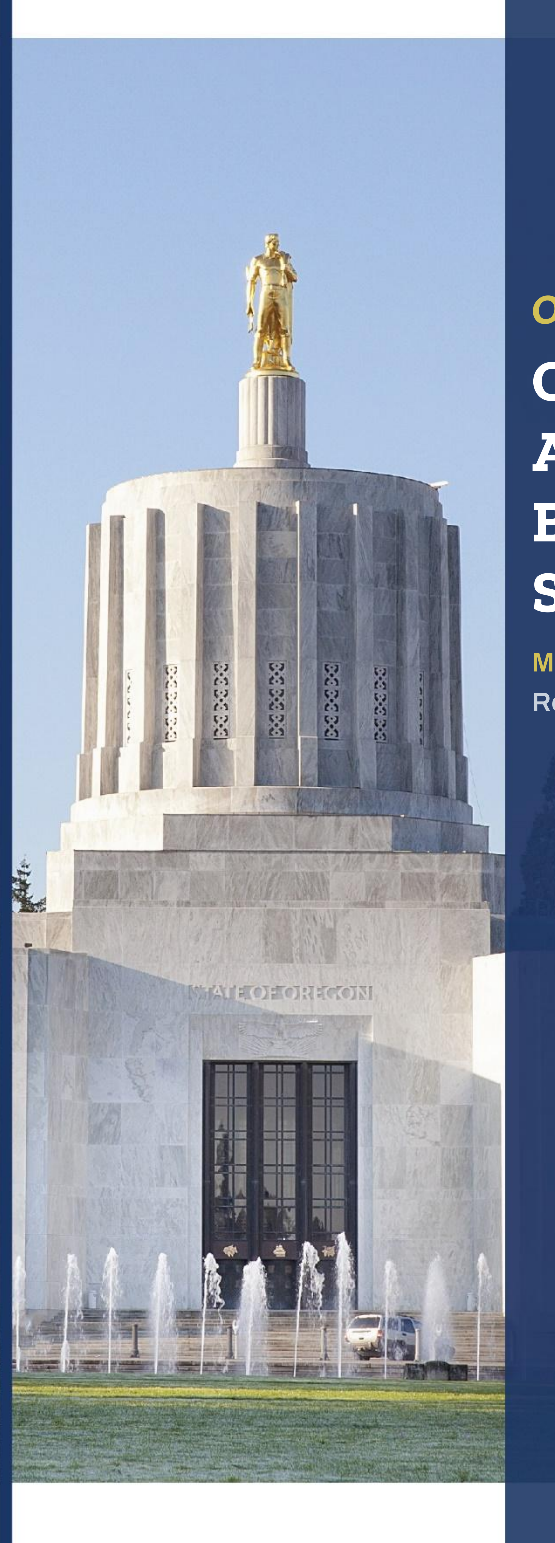

Oregon Health Authority

Oregon Faces Challenges in Addressing Gaps in the Behavioral Health Crisis System

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Report 2025-14

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Audit Summary

Oregon Health Authority

Oregon Faces Challenges in Addressing Gaps in the Behavioral Health Crisis System

OBJECTIVE

The objective of this audit was to assess how the Oregon Health Authority (OHA) coordinates behavioral health crisis systems for adults and children.

SCOPE

The audit focused on efforts made by OHA to coordinate the state's behavioral health crisis system that incorporates the new federal 988 program for serving all individuals.

Why this audit is important

For every $1 invested in preventing and treating adolescent mental disorders and suicide, there is a $24 return in health and economic benefits over 80 years.

In 2022, 14.6% of 11th grade students, 11.6% of 8th grade students, and 7.2% of 6th grade students in Oregon reported serious thoughts of suicide.

In 2020, the economic impact of major depressive disorder in adults in the U.S. was estimated to be $326 billion.

Behavioral health programs help the people of Oregon achieve physical, mental, and social well-being.

What we found

Twenty-three years of gaps in Oregon's health systems data make it difficult to plan for behavioral health crises and evaluate the current response system. (pg. 12)
Existing systems are fragmented, and the implementation of a new data system keeps getting delayed. OHA urgently needs to fully implement its strategic plan and work to address fragmentation and coordination of new data systems.

Funding for the state's behavioral health crisis response system is inadequate. (pg. 16)
Crucial elements are underfunded or unfunded. Following the passage of the National Suicide Hotline Designation Act of 2020, Oregon adopted the Crisis Now model, which consists of three main pillars: the hotline, mobile response, and crisis centers. While funding was established for the hotline, less funding was provided for mobile response, and no funding was dedicated for crisis centers. The state needs to adequately fund all three tiers of the system to deliver Oregonians the support they need.

The lack of long-term strategic planning undermines progress on behavioral health in Oregon. (pg. 18)
OHA made progress on this with the August 2024 Strategic Plan; however, work remains to align the operations of the Behavioral Health Division with this overarching strategy.

Legal and jurisdictional challenges limit Tribal Nations' ability to provide timely, effective behavioral health interventions for their communities. (pg. 25)
To ensure equitable access to care for American Indian and Alaska Native populations, OHA will need to strengthen collaboration with Tribal partners and address structural barriers within the behavioral health crisis framework.

What we recommend

To address data collection issues, OHA should:

1. Collaborate with behavioral health crisis partners, such as CMHPs and contractors, to better understand the nature and extent of system data, and pursue measures needed for consistent implementation.
2. Examine and document fragmented internal coordination between Behavioral Health, Fiscal and Operations, and Health Policy and Analytics divisions with respect to data necessary for informed decision making and determine if resources are available for a data analyst embedded within the 988 and Behavioral Health Crisis unit.
3. Develop procedures to aggregate and analyze 988 lifeline call data.

To address funding gaps in behavioral health crisis system, OHA should:

4. Develop a comprehensive funding strategy for all components of the Crisis Now framework.
5. Review funding parity for the children and family's crisis system, including Mobile Response and Stabilization Services, and develop plans to address gaps where necessary.
6. Coordinate with the Legislature as necessary to provide funding for lapsed behavioral health workforce incentive programs.
7. Collaborate with the Legislature, Coordinated Care Organizations, Department of Consumer and Business Services, and insurance providers to develop a comprehensive model that ensures private insurers cover mobile crisis response and stabilization services like leading models from other states.

To address the lack of behavioral health crisis system strategic planning, OHA Behavioral Health should:

8. Develop a behavioral health division strategy aligned with the August 2024 agency strategic plan.
9. Assess the resources needed to appropriately coordinate the developed strategy and communicate unmet need in future funding requests.
10. Monitor, evaluate, and report progress to interested parties, such as the Behavioral Health Crisis System Advisory Committee.

To remediate legal barriers that hinder behavioral health crisis action, OHA 988 and Behavioral Health Crisis unit should:

11. Continue to work with OHA Tribal Affairs to explore culturally responsive services to American Indian or Alaskan Natives living in Oregon and collaborate on any legislative barriers that may hinder services.
12. Incorporate Tribal inclusivity into the behavioral crisis framework, such as support for Tribal members who dial the 988 Lifeline, mobile crisis stabilization services, and collaborating with Tribes on high acuity mobile crisis cases that may lead to civil commitment investigations.

Agency response

OHA agreed with all of our recommendations. The response can be found at the end of the full report.

Read the full audit report

Scan the QR code to read the full audit report, including the agency response, on our website.

Introduction

Meeting the needs of individuals experiencing behavioral health crises is a challenge. In Oregon, successfully doing so requires coordination among the Oregon Health Authority (OHA), Community Mental Health Programs (CMHPs), crisis call centers, hospitals and other behavioral health service providers, and the community. Federal legislation, changes to Medicaid, and actions by the Oregon Legislature have provided OHA and its partners with an opportunity to reimagine how behavioral health crisis services are delivered. Yet advances in the system will require strategic investment and sustained, intentional action to have long-term results.

Key terminology used in this report

Behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis and treatment of those conditions.

Substance Abuse and Mental Health Services Administration (SAMHSA) defines **Serious Mental Illness** as someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

Mental health parity means that mental health and substance use disorder services are treated generally the same as, or better than, medical and surgical services.

As used in this report, the term **youth** refers to individuals 10- 24 years old.

Oregon's behavioral health crisis system has evolved and expanded over the last decade

As behavioral health needs have evolved, so have Oregon's service delivery to patients. Some areas in Oregon have offered mobile crisis response to meet these needs, although the extent and delivery of those services has changed. One of the biggest changes to Oregon's behavioral health crisis system came in 2020 with the federal passage of the National Suicide Hotline Designation Act, which provided 988 as the new, nationwide crisis phone number, and funding for states to implement the program. While investments like these enable some progress, implementing such programs remains difficult as OHA coordinates call centers, mobile crisis response teams, and stabilization centers.

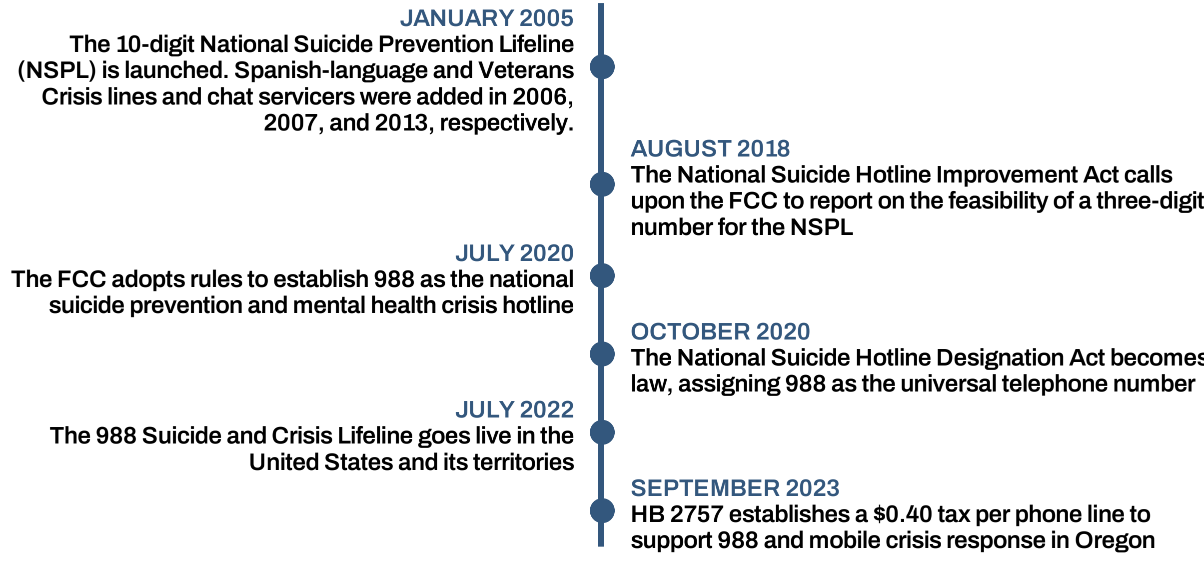
The new 988 Lifeline renewed focus on the behavioral health crisis system

The National Suicide Hotline Designation Act of 2020 transformed Oregon's approach to behavioral health crisis services through the establishment of the 988 Lifeline. This federal legislation mandated all states implement the hotline as a three-digit phone number for behavioral health emergencies. Although Oregon still operates its existing county crisis hotlines — a move experts say is ideal in providing continuity for emergencies — the National Suicide Designation Act of 2020 created a direct, streamlined path for individuals experiencing crises statewide to receive emergency support.

The implementation of 988 in July 2022 was followed with the passage of House Bill 2757 in 2023 that allowed Oregon to collect a nominal telecommunications fee to provide state funding for the 988 crisis hotlines, ensuring sustainable accessibility to services. The uniformity of 988 as a number to call reduces confusion and further lowers barriers to obtaining help.

The National Suicide Hotline Designation Act also promotes the use of mental health professionals in response to behavioral health crises, rather than law enforcement officials. This change ensures people experiencing behavioral health crises receive timely and appropriate care and reduces the burden on law enforcement and emergency departments.

Figure 1: The 10-digit National Suicide Prevention Lifeline became 988, 17 years after it was launched



Effective behavioral health crisis response requires coordination between crisis call centers, mobile crisis teams, and stabilization service centers

While crisis services existed in Oregon before the 988 system, national guidance now provides structure and best practices which aim for swift intervention, harm reduction, connection to ongoing care, and reduction in the use of law enforcement.

Oregon has adopted the following model:[1]

1. Someone to call/talk to (988/crisis hotline)
2. Someone to respond (mobile crisis team)
3. Somewhere to go (crisis stabilization centers)

In Oregon, people in crisis can call 988 and connect with one of the two 988 call centers in the state: one call center serves residents living in Marion and Polk counties, while the other call center covers the rest of the 34 counties in the state. 988 services are accessible by phone or text 24 hours a day, seven days a week, all year.

[1] This model is designed primarily for adults. Oregon's system of crisis support for children and families is detailed on pages 3 and 4.

When a person in crisis calls 988, they are connected to a counselor who can assess and talk with the individual about their situation. If the call can be resolved over the phone, as most calls are, the caller will be provided with resources for follow-up care. Callers can also choose from various specialized counselors, including LGBTQIA2S+, veteran, and Spanish-speaking counselors, ensuring trauma-informed care.

If the situation cannot be resolved over the phone, a mobile crisis team will be dispatched to assist the individual. The call center will connect with the CMHP from that caller's self-identified location. If a caller's location cannot be determined voluntarily, 988 can coordinate with local Public Safety Answering Points, regional call centers used for things like 911, to help dispatch crisis response. When the location can be determined, the CMHP will deploy the mobile crisis response team, which will assess the situation and meet with the individual to provide necessary care and treatment. If a caller needs additional support, they are referred to a crisis stabilization center for short-term treatment, if one is available. If a crisis stabilization center is not available, they may be transported to an emergency department to wait for an opening at alternative care.

Figure 2: The Crisis Now Framework, consists of someone to talk to, respond, and a place to go

Source: Oregon Health Authority

Mobile crisis support for children and youth focuses on the family

In Oregon, children and youth in crisis can wait for hours or days in emergency departments to be connected to outpatient services or inpatient psychiatric beds. OHA previously addressed this problem through the Crisis and Transition Services program which was designed to prevent children and youth in behavioral health crisis from being boarded in emergency departments.[2] That program ran from 2015 to 2022 in 11 Oregon counties.

Since then, OHA implemented a national best practice model for youth and family crisis intervention called Mobile Response and Stabilization Services that replaced the Crisis and Transition Services program. Mobile crisis services were allocated approximately $117.7 million in the 2023-25 Legislatively Adopted Budget. Mobile Response and Stabilization Services funding was approximately $20.5 million and funding for 988 services was approximately $34.3 million.

[2] The Crisis and Transition Services program was run by Oregon Health & Science University and funded by OHA.

Figure 3: Mobile Response and Stabilization Services, the crisis program for children and youth, receives the least money in OHA's 2023-25 Legislatively Adopted Budget

	General Funds	Other Funds	Federal Funds	Total Funds
988	$ --	$32,961,422	$1,360,207	$34,321,629
Mobile Crisis	$79,143,444	$13,935,324	$24,600,000	$117,678,768
MRSS	$20,015,600	$473,992	$--	$20,489,592
Total	$99,159,044	$47,370,738	$25,960,207	$172,489,989

Source: Oregon Health Authority

Mobile Response and Stabilization Services is a rapid response, home and community intervention model designed to meet the needs of youth and families. A parent, caregiver or child can determine if there is an emergency and those needing services can get help without screening through an operator. Once contacted, a response team member supports the child and family for up to 72 hours and helps connect them to the appropriate stabilization services. This support must be initiated within three days of the initial contact and can last up to 56 days. The goal is to help youth in crisis stay in their current living situation, get stabilization support for their behavioral health needs, and avoid unnecessary trips to the emergency department or hospitalizations.

OHA is responsible for coordinating the behavioral health crisis response system

The system for delivering behavioral health services to the people of Oregon is vast and complex. It is comprised of dozens of entities that span the public, private, and non-profit sectors. To oversee the system, OHA must coordinate with over 30 CMHPs, government contractors, county mental health officials, health providers, Coordinated Care Organizations, insurance companies, and other government agencies. The fragmented and siloed structure — a product of decades of state regulatory changes, funding allocation, and legal jurisdictions — makes effective coordination of behavioral health crisis programs even more challenging.

OHA's Behavioral Health Division plays a key role in administering Oregon's complex and decentralized behavioral health crisis system

OHA is charged with managing the state's public behavioral health system and does so through its Behavioral Health Division. Previously, the Behavioral Health program resided under the Health Systems Division, which was dissolved during an April 2024 reorganization. After the reorganization, the Behavioral Health Division has been moved up an organizational level and reports directly to the OHA Director.

The transition sought to prioritize behavioral health by positioning the division closer to the OHA Director's office, reducing potential process and communication delays. The team managing the 988 & Behavioral Health Crisis System has six total full-time staff and resides in the Adult Behavioral Health Services program under the Service Delivery subdivision of the Behavioral Health Division.

Figure 4: Behavioral health crisis services are led by the Service Delivery unit

OHA
Behavioral Health (BH) Division

Equity, community Partnerships & Quality Assurance	Service Delivery	BH Operations & Strategy
	Child & Family BH	
	Adult BH	
	988 & BH Crisis	

However, not all staff who work on the behavioral health crisis system are within the 988 & Behavioral Health Crisis System unit. Several staff liaise from other units. For example, Mobile Crisis Response and Stabilization Services activities are managed by the Child and Family Behavioral Health Services program. The Licensing and Certification unit, a team within Behavioral Health Operations and Strategy, has 988 crisis system staff and oversees the civil commitment certification processes.[3]

OHA's Public Health Division also has a role in behavioral health services. Public Health suicide prevention coordinators work with their counterparts on the behavioral health side of the agency as a cross-division team, while the Healthcare Regulation and Quality Improvement Program investigates complaints in health care facilities, including behavioral health services-related complaints.

Oregon's crisis response system is mostly funded through Medicaid and money from the state General Fund. For the 2023-25 biennium, the now-retired Health Systems Divisions operated with a budget of $28 billion and 660 full-time equivalent staff, with $26.3 billion of that total going to Medicaid. Another $1.3 billion went to behavioral health services not covered by Medicaid and people who did not qualify for the Oregon Health Plan, the state's Medicaid program for low-income individuals.

[3] Civil commitment is a process in which a judge decides whether a person alleged to be mentally ill should be required to accept mental health treatment.

Figure 5: Each component of Oregon's crisis response system is managed by different entities

People in Crisis		
State Contractors	Crisis Hotline	
Community Mental Health Programs	Walk-in Services	Mobile Crisis Response
Health Providers	Crisis Stabilization Center / Emergency Department / Inpatient Psychiatric Facility	

OHA coordinates Oregon's behavioral health crisis services through contractors, regional partners, and Coordinated Care Organizations

To achieve effective coordination and delivery of services, OHA manages relationships with counties, Tribes, CMHPs, providers, contractors, and coordinated care organizations. This complex undertaking requires considerable effort for OHA staff to build relationships and understand the nuances of each entity.

Relationships with the counties and Tribes are necessary for mutual collaboration and to ensure services are provided within the expectations of the respective governing bodies. State agencies are required to establish policies to promote communication and positive intergovernmental partnerships with Tribes. They are also required to make a reasonable effort to cooperate with Tribes in developing and implementing programs that will affect them. To this end, OHA has a Tribal Affairs Director and Tribal Liaisons who work with Tribes to better understand their behavioral health needs.

The entire system is advised by the newly established Behavioral Health Crisis System Advisory Committee, which provides guidance to OHA on the implementation and operation of the statewide coordinated crisis system and provides feedback and recommendations on the 988 Suicide & Crisis Lifeline.[4]

[4] The Behavioral Health Crisis System Advisory Committee consists of 19 members of diverse backgrounds related to the Behavioral Health Crisis System as mandated in House Bill 2575 and ORS 430.629.

Oregon outpaces national trends in mental illness, leading to a costly cycle of poor outcomes

Nationwide reports from the Substance Abuse and Mental Health Services show Oregon as having among the highest level of need for behavioral health services for both adults and youth. These reports highlight the relatively high percentage of people in Oregon with suicidal ideation.

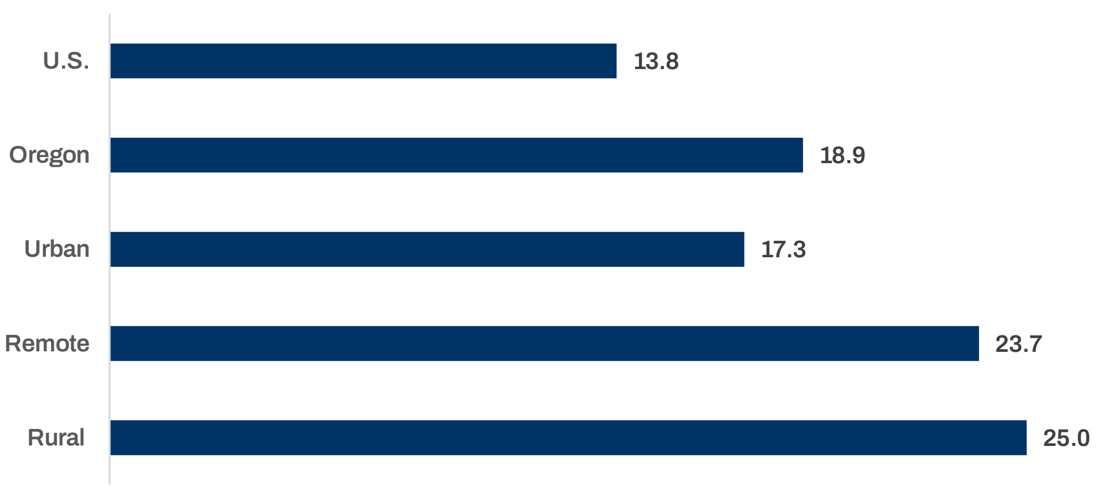
Behavioral health crises, while highly personal, can have costly ripple effects through families and communities. State leadership has demonstrated some recognition of this critical issue, with the state Legislature providing funding to these areas, and the Governor highlighting the need to address behavioral health gaps. These investments coincide with federal funding for behavioral health crisis response. However, based on these severe and longstanding poor outcomes, a higher degree of urgency and prioritization is needed.

Oregon ranks high in behavioral health need and low in availability of services

The high rate of mental illness in Oregon underscores the need for an effective behavioral health crisis response system. The 2022 National Survey on Drug Use and Health shows Oregon as ranking 47th in the nation for its high prevalence of mental illness..

This high ranking for insurance coverage is likely due to the state's efforts to expand Medicaid. However, being insured does not necessarily mean treatment is available. Oregon ranked 46th among states for adults with substance use disorder who needed but did not receive treatment. Likewise, Oregon ranked 24th among states for youth with private insurance that does not cover mental or emotional problems.[5] Further, a June 2024 study found a lack of access to facility-based care in Oregon led to long wait-times and a mismatch between the level of behavioral health care needed and the care received.[6]

Figure 6: From 2016 to 2020, suicide rates were highest in Oregon's remote and rural counties



Source: Oregon Health Authority, Adult Suicide Intervention and Prevention Plan, 2023-2027

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[5] Youth were defined as 12-17 years of age for most of the measures used in the 2024 State of Mental Health in America report. Youth Flourishing was measured among children 6-17 years of age.

[6] The report, *Oregon Health Authority Behavioral Health Residential+ Facility Study*, evaluated facility capacity only for adults.

Oregon's high suicide rates reflect the state's need for behavioral health services

Oregon's high prevalence of mental illness, paired with low access to treatment, has led to tragic outcomes. The state's overall age-adjusted suicide rate has been higher than the U.S. rate since 2000. Oregonians under 24 years of age are particularly vulnerable. In 2022, the state's youth suicide rate was 14.2 per 100,000 compared to 10 per 100,000 nationally, with the highest rates occurring during the age of transition, from 18 to 24 years of age. Every year from 2003 to 2022, Oregon's youth suicide rate has been higher than the national rate, except for the year 2010. The rate decreased for three consecutive years — from 2019 to 2021 — giving hope that the situation was improving but increased again in 2022.[7]

Figure 7: Oregonians, particularly youth, suffer mental health challenges more than most in the United States

	Oregon (%)	National (%)	Oregon's Ranking among States
Adults (18+ years), in the past year, with:			
Serious mental illness	7.03	5.86	46
Serious thoughts of suicide	5.61	5.04	42
Made any suicide plans	1.54	1.45	30
Attempted suicide	0.68	0.67	21
Youth (12-17 years), in the past year, with:			
Serious thoughts of suicide	15.00	13.16	51
Made any suicide plans	7.15	6.35	41
Attempted suicide	4.48	3.67	44

Sources: SAMHSA, 2021-2022 National Surveys on Drug Use

Breaking down the rates by demographic factors reveals differences between groups. About 75% of people who die by suicide in Oregon are male, and rates are higher for men than women across lifespan, with the highest rates being among men 75 years of age or older. Rates are also high in traditionally male occupations, such as construction, military-related work, farming, fishing, and forestry.

Racial, ethnic, and geographic disparities are also present. Between 2016 and 2020, non-Hispanic American Indians and Alaska Natives, and non-Hispanic Whites, had the highest age-adjusted suicide rates among the different racial and ethnicity groups (20.2 and 20.7 per 100,000, respectively). Deaths by suicide among non-Hispanic White youth decreased overall since 2019, but the number of youth suicides among other races and ethnicities have remained similar to 2018 levels or increased. Oregonians living in rural and remote counties have suicide rates higher than those residing in urban counties. The intersection of risk factors — such as a disabled youth living in a rural area — compounds challenges around receiving quality care.

[7] Auditors were told caution needs to be taken when interpreting youth suicide rates. Several years of data, and other indicators like the number of suicide-related hospital emergency department visits, are needed to determine a trend.

The age of transition — 18 to 24 years — is a vulnerable period for young adults

The majority of youth suicides, in Oregon and nationally, occur among 18- to 24-year-olds. In 2022, 78% of Oregon youth suicides were in this age group. This "age of transition" is a time of increased risks for youth. Brain development and maturity varies, which influences problem-solving and foresight. Young adults are often away from home for the first time, without their usual social supports. Feelings of loneliness and a lack of belonging, new mental health diagnoses, and increased substance use are all risk factors. Common circumstances surrounding Oregon suicides in this age group include suicidal thoughts and behaviors, intimate partner problems, and having experienced a recent crisis.

This age is an important period for prevention and intervention, but young adults can be hard to reach and connect with if they are not in school. Young adults can also slip through the cracks in Oregon's child and adult behavioral health systems. They may be too old for children's programs and too young for adult programs. A lack of culturally sensitive resources may place marginalized groups at even greater risk, such as LGBTQ+, Native, and Black youth.

OHA recognizes the increased risk and developmental span for this age group, and as a result, includes 18- to 24-year-olds in both their youth and adult suicide intervention and prevention plans. Each plan is based on a prevention framework developed in collaboration with the University of Oregon Suicide Prevention Lab, and received feedback from partners across Oregon. Together, the two plans present strategic goals and priority initiatives to address suicide across the lifespan.

State legislation addresses some behavioral health crisis needs

State lawmakers are aware of the challenges facing the state's behavioral health system. Actions over the last decade demonstrate efforts to provide funding and make improvements. These legislative efforts serve as evidence that legislators have been engaged in addressing behavioral health crisis needs through the lawmaking process. Although additional legislative work may yet remain, it is important to recognize this issue has received ongoing legislative focus.

In response to the rising number of behavioral health crises in emergency departments, the Legislature passed House Bill 2023 in 2015 to improve quality and consistency of discharge practices. The legislation required emergency departments to assist individuals with discharge planning, including referrals to appropriate care facilities. Additionally, hospitals were mandated to encourage patients to authorize the disclosure of necessary information for caregivers or support systems to participate in the discharge process and provide post-discharge support.

Subsequent legislation, House Bill 3090, in 2017, further enhanced discharge planning for behavioral health crises and substance use. It mandated written discharge policies, caring contacts between a patient and follow-up services, and follow-up appointments within seven days.[8] Hospitals were required to

[8] Caring contacts are brief communications with a patient that start during care transition such as discharge or release from treatment. The intent of these contacts is successful transition of a patient to outpatient services.

designate a lay caregiver, with consent, and collaborate with providers to ensure continuity of care, including contacting patients within 48 hours of discharge.[9]

In 2021, House Bill 2417 focused on expanding access to behavioral health crisis response services, improving equity in treatment, and reducing hospitalizations and interactions with the criminal justice system. This bill allocated funds to support 988 crisis lines and mobile crisis teams but left crisis stabilization services unfunded.

Finally, in 2023, House Bill 2757 established the 988-trust fund, financed by a new telecom fee, to fully fund 988 and remaining funds can be used on mobile crisis response. While this legislation created oversight for the behavioral health crisis system, the revenue generated by the telecom fee cannot be used for crisis stabilization, leaving a gap in service funding.

State action since 2021 includes:

- Funding for crisis hotline centers and mobile crisis response;
- Funding for additional residential treatment beds;
- Increasing reimbursement rates through Medicaid for behavioral health services;
- Specifying behavioral health services that must be provided by coordinated care organizations and covered by group health insurers;
- Improving youth suicide intervention and prevention for children 5- to 10-years-old; and,
- Requiring OHA to study behavioral health costs and access to services.

[9] The lay caregiver for a person younger than 14 years of age would be a parent or legal guardian. A person 14 years of age or older, or their parent or legal guardian, would designate a person as the lay caregiver.

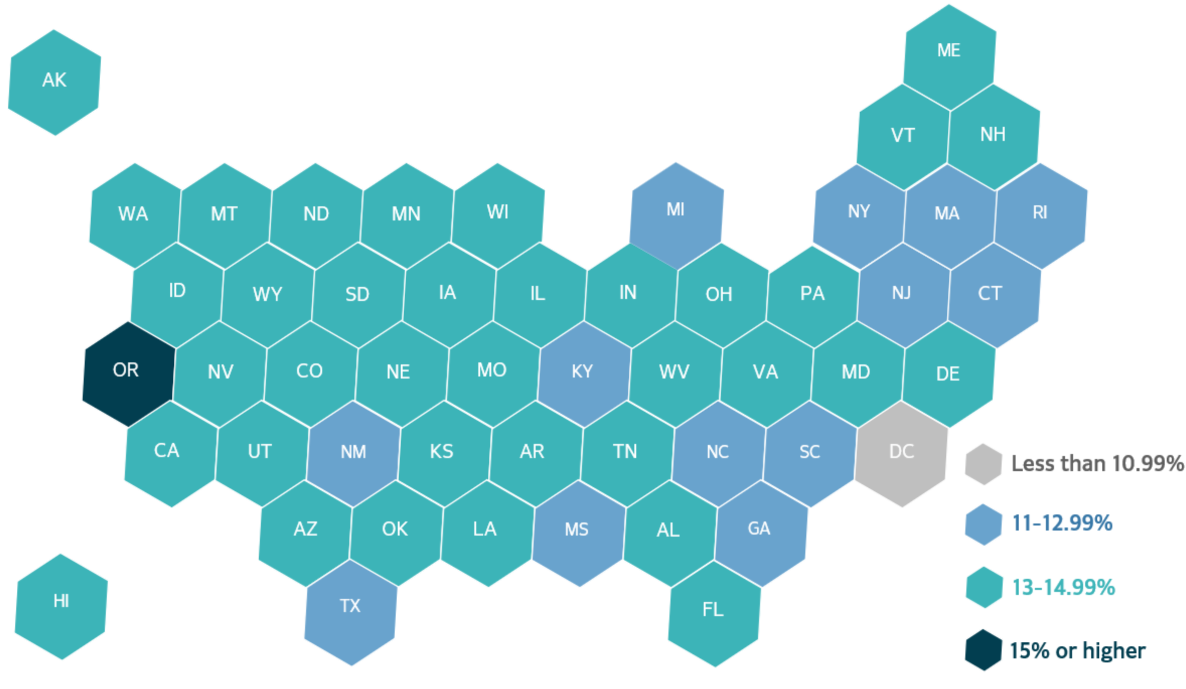
Audit Results

Oregon's behavioral health crisis response system is relatively new and complex. It is overseen and supported by OHA and includes multiple processes and partners. This includes the oversight of the 988 and Suicide Crisis Lifeline program. This program provides a single, national number that can be used by individuals in crisis to speak to a trained professional and be directed to appropriate services. If a caller is at immediate risk, 988 can dispatch a Mobile Crisis Team that will provide appropriate and trauma-informed care to the individual. Stabilization services are the final component of the system.

Each of these components — the 988-crisis line, mobile crisis teams, and stabilization services — is at a different stage of development and the availability of these services varies throughout the state. Oregon's implementation of this system lacks adequate state-level planning, data collection, and funding to ensure these services are always available in all parts of the state, as currently required by statute and rule. The urgency of this issue is underscored by Figure 8 which demonstrates Oregon has the highest rate of serious thoughts of suicide for youth in the nation.

While not a component of the crisis response system, related factors include the hospital discharge requirements for individuals experiencing a behavioral health crisis. In 2015 and 2017, the Legislature passed laws that required a variety of services for individuals who seek care for a behavioral health crisis in a hospital or emergency department. While these laws have been in place longer than the crisis response system, OHA conducts limited oversight, and stakeholders expressed significant concern that hospitals are not complying with these important requirements.

Figure 8: Oregon youth (12-17 years) have the highest rate for serious thoughts of suicide in the nation



Source: Substance Abuse and Mental Health Services Administration

Data collection issues hinder planning efforts and limit evaluation of 988 and mobile crisis response

The behavioral health crisis system lacks the data necessary to identify the level of need statewide and measure crisis intervention outcomes. Existing systems — such as those that capture crisis hotline usage — are fragmented, and implementation of a modernized system has been repeatedly delayed. OHA contracted with Oregon Health & Science University (OHSU) Data, Evaluation, and Technical Assistance (DAETA) team to bridge mobile crisis data gaps; however, this partnership was not intended to be a permanent solution. Health-related data gaps in Oregon have been noted in multiple reports and this history underscores the need for urgent action.

Without an effective system to measure behavioral health crisis needs, outcomes of services provided, and costs of those services, the full picture of the Oregon system is unclear. As a result, OHA is unable to answer important questions about the adequacy of the system.

Figure 9: Lines for Life, one of Oregon's two 988 vendors, outperformed the national average on call answering times until fall of 2023

Source: Lines for Life

OHA and state leaders cannot fully understand the state's need for crisis services due to missing user data

OHA lacks a comprehensive estimate of the total number of calls made to 988 and county behavioral health hotlines, an essential data point for determining the need for crisis services across the state. Although 988 call centers have been submitting call data since October 2022, OHA only recently

requested CMHPs to submit a one-time county crisis line data report.[10] As a result, OHA has an incomplete picture of the number of calls to hotlines and the percentage of those calls that lead to dispatches, making it difficult to assess the statewide demand for crisis services.

Within the available call data, substantial amounts of information are missing about caller demographics, such as age, race/ethnicity, gender, and county. This also hinders the state's understanding of service needs. OHA personnel and clinicians at the 988 call centers say collecting demographic information from callers is frequently inappropriate due to the nature of the interactions and that 988 was designed to prioritize anonymity and confidentiality. In areas with low numbers of calls, demographic data may be obscured to protect privacy. However, the national 988 lifeline program has published guidance on how to gather demographics during crisis calls. Doing so informs the clinical approach and helps to find the right referrals for callers. As a result of the missing data, OHA cannot accurately say which groups are, or are not, using crisis services.

Accurate demographic data is also important for identifying potential negative experiences for those accessing crisis services among people in marginalized groups who have disproportionately higher rates of mental health issues and suicide. If callers from these communities have a poor experience, they may not return to the service and could discourage others from using it. Marginalized communities often experience deep mistrust of government and health systems due to historical and ongoing injustices, whether perceived or in fact. Without demographic data, the agency's goal of eliminating health inequities by 2030 in the behavioral health crisis system is unlikely.

Oregon families burdened by system failures

The OHA Ombuds Office was contacted by the caregiver of a young OHP member with complex mental health needs and developmental disabilities. Because of their persistent challenges, the behavior of the young person in the home was increasingly unpredictable and unsafe.

The family, who lived in a rural area, previously tried to access 988 and Mobile Response Stabilization Services when this person would go into crisis. The caregiver reported responders were either delayed in getting to the house when called or did not come at all. Due to their rural location, the caregiver was informed their calls were routed to a service center in a more populated area that would then contact their local services, creating delays.

In addition, the local agency struggled to recruit and retain staff who could be available to provide Mobile Response services around the clock. As a result, the family had to develop an alternative approach in the form of an agreement with local law enforcement. This agreement allowed the family to contact the police non-emergency number directly to cut down on delays in response and to be assured that someone would come to the house.

[10] Oregon's 988 call centers contract with some counties to answer calls to their local behavioral health hotlines. One call center, for example, answered an average of 1,782 calls a month during all hours or non-business hours for Clackamas, Clatsop, Columbia, Crook, Deschutes, Jefferson, Yamhill, and Wallowa Counties from July 2023 through June 2024.

Health system fragmentation and implementation delays make effective data management challenging

OHA lacks the data to understand the need for crisis services across the state and how the system has performed because data collection efforts have either been fragmented or nonexistent. The agency contractually required 988 call centers to report crisis call data since 2022; however, county crisis line data is not required. OHA did, however, request a one-time county crisis line report. During the COVID-19 pandemic, OHA paused data reporting on local mobile response efforts until 2023. This lack of data left OHA and its CMHP partners without sufficient information to plan a transition to an enhanced system.

The DAETA team from Oregon Health & Science University now supports CMHP efforts to submit data for local mobile crisis intervention services. This effort was to have lasted one year while OHA replaced its Measurements and Outcomes Tracking System with the Resilience Outcomes Analysis and Data Submission system.[11] However, the OHSU contract was extended three times because of delays around implementing the system, which was expected to launch in late 2024, but launched March 11, 2025.

How the agency organizes its data analytic functions has contributed to these data challenges. Behavioral Health personnel have limited control over data analysis for their programs and instead must rely on the availability of data analysts in another division to meet their needs. Just one analyst in that other division is assigned to 988, and only on a part-time basis. No data analysts are embedded with the recently created 988 and Behavioral Health Crisis System unit.

According to the OHSU DAETA team, establishing a unified data platform or better linkages among the different parts of the crisis system would allow for a better understanding of how the system is functioning as a whole. The urgency of the state's mental health crisis requires prompt action to address the current fragmentation in data systems and strengthen the crisis response infrastructure.

A history of gaps emphasizes the need for urgency to gather high-quality data

For over 23 years, reports have noted the necessity for an integrated data system to assess health system needs and performance. These issues are persistent because many of the solutions are complex, but there are areas where the state can improve its approach: specifically, by addressing the continued delays in implementing new data systems and by fully utilizing available data.

> For over 23 years, reports in Oregon have noted the need for an integrated data system to assess health systems need and performance.

In 2001, a report from the Governor's Mental Health Alignment Workgroup found a statewide data system was needed to track provider and community performance and found that the data system should provide linkages to related systems.[12] The report also noted that, without uniform data from providers, there is no way to measure successful outcomes. The 2016 Behavioral Health Collaborative Report reiterated the call

[11] Resilience Outcomes Analysis and Data Submission is a web-based data submission and reporting solution for the agency and its behavioral health partners.
[12] Governor's Mental Health Alignment Workgroup Report from 2001.

to develop an outcome-focused behavioral health measurement framework.[13] Four years later, an audit from our office explicitly noted data shortfalls prevent OHA from consistently understanding mental health needs, availability of treatment, and outcomes.[14] In 2024, an OHA internal audit found inadequate data collection with respect to behavioral health investments.

Understandably, the data and circumstances at the time of each report are unique and the solutions available in 2001 may not be applicable now. Yet, the beleaguered history of data collection and use is more likely indicative of state leadership not prioritizing fixing this issue in a timely manner.

While some delays may be difficult to anticipate or control, habitual delays may be indicative of poor planning. Without adequately addressing this issue, the state compromises its ability to effectively serve the vulnerable people supported by the behavioral health crisis system.

Figure 10: Oregon's behavioral health crisis care system partially meets national guidelines and best practices

SAMHSA Guidelines	Practices in Oregon	Criteria Met?
Hotline Minimum Expectations	Hotline providers operate 24 hours per day, every day. Hotlines are staffed with clinicians who triage and respond, and all calls are either answered or overflow coverage provided. Risk of suicide is assessed within required standard. Hotlines coordinate connections with mobile crisis teams. Hotlines can connect to facility-based care, with transportation, but not in all cases.	Partially
Hotline Best Practices	Hotline providers incorporate call identification in their centers but do not use GPS technology for efficient dispatch or have access to a real-time regional bed registry. Oregon hotline providers do not schedule outpatient appointments in a manner synonymous with a warm hand-off to support ongoing care.	Partially
Mobile Response Minimum Expectations	Mobile crisis responders include licensed and/or credentialed clinicians capable of assessing needs of individuals and respond where the person is, rather than restricting services to select locations or times. Mobile teams also connect individuals with facility-based care as needed.	Yes
Mobile Response Best Practices	Teams incorporate peers and often respond without law enforcement unless special circumstances warrant inclusion. Mobile teams schedule outpatient follow-up appointments to support connection to ongoing care but do not use GPS technology to support efficient connection and tracking of engagement.	Partially
Stabilization Center Minimum Expectations	There is no dedicated funding for crisis stabilization centers in Oregon. Not all referrals are accepted, and centers may not operate 24 hours per day, every day. Not all centers have walk-in and first responder drop-off options and may not always have capacity for 90% of referrals. Centers do not always screen for suicide or violence risk.	Partially
Stabilization Center Best Practices	Not all centers function as a 24-hour or less crisis receiving facility or have a dedicated first responder drop-off area. Connections for ongoing care is not always coordinated. Centers do not have intensive support bed partner programs or include any beds in a real-time bed registry.	Partially

[13] Oregon 2016 Behavioral Health Collaborative Report.
[14] Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis.

Inadequate funding undermines Oregon's Crisis Now model

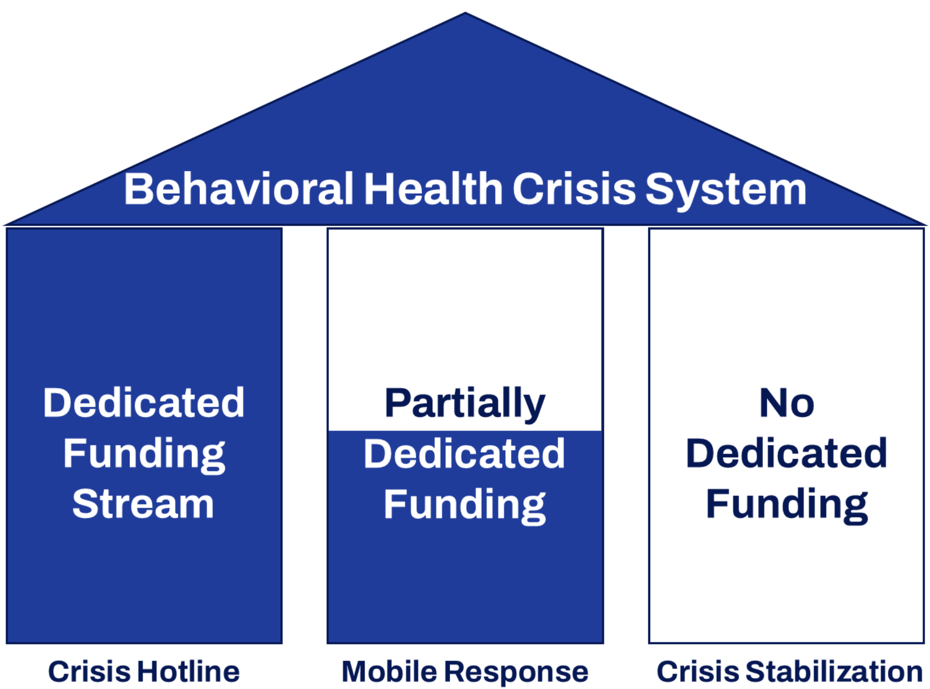
In 2020, SAMHSA created National Guidelines for Behavioral Health Crisis Care, a toolkit that provides guidance on program design, implementation, and quality improvement efforts to help meet the needs the of the community that follows the "anyone, anytime, anywhere" model. Oregon has begun work to meet these guidelines but has only partially met them so far.

Oregon's behavioral health crisis system only funds one of its three pillars

SAMHSA recommends incorporating what is known as an air traffic control model that has two objectives: never lose contact with the aircraft and verify hand-off has occurred when another controller takes over. Air traffic control technology is being used in some states, including real-time connection to mobile teams utilizing GPS, real-time access to available beds or recliners across the state, and the ability to schedule follow-up appointments with short- or long-term care providers. For this to be effective, there needs to be a method to track referrals made for those needing a higher level of care. Oregon does not currently follow this model.

CMHPs across the state are largely operating at the minimum expectations but, depending on the region, some are struggling to meet the requirement of having a qualified clinician available for every call. This program gap is currently being compensated for by CMHP managers, who are qualified, but this approach lends itself to worker burnout. CMHPs in remote and rural counties are particularly struggling with this due to the geography of the counties, as they are often large and less populated, and it is difficult to attract employees who want to stay long-term in rural counties.

Figure 11: Only one of Oregon's three crisis system pillars has dedicated funding



Source: Oregon Health Authority

It is unclear if there is adequate funding for CMHPs to meet expectations and best practices for crisis services. In 2024, House Bill 4092 required OHA to study how much money local mental health programs need to comply with state laws, report the findings to the Legislature by November 1, 2024, and compile a report of the findings by December 15, 2025.

Oregon currently has three crisis stabilization centers and there is significant work remaining to meet the expectations of the SAMHSA guidelines. There is no designated funding stream for the development and the continued operations of crisis stabilization centers. At the time of the audit, Oregon lacked administrative rules for crisis receiving and stabilization centers, although OHA was in the process of creating those rules. Lack of funding for crisis stabilization endangers the entire third pillar of the crisis model, a critical piece that serves vulnerable individuals who need additional treatment. Many individuals needing crisis stabilization end up in emergency departments, waiting for a space to open at one of the few crisis centers that do exist. This creates a backlog of patients waiting for the appropriate care, including those who may be placed on a hold awaiting civil commitment.

Funding uncertainty impacts sustainability of mobile crisis and stabilization services

While the Legislature provided funding for crisis hotlines through House Bill 2757's telecom fee, funding for the provision of mobile crisis and crisis stabilization centers is less certain. House Bill 2757 allows some funding for mobile crisis response. Crisis stabilization centers, while required and part of the third pillar of crisis response, were not provided funding in that bill even with more expectations included in the revised Oregon Administrative Rules. OHA gave CMHPs one-time funding to help get stabilization centers established, but counties that are trying to stand up such centers report funding and regulatory challenges.

A key funding mechanism for mobile crisis is reimbursements through Medicaid, but this funding source also creates uncertainty and administrative burden. CMHPs must bill for crisis services, which the federal government covers for Medicaid recipients, but CMHPs do not have the capacity to bill private insurance. Funding mobile crisis response through billing is similar to paying firefighters only when they are actively responding to a fire.[15] The administrative cost of this process reduces the impact of the reimbursement while increasing the workload of providers.

Furthermore, Medicaid reimbursement for mobile crisis is only guaranteed until 2027 by Section 9813 of the American Rescue Plan. CMHPs and OHA will need to plan how to continue providing mobile response services if this enhanced rate is not extended.

The complexities of private insurance and Medicaid add stress to the already burdened system providers

House Bills 3090 and 3091 were both intended to improve patient care with standardized assessments and enhanced discharge planning. However, hospital staff have voiced concerns with the legislation, finding it confusing and sometimes ineffective in its intended outcomes. Hospital staff thought insurers would be

[15] Unlike the funding model for behavioral health crisis response teams, the "firehouse model" pays firefighters and other emergency responders to be on-call and ready to respond at all times to anyone regardless of insurance status.

funding the extra duties required, as well as taking on the case management and care coordination pieces — instead, hospitals have been left with increased work with little to no reimbursement.

There is confusion regarding how hospitals are reimbursed for crisis work and if insurers are going to cover that cost. Insurers are required to align with federal guidelines on health parity, but private insurance companies are not required to cover crisis services; the follow-up services recommended in House Bill 3091 may not be covered. Health care providers told auditors they believed private insurers were to assume discharge planning requirements, as they have knowledge of in-network providers; however, this has been left to the hospital staff.

On September 9, 2024, the White House finalized a regulation aimed at strengthening the 2008 Mental Health Parity and Addiction Equity Act.[16] The 2008 legislation required insurers to provide payment structures for mental health services on par with other medical services, but this was not always the case. It is possible the new rule addresses the lack of coverage for crisis services by private insurers; however, Oregon should consider state legislation or coordination with insurers if further action is necessary.

Legislative clarity can improve Oregonians' access to behavioral health crisis services

Crisis services are supposed to be provided without regard for a person's insurance status, but currently, only Medicaid reimburses for crisis services delivered to Medicaid-covered individuals. Many private insurers do not cover crisis services. While Oregon has passed legislation to improve this issue, additional steps can be taken to strengthen the ability of insured individuals to receive behavioral health crisis care without fear of paying exorbitant out-of-pocket costs.

For example, House Bill 1688 (2022) from Washington State explicitly requires health carriers to cover mobile rapid response teams, crisis stabilization units, and outpatient crisis services. By explicitly defining these as part of behavioral health crisis services, the state can make clear they are to be covered by private insurers, even if the behavioral health provider is out-of-network.

The state has made progress, but does not have a formal strategic plan that addresses the needs of Oregon's Behavioral Health Crisis System

Oregon leadership has acknowledged the behavioral health crisis and passed legislation to address some of the complex challenges. Even so, the approach over the last decade has been inconsistent. The lack of a strategic approach was noted in over two decades of studies and is compounded by turnover and restructuring within OHA. The agency made significant progress in August 2024 when it released its strategic plan; however, aligning organizational processes to the plan will take time. Oregon can look to other states that have successfully integrated such a strategy to facilitate a path forward.

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[16] The 2008 Mental Health Parity and Addiction Equity Act requires insurers and corporate-backed health plans to provide access to mental health care services on par with other medical services. However, that did not always happen in practice, in part, because mental health providers were insufficiently covered by insurance plans. This led to patients paying high out-of-pocket costs or giving up on care. In September 2024, the federal government finalized a regulation to close this gap by requiring insurers to evaluate provider services covered by their plans, how much those providers are paid, and how often insurers require or deny prior authorizations for coverage.

Decades of studies and audits underscore a need for action to address Oregon's behavioral health system

A 2001 report from the Mental Health Alignment Workgroup described barriers to an ideal mental health system that resonate with today's issues: fragmentation; lack of a statewide-shared data system; need for competitive wages; and the lack of continuity of care and social supports, including respite care. Twenty years later, our office issued an audit noting the disarray within the system with familiar contributing factors: data shortfalls, leadership turnover, chronic workforce shortages, weak state statues, and poor monitoring of funds.[17]

OHA's goal of diverting people in crisis away from emergency departments is hampered by limited community treatment services, insurer involvement, and agency oversight

The enhanced crisis response model seeks to divert individuals from emergency departments, which are not set up to care for people in behavioral health crisis. Emergency departments can be noisy, stressful, and traumatizing. The job of hospital emergency departments is to stabilize patients and refer them to treatment. When there is nowhere to refer someone in crisis, an emergency department visit may turn into a stay of hours or days (i.e., boarding) or the person might leave without a treatment referral only to return when another crisis occurs.

A trio of bills passed in 2015 and 2017 sought to improve emergency department practices for people in crisis. House Bill 2023 (2015) and House Bill 3090 (2017) required hospitals to adopt specific discharge procedures. A 2019 OHA survey found most hospitals were meeting that requirement, but respondents cited the lack of funding, staff, and community-based resources as barriers to implementation. Four Oregon hospitals sued OHA in 2024 about the lack of services for people who were civilly committed and placed on hold in emergency departments.

House Bill 3091 required Oregon's coordinated care organizations and commercial insurers to provide specific services to individuals, including medically necessary services to transition a person to a lower level of care. Hospital personnel believed insurers would fund their emergency department work, but in the 2021 survey, almost half of respondents said they faced challenges in billing or were unaware they could bill for these services. Auditors were also told no funding mechanism was created, resulting in hospitals absorbing the costs. Hospital personnel say insurers should do the care coordination because they know what services are covered for their clients.

OHA has limited its involvement on these matters. The agency interpreted its responsibilities for House Bill 3090 as conducting surveys in 2019 and 2021. OHA's Healthcare Regulation and Quality Improvement Program investigates complaints about emergency departments, but filing a complaint is likely a low priority for those who are working through a crisis. Oregon will not be successful in diverting people in crisis away from emergency departments until the state expands access to community treatment services and addresses the oversight and role of emergency departments and insurers in the crisis response system.

[17] Oregon Audits Division, *Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis*, report #2020-32.

Past reports have also described the need to expand community mental health services. In 2010, the U.S. Department of Justice (DOJ) began an investigation into whether Oregon was illegally segregating individuals with mental health disabilities into institutional settings when they could receive care through community-based services. Two years later, the DOJ entered into an agreement with Oregon on a process to better provide individuals with community services, including making mobile crisis services available statewide by June 2018.

In 2012, an audit recommended OHA work to ensure continuity of mental health services, and in 2016, an OHA contractor's report about the boarding of patients with mental illness in hospital emergency departments recommended expanding community-based mental health services, improving services in emergency departments, and promoting insurance reimbursement changes to incentivize community services.[18] In 2023, OHA's ombudsperson recommended strategies to prioritize community-based child, youth, and family mental health care in the state.

For over 20 years, Oregon leaders have not done enough to fix the state's broken behavioral health system, including crisis services.

This inaction carries risk, as illustrated by two lawsuits:

- Initiated in 2022, four hospitals sued OHA for not having sufficient treatment available for those who are placed on hold in emergency departments and are involuntarily civilly committed. The boarding of people in crisis in emergency departments due to the lack of available community treatment services has been a long-standing issue.
- In February 2024, the nonprofit organization Disability Rights Oregon filed a federal lawsuit against Washington County, in part because it does not fully fund, staff, or integrate existing mobile crisis teams into the emergency response system and sends out law enforcement officers when people in behavioral health crisis seek help. The lawsuit alleges the county discriminates against people with mental health disabilities and violates their civil rights.

Oregon's present-day challenges demonstrate how these calls to action over 20 years have not been heard. Reasons for the inaction include inconsistent leadership, vision, and effective governance, along with the state's scattered system for responsibility and accountability. Recent legislation to enhance the behavioral health crisis response system has been described as aspirational by OHA personnel and community stakeholders. Aspiration is not enough — it must be followed by actionable, time-bound steps, like those found in strategic plans, to effect change.

[18] Oregon Audits Division, *Children's Mental Health: Ensuring Access and Sustaining Services*, report #2012-16.

Children's mental well-being is not prioritized, creating a lack of parity between Oregon's child and adult behavioral health systems

Actions taken by policymakers tend to overlook children, even though the state's youth have poor access to care and persistently high suicide rates. This lack of attention shows up in small and large ways.

A 2024 update to Oregon's Senate Health Care Committee from the Governor's Behavioral Health initiative team did not discuss services for children, which a community partner described as a glaring omission. A 2024 OHA-sponsored study evaluated residential facility capacity for adults, but not children. The state's few long-term crisis stabilization centers are only for adults, and Mobile Response and Stabilization Services — a program directed at children — was supposed to have launched in 2022 but has not yet been implemented in all counties. A consultant's 2023 report noted that while Oregon has most of the components in place for a crisis response system for adults, the state has a much steeper climb for children because such a system needs to be built rather than enhanced.

In July 2023, 58% of Oregon children (ages birth to 17) were enrolled in the Oregon Health Plan, compared to 29% of Oregon adults (18+ years of age). This breakdown is not reflected in how OHA staffs its child and adult programs. The Child and Family Behavioral Health Services program has 20 full-time equivalent staff while the Adult Behavioral Services program has three times as many at 60 staff, not including the 20 staff assigned to the Measure 110 program. OHA has dedicated only 1.5 staff to children's crisis services and only one staff to young adult services.

According to OHA staff, greater attention is paid to adults because there are more adults than children who need help, and children's issues are less complicated. However, addressing behavioral health in children has long-term benefits when they become adults. Preventing causes of mental distress, such as adverse childhood events, and addressing mental health in childhood reduces problems in adulthood. A global study found that for every $1 invested in interventions for preventing and treating adolescent mental disorders and suicide, $24 is saved in health and economic benefits over the course of 80 years.

People working within behavioral health caution that resources for children and adults should not be pitted against each other. Parity in resources is needed between the two systems. OHA's 2024 strategic plan states the agency is working to eliminate health inequities by 2030, including those due to age, which may help reverse policymakers' inattention to children's behavioral health. The Governor's work with Coordinated Care Organizations on a plan to reinvest surplus Medicaid dollars into communities for youth behavioral health projects is also promising.

OHA released an agency strategic plan in August 2024, but implementing it will take years of consistent direction

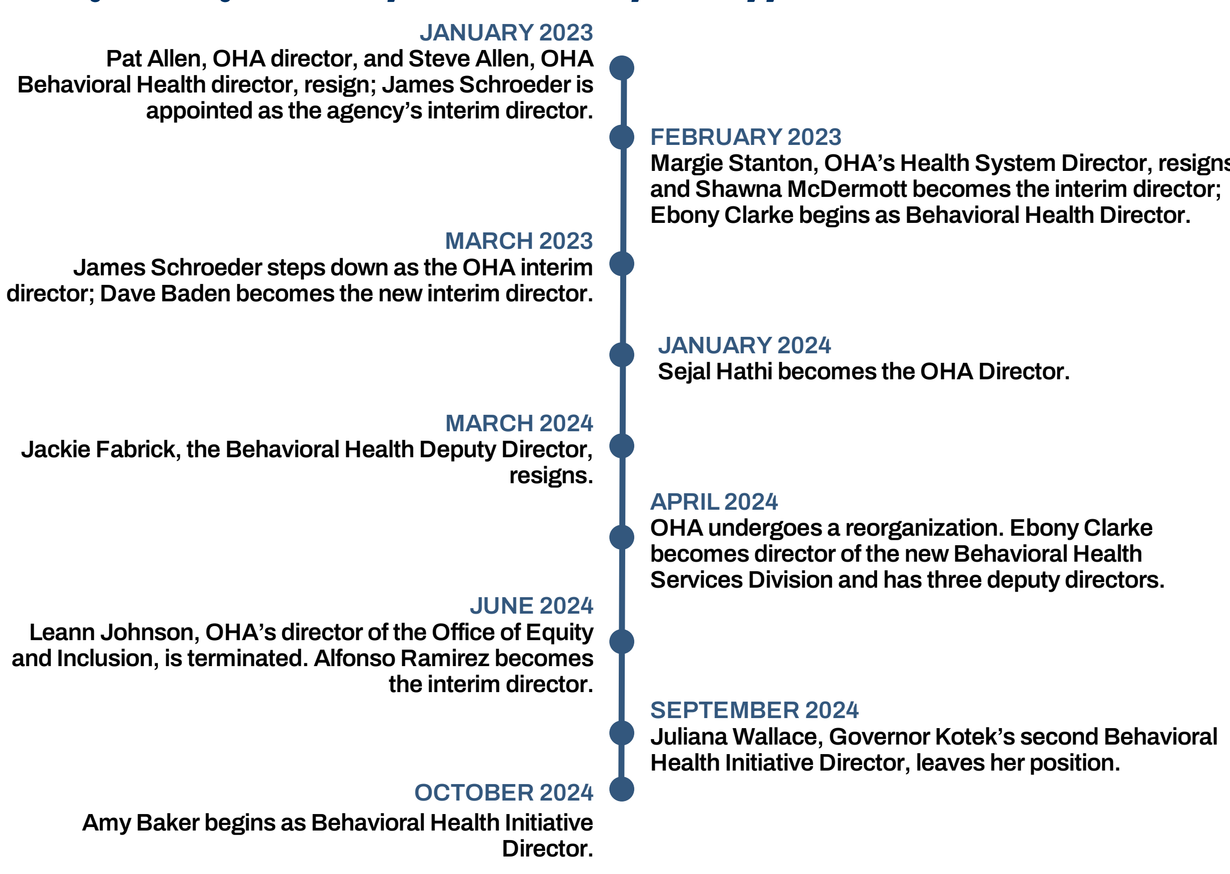
For many years, multiple reports have recommended OHA develop agencywide and division-specific strategic plans. In August 2024, OHA finally released an agency strategic plan.[19] The overarching goal of

[19] In a January 2023 memo, Oregon's Governor directed all state agencies to produce strategic plans.

OHA's plan is to eliminate health inequities by 2030, and one of its five strategic goal areas is to transform behavioral health. OHA's strategy for doing so is to build system capacity by further integrating and expanding crisis services. Success will be measured by reductions in the number of emergency department visits for behavioral health care.

OHA should next develop strategic plans for the Behavioral Health Division and the new 988 and Behavioral Health Crisis Systems unit to address the crisis system's current fragmentation. According to the agency, a strategic framework for the Behavioral Health Division is being finalized as of the time of this report. Objectives, action steps, and outcome measures should align across unit, program, and agency-level plans. This alignment should include the Governor's yet-to-be-released goals and outcome metrics for the behavioral health initiative.

Figure 12: Oregon has recently seen movement in key leadership positions related to behavioral health



Other OHA units have produced plans that could serve as models or be referenced within an overarching behavioral health strategic plan. The Child and Family Behavioral Health unit produced a policy vision in October 2020 and an action plan for 2020-24 that continues to track progress on strategies, action steps, and milestones. OHA's suicide prevention coordinators, who work as a cross-division team in OHA's Behavioral Health and Public Health Divisions, produced two suicide intervention and prevention plans, one for youth and one for adults. OHA could also revisit the two plans that came out of the DOJ investigation: the 2016 Oregon Performance Plan, and its continuation plan, the 2020 Behavioral Heath Quality and Performance Improvement Plan.

To provide continuity for the vision and operation of an improved behavioral health system, OHA needs to create a stable environment in the agency's leadership and staffing of its crisis system team. In less than two-years' time, OHA has undergone one reorganization and had four interim or permanent agency directors and two behavioral health directors. A 2020 audit of Oregon's mental health system for children also noted frequent turnover and reorganization in the decade before that audit.

Leadership turnover has limited the agency's progress on addressing fragmentation in the behavioral health system. In addition, a unit dedicated to the crisis system was not created within Behavioral Health until the agency's reorganization in April 2024, despite the DOJ requirement to expand mobile crisis services by 2018 and the passage of House Bill 2417 in 2021 to enhance the crisis system. Without stability, operationalizing the agency's new strategic plan may prove challenging.

The ongoing workforce crisis impacts the behavioral health crisis system

A study conducted by Public Consulting Group for OHA found Oregon's workforce issues need to be prioritized when considering any capacity expansion for behavioral health facilities.[20] Staffing shortages in the behavioral health workforce severely impacted CMHPs, especially since a change to Oregon law allowed Qualified Mental health Professionals to open private practices without completing clinical hours at CMHPs.

While this change aimed to improve access to mental health providers, it undermined CMHPs' ability to retain qualified mental health professionals. The issue is particularly acute in rural and remote counties, where attracting and retaining employees is inherently more difficult. CMHPs in these regions face additional challenges in meeting guidelines that require licensed, qualified professionals, Qualified Mental Health Associates, and Family Support Specialists on staff, particularly for 24/7 crisis response services. Without a Qualified Mental Health Professional during crisis calls, CMHPs are ineligible for enhanced Medicaid reimbursement, further straining resources.

Housing affordability further complicates staffing issues. Mental health workers earn lower wages compared to other health care professionals.[21] The high cost of living throughout much of Oregon exacerbates the problem, making it difficult to recruit and retain employees. While some counties have implemented strategies like housing assistance and retention bonuses, these efforts did not fully resolve hiring challenges. Statewide efforts to increase the behavioral health workforce through incentive programs such as scholarships, loan repayment, and housing stipends were initially beneficial, but have since lost funding, leaving no long-term solutions in place.[22] Providing sustained funding for workforce incentive programs may alleviate future staff shortages.

Chronic understaffing forces existing employees to manage higher caseloads, which can lead to burnout that further exacerbates the staffing crisis. This cycle of turnover impacts not only staff, but patients, who face longer waitlists, fewer appointments, and inconsistent care due to frequent provider changes, ultimately disrupting the quality and continuity of care provided by CMHPs.

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[20] Public Consulting Group LLC, Oregon Health Authority Behavioral Health Residential+ Facility Study, June 2024 Final Report.

[21] House Bill 2235 (2023) addresses behavioral health workforce challenges including low pay.

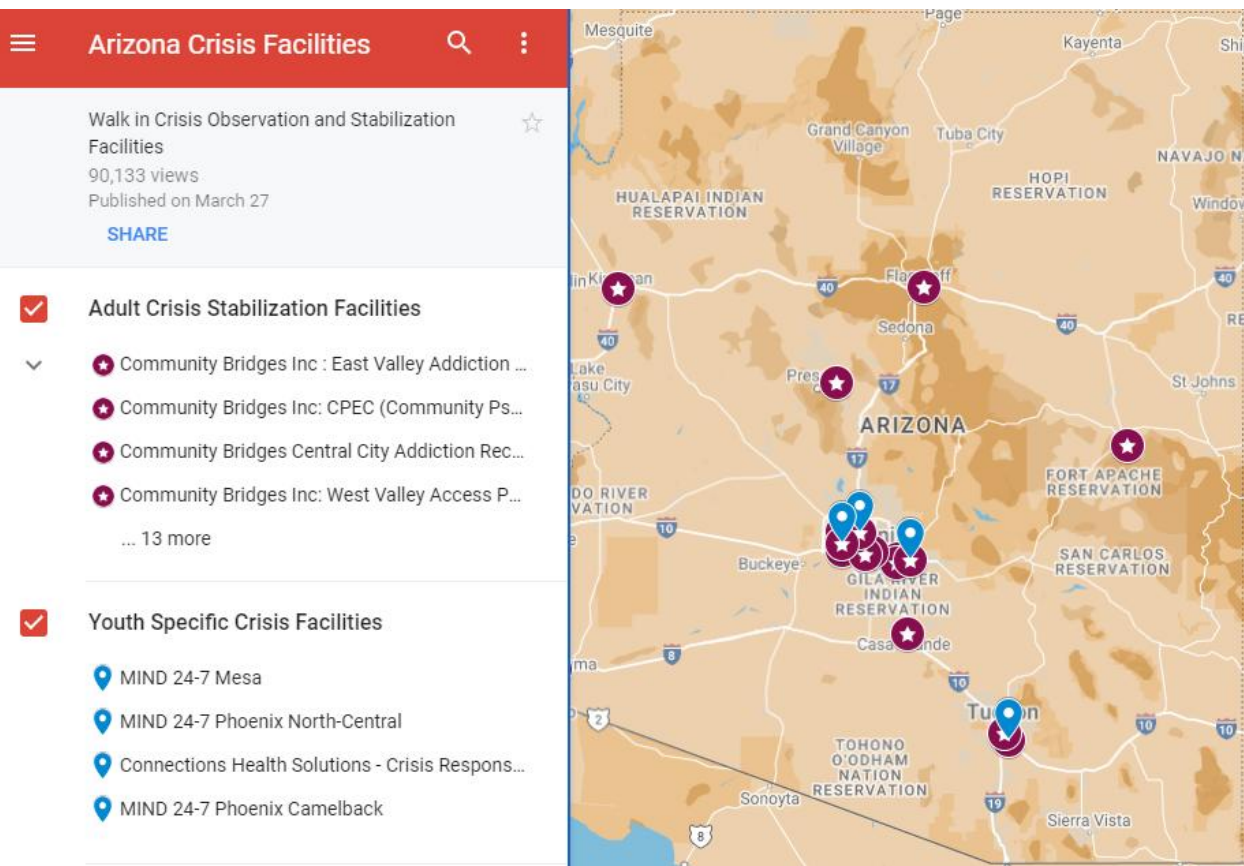
[22] House Bill 2949 (2021) and House Bill 4071 (2022) included temporary funding for behavioral health workforce incentive programs.

Oregon can learn from elements of other states' behavioral health crisis systems

OHA can look to models in Arizona, Washington, and Virginia as it works to improve and expand its behavioral health crisis system and secure sustainable funding.

Arizona's crisis system, managed through Regional and Tribal Regional Behavioral Health Authorities, is recognized for its Crisis Now Model.[23] This model uses technology and GPS to coordinate real-time crisis responses, ensuring safety and efficiency. Arizona's crisis services include stabilization units for short-term care and behavioral health crisis centers for individuals needing longer-term support. Funding for Arizona's system is drawn from diverse sources, including Medicaid, the state General Fund, and federal block grants, providing a sustainable financial base.

Washington State operates three crisis call centers covering the entire state. These centers offer culturally specific support through the Native and Strong Lifeline, designed for American Indian and Alaskan Native communities. Although Washington lacks a robust network of stabilization centers, legislation passed in the 2023-24 session aims to establish 23-hour behavioral health crisis relief centers, moving the state toward a more comprehensive behavioral health crisis system.



Arizona provides an interactive map of the state's crisis centers. | Source: Arizona Health Care Cost Containment System

[23] Tribal Regional Behavioral Health Authorities offer culturally specific services for Tribal community members.

Virginia has developed a continuum of care through the Virginia Medicaid Continuum of Behavioral Health, which focuses on evidence-based, trauma-informed, and cost-effective services. The agency partners with private and Medicaid insurers, allowing a variety of mobile crisis providers to be reimbursed for services, even for uninsured individuals. Virginia's crisis system includes crisis stabilization units, crisis intervention team assessment centers, and the MARCUS Alert System, which coordinates crisis responses between 911 and mental health providers to reduce police involvement in behavioral health emergencies. Crisis receiving and stabilization centers are funded through Medicaid, the state General Fund, and federal block grants, and operated by the state's regional Community Service Boards. [24] This diversified funding structure ensures comprehensive support for Virginia's crisis system.

While each of these states continues to refine their systems, their practices — ranging from diverse funding streams to culturally responsive services and coordinated crisis responses — offer valuable lessons for Oregon as it works to build a more effective and sustainable behavioral health crisis system.

Washington's Native and Strong Lifeline is the first program in the nation to serve American Indian and Alaska Native communities

Washington's Native and Strong Lifeline employs Native crisis counselors and is integrated into the state's 988 Suicide and Crisis Lifeline system. When someone calls the 988 Lifeline from a Washington State area code, they can choose option 4 during the automated greeting to be connected to the Native and Strong Lifeline. In Oregon, OHA, Tribal leadership, and legislators could discuss whether contracting with the Native and Strong Lifeline might be preferred choice for serving Oregon's Tribal communities.

Although Tribal outreach appears to be adequate, more coordination will help meet communities' needs

Among the many challenges with behavioral health is the coordination between the state and the nine sovereign Tribal nations within Oregon's geographical boundary. Tribal communities in Oregon have long faced systemic barriers to accessing health resources. While the launch of the 988 Lifeline was a major step in expanding crisis response capabilities, gaps exist in culturally responsive and effective services for American Indian and Alaskan Native people. These gaps stem primarily from a combination of historical trauma, legal and jurisdictional complexities, and a lack of historical tribal collaboration.

OHA has worked to facilitate a positive relationship in this regard. The agency's efforts are reflected in positive comments made by Tribes interviewed for this audit. Tribal representatives expressed appreciation for their relationship with OHA, citing the support they receive and being informed of funding opportunities. Despite this positive relationship, no mention was made of Tribes in House Bill 2417 (2021), which sought to enhance Oregon's behavioral health crisis response system. Improvements to the whole system cannot be accomplished without Tribal input and considerations around funding.

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[24] Virginia has 39 Community Service Boards that are established by local government and are responsible for assuring, with resources, the delivery of community-based behavioral health and developmental disability services to individuals with behavioral health and developmental disability service needs

Tribal engagement in 988 Mobile Crisis Response is essential to meet the behavioral health needs of American Indian and Alaskan Native Populations

The 988 and Behavioral Health Crisis unit works to coordinate across the state and facilitate work with the nine federally recognized Tribes. This work often intersects with the OHA Tribal Affairs team who have deep connections and experience in navigating the complex government-to-government relationships with the Tribes. Tribal Affairs works diligently to fulfill ORS 182.162 to 182.168 which specify agencies must coordinate with Tribes when developing and implementing policies that may impact them. As a result, the unique behavioral health issues faced by the Tribes may best be understood by Tribal Affairs.

The three components of the behavioral health crisis response system: someone to call, someone to respond, and somewhere to go, each have their own set of challenges. These challenges extend into serving Tribal populations as well, regardless of where Tribal members are located. For example, auditors were told that the lack of an option to identify as American Indian or Alaskan Native for the 988 Lifeline remains a barrier. Likewise, challenges exist in ensuring Tribal representation is possible when navigating the behavioral health crisis system after the initial call. For example, if an individual must appear in civil commitment proceedings, there is no current mechanism to ensure Tribal representation is present. In this regard, incorporating measures in the behavioral health crisis framework that are responsive to the needs of the Tribal population is necessary. Behavioral Health Division staff should continue to work with Tribal Affairs and Tribal partners in building a collaborative framework that meets the needs of all people in crisis.

Recommendations

To address data collection issues, OHA should:

1. Collaborate with behavioral health crisis partners, such as CMHPs and contractors, to better understand the nature and extent of system data, and pursue measures needed for consistent implementation.

2. Examine and document fragmented internal coordination between Behavioral Health, Fiscal and Operations, and Health Policy and Analytics divisions with respect to data necessary for informed decision making and determine if resources are available for a data analyst embedded within the 988 and Behavioral Health Crisis unit.

3. Develop procedures to aggregate and analyze 988 lifeline call data.

To address funding gaps in behavioral health crisis system, OHA should:

4. Develop a comprehensive funding strategy for all components of the Crisis Now framework.

5. Review funding parity for the children and family's crisis system, including Mobile Response and Stabilization Services, and develop plans to address gaps where necessary.

6. Coordinate with the Legislature, as necessary, to provide funding for lapsed behavioral health workforce incentive programs.

7. Collaborate with the Legislature, Coordinated Care Organizations, Department of Consumer and Business Services, and insurance providers to develop a comprehensive model that ensures private insurers cover mobile crisis response and stabilization services like leading models from other states.

To address the lack of behavioral health crisis system strategic planning, OHA Behavioral Health should:

8. Develop a behavioral health division strategy aligned with the August 2024 agency strategic plan.

9. Assess the resources needed to appropriately coordinate the developed strategy and communicate unmet need in future funding requests.

10. Monitor, evaluate, and report progress to interested parties, such as the Behavioral Health Crisis System Advisory Committee.

To remediate legal barriers that hinder behavioral health crisis action, OHA 988 and Behavioral Health Crisis unit should:

11. Continue to work with OHA Tribal Affairs to explore culturally responsive services to American Indian or Alaskan Natives living in Oregon and collaborate on any legislative barriers that may hinder services.

12. Incorporate Tribal inclusivity into the behavioral crisis framework, such as support for Tribal members who dial the 988 Lifeline, mobile crisis stabilization services, and collaborating with Tribes on high acuity mobile crisis cases that may lead to civil commitment investigations.

Objective, Scope, and Methodology

OBJECTIVE

The objective of this audit was to assess how OHA coordinates behavioral health crisis systems for adults and children.

SCOPE

The audit focused on efforts made by OHA to coordinate the state's behavioral health crisis system that incorporates the new federal 988 program for serving all individuals.

METHODOLOGY

To meet our objective, we performed the following procedures:

- Analyzed behavioral health crisis hotline call and mobile response dispatch data.
- Reviewed laws, administrative rules, contracts, annual and legislative reports, budgets, and planning documents.
- Reviewed OHA's policies, procedures, and processes related to behavioral health crisis response.
- Interviewed OHA executives, managers, operations and policy analysts, and other staff.
    - External interviews included legislators and subject matter experts from the University of Oregon, Oregon Health & Science University, Behavioral Health Crisis System Advisory Committee members, Community Mental Health Program staff, Tribal Behavioral Health managers, a behavioral health director from Arizona, and other outside groups such as the National Association of State Mental Health Program Directors.
- Observed meetings and reviewed minutes for the crisis system advisory committee meetings.
- Identified and reviewed leading governance practices from the International Organization of Supreme Audit Institutions, International Federation of Accountants, and Project Management Institute.
- Obtained and reviewed audits, reports, and documents, including from the Substance Abuse and Mental Health Services Administration and OHA, and about other states' behavioral health programs.
- Reviewed research, reports, or other documents from related professional organizations and outside groups, such as National Association of State Mental Health Program Directors, Public Research Group, and Recovery Innovations International.

INTERNAL CONTROL REVIEW

We determined the following internal controls were relevant to our audit objective.[25]

- Control Environment
    - We reviewed agency organizational charts, and agency budget and staffing data.
    - We analyzed agency turnover and assessed tone at the top.
- Risk Assessment

[25] Auditors relied on standards for internal controls from the U.S. Government Accountability Office, report GAO-14-704G.

  - We interviewed OHA management and staff.
- Control activities
  - We evaluated policies and procedures for behavioral health crisis system program implementation.
- Information and communication
  - We observed oversight committee meetings, reviewed communication processes, and interviewed community members from three federally recognized tribes and 13 counties.
- Monitoring activities
  - We analyzed hotline and mobile response dispatch data.
  - We interviewed OHA and Oregon Health & Science University staff responsible for monitoring the program.

Deficiencies with these internal controls were documented in the results section of this report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of OHA during the course of this audit.

Audit team

Andrew Love, CFE, Audit Manager
Casey Kopcho, CIA, Principal Auditor
Kathy Scott, DrPH, Staff Auditor
Emily Alexander, BA, Staff Auditor

ABOUT THE SECRETARY OF STATE AUDITS DIVISION

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The Secretary of State has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

May 2, 2025

Steve Bergmann, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 180
Salem, OR 97301

Dear Mr. Bergmann,

This letter provides a written response to the Audits Division's final draft audit report titled, "Oregon Faces Challenges in Addressing Gaps in the Behavioral Health Crisis System."

The 988 & Behavioral Health Crisis System unit in the Behavioral Health Division (BHD) of Oregon Health Authority (OHA) has reviewed the audit report and findings and provided responses to each of the 12 recommendations in the report. We agree with the audit recommendations and have provided planned activities and target dates to address each recommendation.

Below is a detailed response to each recommendation in the audit.

RECOMMENDATION 1 OHA should collaborate with behavioral health crisis partners, such as CMHPs and contractors, to better understand the nature and extent of system data, and pursue measures needed for consistent implementation.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	07/31/2026	Lauren Palma (971) 240-3800

Narrative for Recommendation 1

The 988 & Behavioral Health Crisis System unit has been in close coordination with our behavioral health crisis system partners since before the launch of 988 in July 2022. Examples of coordination include Community Mental Health Program meetings, technical assistance, and ongoing contract administration with 988 call centers. OHA agrees with the need to improve data. The unit will continue to convene discussions and/or listening sessions with behavioral health crisis system partners to better understand the nature and extent of system data, and pursue measures needed for consistent implementation of data collection and analysis for 988 call centers, mobile crisis intervention services, mobile response and stabilization services, and crisis stabilization centers.

RECOMMENDATION 2 OHA should examine and document fragmented internal coordination between Behavioral Health, Fiscal and Operations, and Health Policy and Analytics divisions with respect to data necessary for informed decision making and determine if resources are available for a data analyst embedded within the 988 and Behavioral Health Crisis unit.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	6/30/2026	Steve Westberg (503) 931-6729

Narrative for Recommendation 2
OHA agrees with the recommendation made by the Secretary of State's Audits Division. OHA will take a multi-pronged approach to address gaps and fragmentation in data collection and analytics: 1) Through its Office of Data Strategy and Operations (ODSO), OHA will continue work to improve data governance and the integrity of data submission by external partners. 2) OHA will work with the Health Policy and Analytics (HPA) team to understand how we can leverage 988/crisis-specific data, in addition to other data sources—such as Medicaid claims data, All Payer All Claims data and CCO utilization and quality data—to better track unmet needs and outcomes. 3) OHA will assess current staff resources allocated within ODSO, HPA and the Behavioral Health Division units to identify and address unmet staffing needs.

RECOMMENDATION 3 OHA should develop procedures to aggregate and analyze 988 lifeline call data.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	07/31/2026	Lisa Wyman (971) 372-1981

Narrative for Recommendation 3
OHA will design an internal-facing dashboard to aggregate and analyze data from call lines by the middle of 2026. The dashboard will help guide the data that needs to be collected in order to highlight data trends of interest. The dashboard will outline needed data collection and then further visualize insights once the data once collection is completed.

RECOMMENDATION 4 OHA should develop a comprehensive funding strategy for all components of the Crisis Now framework.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	06/30/2027	Lauren Palma (971) 240-3800

Narrative for Recommendation 4
The 988 & Behavioral Health Crisis System unit will develop a funding sustainability plan for 988 call centers, mobile crisis intervention services, mobile response and stabilization services, and crisis stabilization centers by the middle of 2027.This plan will take into consideration Medicaid claims, the 988 tax funds, general fund, and federal funding sources. Within this plan we will include the true funding needs for all parts of the system through the outcome of the HB4092 cost study. The Certified Community Behavioral Health Clinic team will work closely the 988 & Behavioral Health Crisis System unit to incorporate CCBHCs within the sustainability plan. Additionally, the CCBHC team and the 988 & Behavioral Health Crisis System unit will collaboratively review and approve written agreements between non-CMHP CCBHCs and CMHPs regarding shared requirements to provide crisis services. This review will ensure funding resources are effectively and efficiently leveraged to ensure sustainable crisis services across the provider types.

RECOMMENDATION 5 Review funding parity for the children and family's crisis system, including Mobile Response and Stabilization Services, and develop plans to address gaps where necessary.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/2027	Chelsea Holcomb (971) 719-0265

Narrative for Recommendation 5
The 988 & Behavioral Health Crisis System and Child and Family Behavioral Health units will use the outcome of HB 4092 to reduce administrative burden to Community Mental Health Programs to quantify funding gaps and develop a plan (including but not limited to Mental Health Block Grant and Policy Option Package development for the 2027 Legislative Session) to achieve parity of funding for children and families services and supports for each component of the crisis system, including mobile crisis intervention services, mobile response and stabilization services, and crisis stabilization centers.

RECOMMENDATION 6 OHA should coordinate with the Legislature as necessary to provide funding for lapsed behavioral health workforce incentive programs.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	06/30/2025	Tim Nesbitt (503) 551-9040

Narrative for Recommendation 6
The HB 2235 Workgroup has provided recommendations to inform a legislative report due January 15, 2025. Several recommendations within the report directly indicate the need for funding "lapsed behavioral health workforce incentive programs" that were implemented by OHA's Behavioral Health Workforce Incentives (BHWI) team. Furthermore, BHWI has submitted a Policy Option Package (POP 550) to include continued funding of BHWI programs. These programs include tuition assistance, loan repayment, bonus and housing stipend grants, recruitment and retention grants for peers, and the provision of no-cost registrations for behavioral health credentials through an agreement with the Mental Health and Addiction Counselor Board of Oregon (MHACBO).

RECOMMENDATION 7 OHA should collaborate with the Legislature, Coordinated Care Organizations, Department of Consumer and Business Services, and insurance providers to develop a comprehensive model that ensures private insurers cover mobile crisis response and stabilization services like leading models from other states.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/2027	Lauren Palma (971) 240-3800

Narrative for Recommendation 7
The 988 & Behavioral Health Crisis System unit will develop a plan to collaborate with the Legislature, Coordinated Care Organizations, Department of Consumer and Business Services, and insurance providers pending the introduced legislation House Bill 2203 that would direct the Department of Consumer and Business Services to study options to require a carrier to include mobile crisis intervention as a covered service that is not subject to coinsurance, copayments, deductibles or other out-of-pocket expenses.

RECOMMENDATION 8 OHA Behavioral Health should develop a behavioral health division strategy aligned with the August 2024 agency strategic plan.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	10/31/2025	Lynnea Lindsey

		(971) 388-0544

Narrative for Recommendation 8
The Behavioral Health Division (BHD) began developing a strategic framework to guide the division's work in fall 2023. The development and finalization of the BHD Strategic Framework was paused for the OHA Strategic Plan development in order to ensure alignment, capacity and resourcing that was in concert and not competition of broader agency strategic needs. As the OHA Strategic Plan has been launched, BHD is aligning the division-based Strategic Framework with the plan. Additionally, programmatic areas and units have developed their own strategic workplans to collate and align to the BHD Strategic Framework and OHA Strategic Plan. A finalized framework with accompanying planning documents will be available by the listed target date.

RECOMMENDATION 9 OHA Behavioral Health should assess the resources needed to appropriately coordinate the developed strategy and communicate unmet need in future funding requests.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/2026	Samantha Byers (503) 519-1840

Narrative for Recommendation 9
The 988 & Behavioral Health Crisis System unit is completing its mission, vision, values and strategy workplan that forms the basis of determining the existing and needed resources. This plan aligns with the OHA Strategic Plan and forms the basis for understanding unmet programmatic and funding needs. Additionally, HB 4092 requires OHA to conduct an ongoing Cost Study for services that CMHPs are legally required to provide such as mobile crisis, and create a workgroup through Oregon Council of Behavioral Health to study redundancies, contradictions, outdated language within ORS 414 and 430 (which impact crisis services including mobile crisis), and better define and clarify roles and responsibilities for major health systems partners such as CMHPs, CCOs, and hospitals and provide a list of recommendations. This work will be leveraged to develop a summary of the strategy, funding gaps and recommendations will be developed and submitted to executive leadership.

RECOMMENDATION 10 OHA Behavioral Health should monitor, evaluate, and report progress to interested parties, such as the Behavioral Health Crisis System Advisory Committee.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**

Agree	06/30/2025	Lauren Palma (971) 240-3800

Narrative for Recommendation 10

House Bill 2757 (2023) requires a Behavioral Health Crisis System Advisory Committee (BHCSAC) to advise Oregon Health Authority (OHA) on implementation and operation of the statewide coordinated crisis system and feedback and recommendations on the 988 Suicide & Crisis Lifeline. BHCSAC held its first meeting in March 2024 and continues to meet monthly where the 988 & Behavioral Health Crisis System unit provides regular standing updates and facilitates presentations to the committee on a variety of crisis system-related topics as requested. The 988 & Behavioral Crisis System Unit also responds to requests about the progress of Oregon's crisis system to a wide range of interested parties, including community partners, research entities, and the media.

RECOMMENDATION 11 OHA 988 and Behavioral Health Crisis unit should continue to work with OHA Tribal Affairs to explore culturally responsive services to American Indian or Alaskan Natives living in Oregon and collaborate on any legislative barriers that may hinder services.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/2027	Lauren Palma (971) 240-3800

Narrative for Recommendation 11
The 988 & Behavioral Health Crisis System unit will continue to collaborate with the OHA Tribal Affairs team to explore and identify culturally responsive services for American Indian or Alaskan Natives living in Oregon. The unit will also work with the OHA Tribal Affairs team on elevating any legislative barriers that hinder behavioral health crisis services through legislative concepts or other appropriate means.

RECOMMENDATION 12 OHA 988 and Behavioral Health Crisis unit should incorporate Tribal inclusivity into the behavioral crisis framework, such as support for Tribal members who dial the 988 Lifeline, mobile crisis stabilization services, and collaborating with Tribes on high acuity mobile crisis cases that may lead to civil commitment investigations.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific**

		point of contact for implementation
Agree	06/30/2027	Lauren Palma (971) 240-3800

Narrative for Recommendation 12
The 988 & Behavioral Health Crisis System unit will continue to explore and implement opportunities to further support Tribal members who are connecting to Oregon's behavioral health crisis system. The unit will collaborate with Tribes, CMHPs and OHA program staff on high acuity mobile crisis cases that may lead to civil commitment investigations.

Please contact Ebony Clarke, Behavioral Health Director at 503-428-7385 with any questions.

Sincerely,
Ebony Clarke
Behavioral Health Director

cc:
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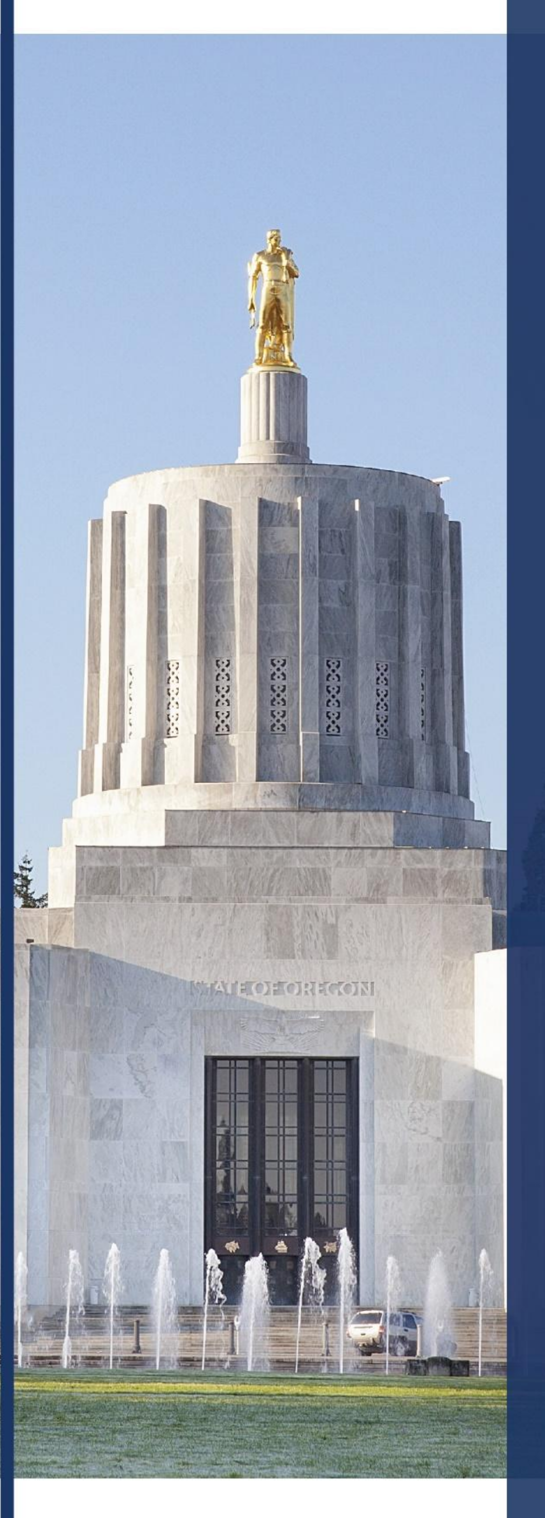

Secretary of State **Tobias Read**
Audits Director **Steve Bergmann**

This report is intended to promote the best possible management of public resources.

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