and Accountability within OHA BHD for Forensic Behavioral Health Oversight, Planning and Reporting.** OHA should develop a leadership and accountability structure within OHA BHD, including designating a single office or entity within OHA BHD, responsible for coordinating forensic behavioral health planning, data governance, reporting, forecasting, and system monitoring. Doing so would allow OHA to establish clear accountability for maintaining a comprehensive understanding of Oregon's forensic behavioral health system and ensuring that planning and investment decisions are informed by consistent and reliable information. This should not be a standalone unit, but an integrated component within Oregon's

broader behavioral health system to avoid siloing of data and forensic populations. Accomplishing this could include but is not limited to re-evaluating current structures, leveraging existing resources, or seeking alternative resources. Responsibilities could include:

- Maintaining a comprehensive forensic behavioral health data repository.
- Coordinating population forecasting and planning activities.
- Reconciling financial, program, utilization, and capacity data.
- Producing recurring forensic behavioral health reports.
- Monitoring implementation of forensic investments and initiatives.
- Supporting legislative, executive, and court reporting requirements.
- Coordinating data collection across OHA divisions, providers, OSH, PSRB, courts, and other relevant partners as feasible and legally permissible.

2) **Establish a Statewide Forensic Behavioral Health Annual Report and Planning Process.** OHA should establish a recurring statewide forensic behavioral health reporting process updated at least annually, that provides a consistent and transparent view of:
   - A&A and GEI population trends
   - Community restoration utilization
   - OSH forensic utilization and patient flow
   - Funding allocations and expenditures both for Medicaid and non-Medicaid enrolled populations
   - Infrastructure investments and capacity development
   - Workforce capacity
   - Service gaps and unmet needs
   - Key performance and outcome measures

   This report could serve as a common framework for legislative planning, budget development, public transparency, and court monitoring.

3) **Standardize Forensic Behavioral Health Data Governance and Systems.** OHA should build on recent changes to the CFAA framework, which are intended to improve flexibility and accountability, to establish standardized data governance, ownership, reconciliation, and reporting processes for forensic behavioral health information, including:

   - Standardized definitions for forensic populations and related expenditures.
   - Routine reconciliation processes between Program Team and Budget Unit data.
   - Consistent reporting methodologies across OHA divisions.
   - Improving documentation regarding how expenditures are attributed to specific populations and services.
   - More proactive budget and contract management tools for forensic populations to support timely funding adjustments and ensure resources remain aligned with A&A and GEI caseloads.

4) **Develop a Longitudinal Monitoring Framework for the Revised CFAA Structure.** OHA should follow the recently established data monitoring guidelines for the new CFAA framework, including quarterly reporting based on CMHP/LMHP-provided data. To support a comprehensive understanding of system financing, reporting should also include information on Medicaid-funded services administered through CCOs, allowing state-funded CFAA expenditures to be considered within the broader context of all funding supporting forensically involved individuals. Using this and the crosswalk developed through OHA's Phase 2 Cost Study as a foundation, OHA should further develop and maintain a standardized crosswalk and reporting framework linking historical Service Elements to the revised Core Service Areas to preserve the ability to evaluate long-term trends and assess the impact of future policy changes and investments. This framework should:
   - Maintain historical comparability

- Document methodological changes
- Track forensic populations separately
- Support future legislative, operational, and court reporting

5) **Continue Monitoring Community Restoration Demand and Capacity.** The report demonstrates substantial growth in community restoration services, but future demand remains uncertain due to potential changes in federal court orders, HB 2005 implementation, Medicaid policy, and other factors. OHA should continue monitoring community restoration demand and capacity on a quarterly or biannual basis (and incorporate findings into the annual report discussed in recommendation 2):
   - Community restoration utilization and outcomes.
   - Population growth and service demand.
   - Provider capacity and workforce availability.
   - Non-Medicaid restoration populations and reasons for non-Medicaid enrollment or eligibility.
   - The impacts of legal and policy changes on service demand and expenditures.

   Future planning strategies for community restoration services as well as community alternative strategies should be driven by ongoing monitoring rather than historical growth trends alone. As community restoration demand and capacity continue to evolve, consideration should be given as to whether to memorialize current federal court orders in state law in order to preserve existing guardrails around inpatient versus community placements.

6) **Continue Monitoring and Enhance Behavioral Health Infrastructure Investments Tracking.** OHA should enhance the existing external BHI Housing and Licensed Capacity Investments dashboard with functionality to track and report behavioral health infrastructure investments through all stages of project implementation, including:
   - Allocations
   - Encumbrances
   - Expenditures
   - Project status
   - Bed creation and preservation
   - Geographic distribution
   - Occupancy and utilization following implementation

   Such reporting would provide policymakers, taxpayers, and other community members with a more complete understanding of and transparency around infrastructure investments and the timeline required for investments to translate into operational capacity.

7) **Implement Standardized Provider-Level Reporting.** In collaboration with CMHPs and AOCMHP, OHA should implement standardized service level data collection of provider-level services, expenditure, utilization, staffing, and capacity information for providers serving A&A and GEI populations. This recommendation builds on work already underway through HB 4092, which requires OHA to assess the funding necessary for CMHPs to fulfill their statutory responsibilities. At a minimum, future reporting should seek to capture:

   - Service utilization across all funding sources.
   - Provider expenditures by service category.
   - Workforce and staffing levels.
   - Program or bed occupancy and waitlist data.
   - Housing and residential placement capacity.
   - Capacity constraints and unmet demand.

8) **Complete the Second Phase of Analysis Ordered by the Court.** To address the court's second question, OHA has been directed to support a second phase of work examining the adequacy of Oregon's community-based behavioral health continuum for forensic populations. Subject to data availability and court-mandated timelines, the study will include additional data collection and may incorporate community engagement findings, in addition to review and refinement of previously analyzed data, to assess unmet service needs and identify where additional capacity may be needed for individuals found unable to A&A and individuals found GEI.