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OREGON'S MENTAL HEALTH CRISIS: ACCESS, OUTCOMES, AND THE COST OF INACTION

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ABOUT THE AUTHORS



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INTRODUCTION

Mental health is a critical component of public health and community well-being, yet Oregon has long struggled to meet the needs of its residents. By many metrics, Oregon's mental health system ranks among the worst in the United States, with high prevalence of mental illness and substance use disorders but limited access to care.ⁱ The state's suicide rate has exceeded national averages since 2000, and untreated mental health conditions contribute to homelessness, incarceration, and lost economic productivity. Recent audits and reports – including a May 2025 Secretary of State audit – reveal deep gaps in Oregon's behavioral health infrastructure. At the same time, policymakers have poured unprecedented funding into behavioral health (\$1.3 billion in 2021 alone)ⁱⁱ and introduced reforms like 988 crisis hotline. This report provides a comprehensive overview of Oregon's mental health system, drawing on academic research and policy analyses to examine service gaps, the costs of inaction, crisis intervention strategies, workforce challenges, and funding models. The goal is to provide background analysis on where Oregon stands and contribute to the discussion on what's at stake and how the state might work toward a more effective, equitable mental health system.

KEY FINDINGS

- **Oregon has some of the worst mental health outcomes in the nation.** Nearly 1 in 3 adults experience mental illness, and the state ranks 51st overall in mental health prevalence and access.
- **Suicide and overdose deaths are far above national averages.** Suicide rates in rural counties top 40 per 100,000, and fentanyl-related overdoses have surged, with an estimated 1,400 deaths in 2023.
- **Substance use and mental illness often go hand in hand.** Half of youth suicide victims in Oregon had a diagnosed mental health disorder, and many also struggled with substance use.
- **Untreated mental illness drives homelessness and incarceration.** Around 40% of Oregon's homeless population has a serious mental illness, and encampment sweeps may be worsening outcomes.
- **The economic cost of depression alone is staggering.** Oregon's estimated annual burden from major depressive disorder exceeds \$93 billion, driven by healthcare costs and lost productivity.
- **Services are fragmented and hard to access.** Many Oregonians can't find care until they're in crisis. A state audit found poor data coordination and long wait times for youth and adult treatment beds.
- **988 is working—but other crisis supports are underbuilt.** Oregon's 988 hotline resolves 97% of calls without 911, but mobile crisis teams and stabilization centers remain underfunded and unevenly available.
- **Despite billions in new investment, Oregon still ranks near the bottom in access.** Recent funding boosts are meaningful, but without stronger coordination and accountability, progress will remain limited.

OREGON'S MENTAL HEALTH OUTCOMES AND THEIR SOCIETAL IMPACTS

Oregon's mental health outcomes paint a stark picture of high need and high stakes. By virtually every indicator – prevalence of illness, suicide and overdose rates, homelessness, and other downstream effects – Oregon is near the top of the nation in problems related to mental health. This section examines the data on mental health outcomes and the associated social and economic impacts of inadequate treatment.

Prevalence of Mental Illness: Oregon has the unenviable distinction of having one of the highest rates of mental illness among the states. According to the 2022 National Survey on Drug Use and Health, about **27.5% of Oregon**

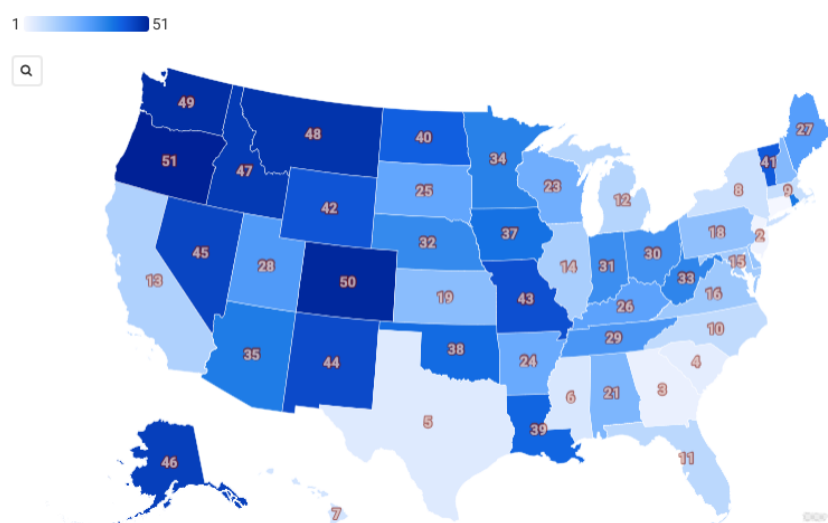
adults –roughly 992,000 people– experienced mental illness in the past year. This places Oregon 49th out of 51 (including District of Columbia) for adult mental health.ⁱⁱⁱ When combining adult and youth indicators, **Oregon ranks 51st out of 51 overall** in the 2024 *State of Mental Health in America* report. This composite prevalence ranking is based on seven prevalence measures, including rates of mental illness, substance use disorders, suicidal ideation, and youth flourishing. (Figure 1.)

FIGURE 1

Mental Health Prevalence Ranking

(Lower Rank = Better Outcomes)

A ranking of 1–51 reflects a lower prevalence of mental health and substance use issues, while states ranked 39–51 experience higher levels of these challenges. This ranking is based on seven indicators that reflect the mental health status of both adults and youth. According to the 2022 National Survey on Drug Use and Health (NSDUH), **Oregon ranks 51st—placing it last among all states**—indicating the highest overall prevalence of mental illness and substance use issues in the nation.



Source: The State of Mental Health In America • These indicators include the share of adults with any mental illness, adults with substance use disorder in the past year, and adults with serious thoughts of suicide. Among youth, the ranking includes the share experiencing at least one major depressive episode in the past year, youth with substance use disorder, youth with serious thoughts of suicide, and youth ages 6 to 17 who are considered "flourishing."



The prevalence of *serious* mental illness (SMI) is especially concerning – around 7% of Oregon adults have a diagnosable SMI such as major depression, bipolar disorder, or schizophrenia, one of the highest rates in the U.S.^{iv} Among youth, the trends are alarming: 15% of Oregon teens (age 12–17) reported having seriously considered suicide in the past year-highest rate in the nation.

Suicide Rates

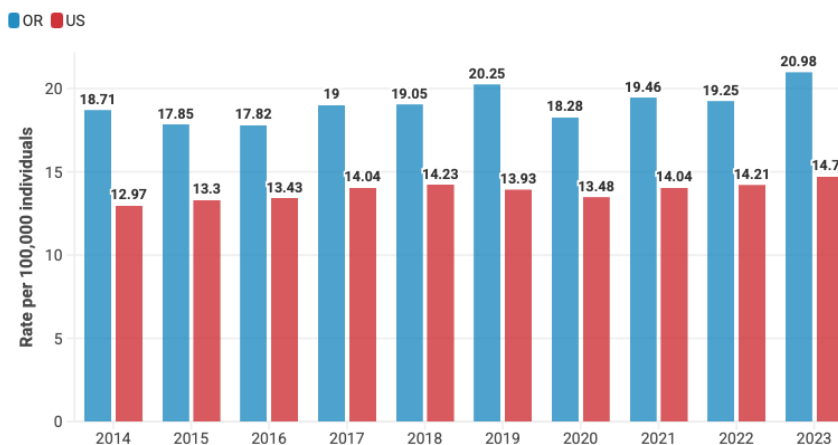
Oregon's high prevalence of mental illness has tragically translated into high suicide rates. For over two decades, the state's age-adjusted suicide rate has consistently exceeded the national average.

In 2023, **Oregon's overall suicide rate was 20.88 per 100,000 individuals**, significantly higher than the national average of 14.72 according to the American Foundation for Suicide Prevention data.^v CDC reports that the age-adjusted suicide rate is 19.3 per 100,000 individuals in 2023. Among youth, the disparity is equally alarming: **in 2022, approximately 14.2 per 100,000 Oregon youths** (ages 10–24) died by suicide, compared to about 10 per 100,000 nationally.

FIGURE 2

Oregon and U.S. Age-Adjusted Suicide Rate Per 100,000 (2014–2023)

Suicide rates per 100,000 population in Oregon compared to the U.S. average (2014–2023). Oregon's suicide rate has consistently exceeded the national average.

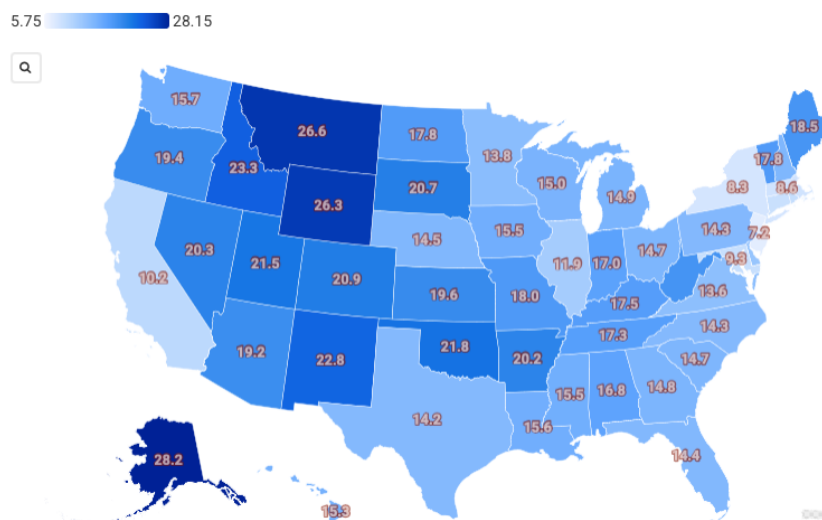


Source: American Foundation for Suicide Prevention

FIGURE 3

Suicide Mortality Rates by State (2023)

This map displays age-adjusted suicide death rates per 100,000 people in each U.S. state for the year 2023, using data from the Centers for Disease Control and Prevention. Oregon reported a rate of 19.3 per 100,000, placing it among the states with higher suicide mortality.



Source: Suicide Mortality Rates by State

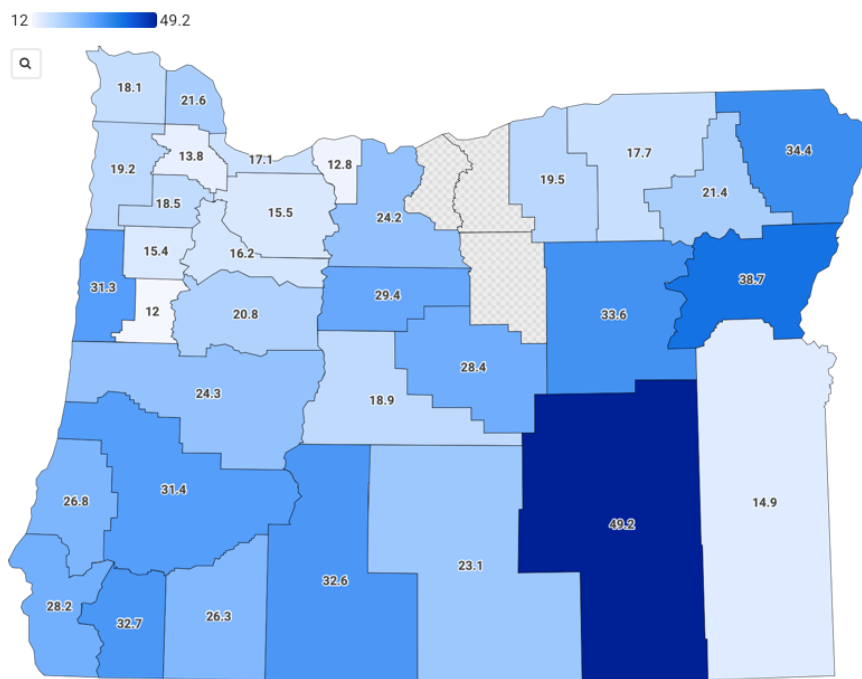
While suicide affects Oregonians across all demographics, it is **most prevalent among non-Hispanic white and Native American/Alaska Native communities**, both averaging rates above 20 per 100,000 between 2016 and 2020.

Geographically, rural Oregon faces the greatest risk of suicide. From 2016 to 2020, suicide rates averaged 25.4 per 100,000 in frontier and rural counties—substantially higher than the 17.6 per 100,000 seen in urban areas. Remote counties also faced elevated risk, with an average rate of 23.7 per 100,000. Several rural counties in eastern and southern Oregon rank among the state's highest in suicide mortality—**Harney (49.2), Grant (33.6), and Douglas (31.4)** leading the list.^{vi} This geographic divide is driven by factors like rural isolation, greater access to firearms, limited availability of mental health services, and entrenched economic hardship.^{vii}

FIGURE 4

Suicide Mortality Rates by Oregon County (2018–2022)

This map shows age-adjusted suicide mortality rates per 100,000 population in Oregon from 2018–2022. Suicide rates are highest in the state's rural and frontier counties, especially in eastern and southern regions. Several counties recorded rates exceeding 30 deaths per 100,000—nearly twice the urban average.



Source: Oregon Health Authority • Rates based on a count < 5 or a denominator < 50 are not reported.



Gender and occupations play a major role in Oregon's suicide risk. About **75% of suicide deaths** in the state are among males—a reflection of national trends. The state audit confirms high suicide rates in traditionally male-dominated, rural occupations—such as **construction, logging/forestry, farming, and other military-related work**.^{viii} National studies support this pattern, finding elevated suicide rates among workers in mining, construction, agriculture, and transportation industries. These insights suggest that prevention strategies should include **targeted outreach in high-risk occupational groups**—especially in less populated areas with limited mental health access.

Substance Use and Overdose

Behavioral health outcomes encompass substance use disorders (SUDs) as well, which often co-occur with mental illness. Oregon faces a severe addiction crisis on top of the mental health crisis. The state has one of the highest rates of substance use disorders and the lowest rates of access to treatment, ranking 46th among the states for adults with substance use disorder who did not receive treatment but was in need.^{ix} This gap has had deadly consequences. The opioid overdose crisis, now driven largely by fentanyl, continues to escalate. In 2022, Oregon recorded nearly 1,000 opioid overdose deaths, and early estimates suggest that number rose to around 1,400 deaths in 2023.^x

These deaths don't occur in isolation. Many individuals struggling with addiction also face untreated depression, anxiety, or trauma. In Oregon, this overlap is clearly visible in youth suicide data. Between **2018 and 2022**, nearly **half of all youth suicide victims** had a diagnosed mental health disorder—**51.2% of those aged 5–17** and **49% of those aged 18–24**. Substance use was also a major factor: **nonalcohol substance use problems in 9.3% of suicides** among 5–17-year-olds and **20.5% among 18–24-year-olds**. Alcohol problems were involved in **4.7%** and **12.3%** of suicides in these age groups, respectively.^{xi} These patterns reflect well-established clinical insights: untreated mental illness can lead to substance use—often as self-medication—and substance use can, in turn, worsen mental health and increase the risk of crisis.^{xii}

Tackling these intertwined crises requires integrated solutions—treating mental illness and substance use separately isn't working. Oregon's Measure 110, originally decriminalizing possession of small amounts of drugs and funding treatment from cannabis taxes, was repealed in 2024. Under the new law (HB 4002), small-scale drug possession became a misdemeanor again as of September 1, 2024.^{xiii} Some counties are beginning deflection programs, but many service providers still face funding and administrative delays in adapting to the change.

On a more hopeful note, the state has expanded access to naloxone, the lifesaving opioid overdose-reversal drug. In 2023, **HB 2395** significantly broadened distribution by allowing schools, libraries, first responders, and social service agencies to receive and administer naloxone without a prescription.^{xiv} **SB 450** complemented this effort by removing labeling requirements for physicians and physician assistants who personally dispense naloxone nasal spray—helping streamline direct access in clinical settings.^{xv} Meanwhile, the **Save Lives Oregon initiative**, led by the Oregon Health Authority and a coalition of statewide partners, has distributed over **724,000 naloxone doses**, documented more than **19,000 overdose reversals**, and provided **opioid response kits to over 665 schools and school-based health centers**. The program also supports **380 community agencies** across all 36 counties—greatly expanding access to life-saving tools throughout Oregon.^{xvi}

Despite recent steps forward, Oregon's substance use and overdose crisis continues to claim lives at an alarming rate. The data reveal a system under strain—where high need is met with limited access, and where substance use and mental health challenges often go untreated until crisis. Lasting progress will depend on building a care system that is proactive, connected, and capable of reaching people before emergencies happen. Anything less risks allowing these parallel crises to deepen further.

Homelessness, Incarceration, and Other Social Costs

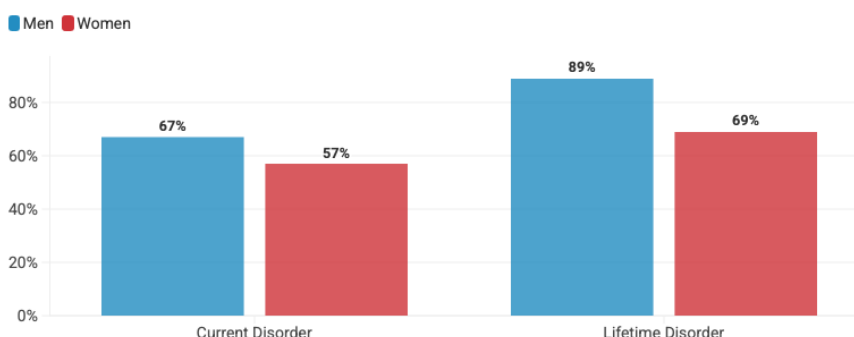
One cannot discuss mental health outcomes in Oregon without addressing the visible humanitarian crisis on the streets. Oregon's homeless population has surged in recent years, and a high fraction are individuals with untreated mental illness or substance use disorders. By some estimates, approximately 40% of people experiencing homelessness in Oregon have a serious mental health condition, and 37% have a substance use disorder.^{xvii} This is not surprising, given that severe mental illness can disrupt one's ability to maintain employment or housing without adequate support. Homelessness, in turn, often worsens mental health through the trauma of living on the street and lack of stability or care.

Oregon's major cities—including Portland, Eugene, and Salem—have seen homeless encampments expand in recent years, especially since the COVID-19 pandemic. In Portland, the number of people experiencing homelessness grew by over 30% between 2019 and 2022, with a significant share living in unsheltered settings. Encampments have become more widespread and visible, often populated by individuals cycling between the street, jails, and emergency rooms—a cycle that is both costly and tragic for all involved.^{xviii}

The state dedicates immense resources to addressing homelessness, particularly in the Portland metro area. In 2024, the tri-county region alone spent more than **\$700 million** on people at “literal and imminent risk.”^{xix} Yet despite these efforts, the death toll among people experiencing homelessness continues to climb. Statewide, **548 deaths** were recorded in 2024, with **229 more** reported between January and May 2025.^{xx} In Multnomah County, deaths rose from **315 in 2022 to 456 in 2023**—more than quadrupling since 2019—with **282 attributed to unintentional overdoses.**^{xxi}

FIGURE 5

Prevalence of Mental Health Disorders Among Homeless Individuals



Source: Prevalence of Mental Health Disorders Among Individuals Experiencing Homelessness A Systematic Review and Meta-Analysis



This sharp rise in deaths has coincided with an aggressive policy of encampment sweeps: more than **19,000 sweeps since 2021** in Portland alone, dismantling over **20 sites each day**.^{xxii} While often framed as a necessary public safety response, public health research tells a different story. A 2023 simulation study, found that **involuntary displacements of unhoused individuals who use drugs could increase overdose deaths by 15–25% over a decade**,^{xxiii} while reducing access to life-saving treatment and increasing hospitalization rates.

In practice, these policies may be worsening the very outcomes they're meant to address. Oregon is spending heavily—but in a **reactive** way that fails to address the root causes of suffering, and may even be compounding them. Sweeps may push people out of sight, but they don't treat mental illness, addiction, or trauma—or provide stable housing. Without addressing these underlying issues, the cycles of crisis and cost are likely to persist.

Economic Productivity and Workforce Impact

Beyond direct social costs, untreated mental health issues take a toll on Oregon's economy through lost productivity. Mental illness often strikes in young adulthood – the prime working years – and can reduce people's ability to complete education, hold jobs, or perform at their full potential. Depression and anxiety are leading causes of disability worldwide.^{xxiv}

Although data on Major Depressive Disorder (MDD) in Oregon are limited, a 2022 state workforce study found that 5.1% of adults experienced serious mental illness (including MDD), equating to roughly 158,000 people. National surveys suggest up to 6.7% of adults have MDD in a given year—around 208,000 Oregonians. Because MDD often coexists with other mental and physical health conditions, it not only makes treatment more complex but also increases the overall cost of care. This co-morbidity contributes significantly to the broader economic burden.

To estimate the financial impact in Oregon, we used per-person cost figures from the 2019 study *The Economic Burden of Adults with Major Depressive Disorder in the United States*. We updated these figures to 2024 using the CPI-U and applied them to Oregon's current adult population, adjusting for the state's gender-specific MDD prevalence (62.7% female).

Table 1 presents the results: an estimated total burden of \$93.1 billion in 2024, or \$20,676 per adult with MDD, men accounting for 60.2% of the burden.

Half of the total incremental economic burden of adults with MDD was driven by direct healthcare costs, \$35.5 billion. The rest is driven by indirect costs, which accounted for \$47.8 billion—or 51.4% of the total. These included work-related losses from presenteeism (\$12 billion; 12.9%), absenteeism (\$10.5 billion; 11.3%), unemployment (\$10.9 billion; 11.7%), all-cause mortality (\$2.6 billion; 2.8%), and disability (\$1.2 billion; 1.3%). In addition, adults without MDD who live in a household with someone affected by MDD incurred \$10.6 billion in indirect costs—representing 22.1% of all indirect costs.

FIGURE 6

Summary of the economic burden of MDD for Oregon - 2024

The total incremental economic burden of adults with Major Depressive Disorder (MDD) in Oregon in 2024 was estimated at \$93.1 billion, or \$20,676 per affected adult. The majority of this burden stems from indirect costs—\$37.3 billion—driven by work-related losses such as unemployment, absenteeism, and presenteeism.

	Total	Female	Male
Total incremental costs associated with MDD	\$93,074,367,656	\$37,033,922,279	\$56,040,445,377
Per individual	\$20,676	\$17,354	\$26,261
Direct healthcare costs	\$34,593,966,421	\$15,461,780,360	\$19,132,186,061
Per individual	\$7887	\$7245	\$8965
Indirect costs	\$47,882,824,719	\$17,618,994,552	\$30,263,830,167
Work-related costs	\$37,285,248,204	\$10,974,565,403	\$26,310,682,801
Per individual	\$7823	\$5143	\$12,329
Unemployment*	\$10,906,497,965	-\$243,471,990	\$11,149,969,955
Per individual	\$1877	-\$114	\$5225
Productivity loss	\$23,755,535,894	\$10,066,126,902	\$13,689,408,992
Per individual	\$5351	\$4717	\$6415
Absenteeism	\$10,521,655,142	\$4,552,664,417	\$5,968,990,725
Per individual	\$2380	\$2133	\$2797
Presenteeism	\$12,006,048,888	\$4,916,563,413	\$7,089,485,475
Per individual	\$2684	\$2304	\$3322
Disability	\$1,230,449,842	\$596,899,072	\$633,550,770
Per individual	\$286	\$280	\$297
All-cause mortality	\$2,623,214,345	\$1,151,910,491	\$1,471,303,854
Per individual	\$595	\$540	\$689
Household-related costs	\$10,597,576,515	\$6,644,429,149	\$3,953,147,366
Per individual	\$4966	\$3114	\$1852

Source: The Economic Burden of Adults with Major Depressive Disorder in the United States (2019) • Per-person cost estimates are based on figures from the referenced article, updated to 2024 using the CPI-U. Total cost estimates were calculated independently by the author using Oregon-specific prevalence and population data.

* For women, unemployment costs were negative because women with depression were slightly more likely to be employed than those without—possibly due to having fewer caregiving responsibilities.

Table 1 breaks down each cost component in detail, while the accompanying Figure 6 shows their relative shares.

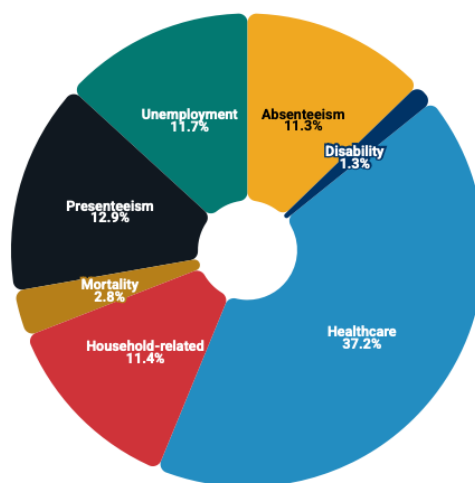
Modeling studies consistently find that **every \$1 invested in mental health treatment**—especially for conditions like depression—through improved productivity, reduced absenteeism, and reduced healthcare^{xxv}. While Oregon is not currently realizing these returns, due to widespread system gaps, this finding underscores what is at stake. For Oregon's business community, this means that mental health isn't just a humanitarian concern—it's a strategic workforce imperative.

FIGURE 7

Percentage breakdown of the cost components, 2024

Share of Oregon's \$93.1 billion economic burden from MDD in 2024: healthcare (\$34.6 B) and presenteeism (\$12B) are the largest categories, followed by unemployment (\$10.9B), absenteeism (\$10.6B), household-related costs (\$10.9B), mortality (\$2.6 B), and disability (\$1.2B).

■ Healthcare ■ Unemployment ■ Absenteeism ■ Presenteeism ■ Disability ■ Mortality ■ Household-related



Source: The Economic Burden of Adults with Major Depressive Disorder in the United States (2019) • Per-person cost estimates are based on figures from the referenced article, updated to 2024 using the CPI-U. Total cost estimates were calculated independently by the author using Oregon-specific prevalence and population data.

GAPS IN OREGON'S MENTAL HEALTH SERVICES AND INFRASTRUCTURE

To address Oregon's mental health crisis, it is essential to first recognize the gaps and shortcomings in the current system that prevent people from getting timely, effective care. Oregon's behavioral health system has been described as "*notoriously fragmented and underdeveloped*", with major disparities between needs and services.^{xxvi} This section identifies key gaps in services and infrastructure – from prevention and early intervention through crisis and intensive treatment – as well as structural issues that underlie these gaps.

Fragmentation and Lack of Coordination

Oregon's mental health care landscape remains fragmented and siloed across multiple entities—including state agencies, counties, Coordinated Care Organizations (CCOs), nonprofit and private providers, and school systems—without a unified infrastructure for planning or data sharing. A 2025 Secretary of State audit notes that OHA must coordinate with more than 30 different entities and describes a "fragmented and siloed structure," making crisis coordination especially challenging.

This lack of shared data has tangible effects. The audit finds that OHA lacks consistent records of 988 or county crisis hotline calls—including demographic breakdowns—due to fragmented systems and delayed implementation of a unified data platform. This makes it difficult for state leaders to assess true demand or identify underserved groups in crisis response. Such fragmentation affects care delivery: crisis call data isn't connected to hospital or treatment records, making it nearly impossible to track whether people receive care after reaching out for help.

The audit also confirms that OHA coordinates behavioral health across many partners—counties, Tribes, CMHPs, providers, and insurers—but emphasizes that this collaboration is difficult to maintain given the system's complexity and lack of shared infrastructure. The report notes that while OHA temporarily partnered with OHSU's DAETA team to address crisis call data gaps, it is not a permanent fix and does not replace the need for a statewide data system.^{xxvii}

Limited Access to Outpatient and Preventive Mental Health Care

A critical gap in Oregon is the lack of accessible outpatient and preventive mental health services – the kind of routine care that can keep a person stable and prevent crises. Many Oregonians cannot get help *until* they reach a crisis point, essentially by design of the system. For youth, this gap is glaring. A decade ago, Oregon committed (under the “K Plan” Medicaid amendment in 2013) to provide home and community-based services to youth with severe psychiatric disabilities. However, nearly a decade later, the state had not fully acted on that requirement. Testimony during the 2024 legislative session for Senate Bill 1557 emphasized that Oregon had failed to deliver the home- and community-based services outlined in the K Plan—services like in-home counseling and wraparound support were underfunded or difficult to access.^{xxviii}

For adults, challenges persist as well. Although Medicaid expansion increased coverage, many Oregon Health Plan (OHP) members still struggle to find available providers. A 2024 OPB investigation highlighted a particularly extreme example: a patient received a 90-page directory listing 772 therapists, but only eight were actually accepting new OHP patients—an example of the so-called “ghost network.”^{xxix}

This problem matters. Routine conditions like depression and anxiety are often left untreated: in 2022, **32.3%** of Oregon adults with symptoms of anxiety or depression reported needing but not receiving counseling or therapy—**higher than the national average of 28.2%**.^{xxx} Without early intervention, people's conditions can worsen until they reach a crisis, making care more expensive, traumatic, and difficult to deliver.

Long Waits and Gaps in the Continuum of Care

When a person's mental health does deteriorate to the point of needing more intensive help, Oregon's service continuum has notable gaps at several levels: specialty outpatient care, residential treatment, and inpatient psychiatric beds. A 2024 legislative report found a *"lack of access to facility-based care in Oregon led to long wait-times and a mismatch between the level of care needed and the care received"*.^{xxxi}

For youth, this is especially concerning. Oregon has 200 licensed psychiatric residential treatment facility (PRTF) beds, but due to workforce shortages, only 165 are currently staffed and available. This gap leaves many adolescents without timely access to intensive services. Families often report waiting months for an open bed—during which time children may cycle between short hospital stays or even be sent out of state for treatment.^{xxxii}

Adult acute and sub-acute facility shortages present similar challenges. With limited psychiatric beds available—compounded by staffing shortages—state hospitals reserve space for the most severe cases, leaving general hospitals and emergency departments to "board" patients for days or weeks waiting for placement.^{xxxiii}

Despite funds allocated between 2021–2023 for expanding residential and behavioral health beds, many of the planned facilities are still not available. A June 2024 study estimated Oregon needs roughly 3,700 additional adult residential treatment beds and would require about \$170 million annually to add around 650 beds each year—plans of which are only partially realized so far.^{xxxiv}

These delays and shortages fracture the continuum of care. People needing intensive support often can't get it—or their conditions worsen during long waits—fueling emergency department visits, hospital overcrowding, and crisis outcomes that timely placement could help avoid.

FUNDING STRUCTURES AND POLICY APPROACHES FOR BEHAVIORAL HEALTH IN OREGON

Financing is often the less visible backbone of the mental health system, determining what services are available, where, and for whom. Oregon's behavioral health funding comes from a mosaic of sources and has undergone major infusions recently. This section examines how Oregon funds mental health services at the state and local level, how those funds are allocated, and what policy approaches are being used or considered to improve the system. Understanding the funding structure is key to identifying sustainable reforms, as money (and how it's managed) drives what can be done on the ground.

EFFECTIVENESS OF CRISIS INTERVENTION STRATEGIES IN OREGON (988 AND BEYOND)

Oregon has embraced the national “Crisis Now” framework (988 hotline + mobile crisis teams + stabilization centers) to overhaul how psychiatric emergencies are handled. However, an audit found only the 988 hotline pillar has a stable funding stream (via a new telecom fee), while mobile teams and crisis facilities remain under-resourced.^{xxxv} In parallel, state leaders have launched broader reforms. For example, the 2024 Legislature passed bills creating task forces and advisory councils on behavioral health funding and workforce (e.g. HB 4092 and HB 4151).^{xxxvi} Governor Tina Kotek and First Lady Aimee Kotek Wilson have publicly championed these issues: the First Lady now chairs a new Behavioral Health Talent Council focused on workforce shortages.^{xxxvii} At the local level, Multnomah County has piloted new programs such as the “Project Respond” 988-connected mobile crisis teams and funded recovery services.^{xxxviii}

988 Suicide & Crisis Lifeline

The **988 Lifeline** (nationwide since July 2022) provides round-the-clock crisis counseling by phone, text, and chat. In Oregon's first year (July 2022–June 2023), OHA reports its two state-run 988 centers handled over **53,000 contacts** (calls, texts, chats) from Oregonians.^{xxxix} Volume continues to climb: on average the centers now field approximately **4,000 calls and 850 texts/chats per month**. The overwhelming majority of these crises are de-escalated over the phone – Oregonians' trained counselors were able to *resolve or stabilize nearly 97% of calls* without dispatching 911.

Oregon bolstered 988 with state support. In 2023, the Legislature (HB2757) enacted a **\$0.40 monthly phone fee** (effective 2024) dedicated to funding 988 and related crisis services.^{xi} This new revenue is projected to generate roughly **\$33 million** in the 2023–25 budget.^{xii} The state contracts with two nonprofits to operate the centers: **Lines for Life** (Portland) handles most of the state, and **Northwest Human Services** (Salem area) covers Marion/Polk County callers.^{xiii} Early data suggest 988 is reaching more people: call volume jumped about 33–50% above the old 10-digit lifeline levels.^{xliii} Many of these contacts are individuals who might not have otherwise sought help. By answering a range of needs (from people having “a really bad day” to those on the brink of self-harm), 988 counselors provide an easily accessible front door to crisis care.

Mobile Crisis Teams

Mobile Crisis Teams (MCTs) — typically a mental health clinician paired with a paramedic or peer — are one of the central pillars of Oregon's mental health crisis response. These teams provide care directly at the scene, helping to de-escalate crises and divert individuals away from police custody or emergency departments when appropriate.

Eugene's CAHOOTS program, operating since 1989, is one of the most well-known examples. At its peak, CAHOOTS handled roughly 24,000 calls per year and requested police backup in less than 1% of cases — around 150 times annually. In 2017, the program responded to about 17% of the Eugene Police Department's total call volume and was credited with saving approximately \$8.5 million annually in public safety costs. This was achieved with a modest annual budget of \$2.1 million, compared to the combined \$90 million budget for Eugene and Springfield's police departments.^{xliv} As of April 2025, however, CAHOOTS is no longer serving the city of Eugene due to local funding limitations.

Portland followed suit in 2021 with its own MCT initiative—Portland Street Response—staffed by firefighter-paramedics teaming up with clinicians. Other Oregon localities have launched similar programs, often co-dispatched with police in smaller jurisdictions.

Supporting evidence from the study *Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization* found community MCTs lowered hospitalization rates by about 8 percentage points compared to hospital-based crisis services. Those receiving hospital-based care were 51% more likely to be hospitalized within 30 days of a crisis. Crucially, shifting treatment into the community did **not** raise the risk of later hospitalization.^{xlv}

Altogether, in Oregon and beyond, MCTs reduce unnecessary hospitalizations, ease strain on emergency infrastructure, and provide on-the-ground care—all without increasing the risk of later admissions.

Crisis Stabilization Centers

The third pillar in Oregon's crisis response is **crisis stabilization centers**—safe, short-term (often under 24-hour) facilities offering a home-like space for counseling, medication, and basic needs until a person stabilizes.

However, as of 2025, Oregon lags in this area. The state has just three centers (all youth-focused), lacks dedicated funding for adult facilities, and only recently finalized administrative rules for licensing. Without these centers, many adults in crisis end up in hospital emergency departments, often boarding—waiting hours or days in ERs, sometimes sedated or restrained—until a psychiatric bed opens. This is costly, traumatic, and often leads to people leaving without follow-up care, increasing the chance of repeat crises.^{xlvi}

Some steps forward include:

- **Federal planning & implementation support:** Oregon got a planning grant under American Rescue Plan Section 9813, and after launching mobile crisis services, it has access to an enhanced 85% federal Medicaid match for the first 12 fiscal quarters from April 1, 2022, through March 31, 2027.^{xlvii}
- **Several counties are preparing to open new crisis stabilization centers** with the help of pilot funding and infrastructure grants. Efforts are underway in Deschutes, Clackamas, and other regions to develop drop-off centers and short-term care facilities that can relieve pressure on hospital ERs and law enforcement.^{xlviii}

Despite these developments, Oregon's crisis stabilization system remains underbuilt and unevenly funded.^{xlix} Without stable, statewide investment, many communities still lack appropriate alternatives to ERs and jails. Among the eight states tracking outcomes at Crisis Receiving and Stabilization Facilities, a median of 73.2% of individuals had their crisis resolved without requiring more intensive care, and fewer than 20% needed transfer to psychiatric hospitals or detox in 2023.^l Economically, the return on investment is substantial—some analyses estimate up to \$24 in downstream savings for every \$1 spent on youth mental health care. Fully building out this “somewhere to go” component would not only reduce strain on hospitals and law enforcement, but also create a more humane, cost-effective system for responding to behavioral health crises.

Funding Structures and Policy Approaches for Behavioral Health in Oregon

Oregon's behavioral health system is financed through a patchwork of federal, state, and local sources.

Medicaid (the Oregon Health Plan) is the single largest payer, covering about 1.4 million Oregonians (roughly one in three residents) and including robust mental health and addiction benefits.^{li} The federal government covers around 58% of Oregon's standard Medicaid costs and an even higher share for specific programs like CHIP and the ACA expansion, with state dollars making up the rest. The Oregon Health Authority (OHA) administers OHP and coordinates Medicaid mental health benefits across the state.

State general funds and county budgets fill critical gaps by supporting safety-net services that Medicaid may not cover. For example, the Portland metro area implemented a **local supportive housing tax** in 2020 to fund housing and services for people with behavioral health needs^{lii} reflecting how local governments are raising revenue to address mental health and homelessness. Outside urban counties, however, access to locally funded services is often limited.

Federal grants—such as the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants—also flow into Oregon, providing flexible support for community programs. These dollars have funded services ranging from crisis stabilization and housing navigation to early intervention for youth, pumping out millions in grants each year to local providers. However, a 2023 audit flagged serious oversight problems in how these federal funds were managed, finding that Oregon's health authority failed to adequately track some spending and, in some cases, allowed unallowable uses of funds.^{liii} This highlighted the growing need for stronger accountability as behavioral health investments increase.

Beyond federal grants and general funds, Oregon's behavioral health system is also supported by several **dedicated revenue streams**. In the 2023–25 biennium, approximately **\$24.6 million** from **tobacco taxes and the Master Settlement Agreement** was allocated to behavioral health services out of the \$625 million in total tobacco-related revenue collected by OHA. Meanwhile, **Measure 110**, passed in 2020, continues to direct cannabis tax revenue into the Drug Treatment and Recovery Services Fund. For 2023–25, **\$230.9 million** in cannabis taxes was distributed to behavioral health and substance use programs, with another **\$25.5 million** specifically supporting community mental health services. These earmarked funds offer flexibility beyond Medicaid, allowing the state to invest in harm reduction, culturally specific programming, and peer-led services.

Historic investments since 2021. In response to Oregon's mental health crisis, policymakers have directed unprecedented funding toward the system in recent years. The 2021 Legislature approved a sweeping **\$1.35 billion behavioral health package**,^{liv} aiming to “transform” the system after decades of underinvestment. This included major one-time infusions of state and federal dollars: for example, about **\$130 million** dedicated to building housing and residential treatment facilities for people with serious mental illness, **\$121 million** to launch **Certified Community Behavioral Health Clinics** that provide 24/7 integrated care,^{lv} and roughly \$80 million—largely from the American Rescue Plan Act (ARPA)—to support workforce recruitment and retention programs. Additional grants targeted peer-run respite services, mobile crisis teams, and culturally specific provider networks.^{lvi}

Persistent gaps between spending and outcomes. Despite the rapid increase in funding, Oregon's mental health system remains strained, and improvements on the ground have been slow. Oregon still ranks near the bottom nationally for mental health **access** and overall system performance. Many of the 2021–2023 investments were slow to roll out or hampered by fragmentation; for example, state officials could not even say how many new treatment beds were created by the big 2021 funding boost.^{lvii} This disconnect between dollars spent and outcomes achieved has underscored that simply pouring money into the system is not enough – how the money is coordinated and deployed matters greatly.

In recognition of this, Oregon's leaders are pivoting toward **greater accountability and strategic oversight** of behavioral health funds. Governor Tina Kotek, who took office in 2023, made behavioral health a top priority and appointed a dedicated **Behavioral Health Initiative Director** in her office to drive reforms and “bring accountability” to the fragmented system.^{lviii} Kotek also pressured the state's Medicaid insurers (CCOs) to reinvest a portion of their record profits into behavioral health services, resulting in a pledge of \$25 million for workforce and treatment programs.^{lix}

A January 2025 report from OHA, produced in response to SB 5525, outlined how Oregon allocated \$227 million during the 2023–25 biennium to expand behavioral health facilities—including funding for residential treatment, youth services, and infrastructure upgrades. While the report offers more detail than in past years, data gaps remain, and the long-term impact of these investments is still being evaluated. SB 5525 also requires OHA to report on outcomes such as bed capacity, utilization, and unmet needs, providing an opportunity to better link budgets to results moving forward.

These steps mark a shift toward ensuring Oregon's large investments translate into real system improvements. The 2025 report begins to provide the kind of tracking and transparency that earlier funding efforts lacked. While it's still too early to assess long-term outcomes, the clearer accounting of where funds went and how spending aligns with service needs represents progress. Oregon's approach to mental health funding is gradually moving away from reactive spending toward more strategic, results-oriented investment—though continued oversight and follow-through will be essential.

THE MOST RECENT BEHAVIORAL HEALTH LEGISLATION (2025)

Building on these funding structures, Oregon lawmakers advanced a new package of bipartisan bills in the 2025 session to further strengthen the state's behavioral health system. Governor Tina Kotek signed the measures into law on **August 6, 2025**, and because several carried emergency clauses, key provisions—such as expanded residential treatment capacity—took effect at the start of July. Together, these laws represent the state's most recent effort to translate funding commitments into real reforms, with a focus on prevention, treatment capacity, intervention tools, and workforce support. Key provisions include:

- **House Bill 2059:** Creates the *Residential Behavioral Health Capacity Program* within the Oregon Health Authority and invests **\$65 million** in one-time funds for the 2025–27 biennium. The money will add roughly **200 new residential treatment beds** for adults with serious mental illness or substance use disorders, while also preserving existing facilities through upgrades. The program sunsets in 2027, but is intended to reduce long wait times and relieve pressure on emergency departments and jails.^{lx}
- **House Bill 2005:** Updates Oregon's *civil commitment and aid-and-assist standards*. By broadening statutory definitions of “danger to self,” “danger to others,” and “inability to meet basic needs,” the law allows earlier intervention for people in crisis. The goal is to divert individuals with severe mental illness into appropriate treatment rather than cycling through jails or emergency rooms.^{lxi}
- **House Bill 2024:** Provides about **\$6 million** in grants to recruit and retain behavioral health professionals. The bill funds scholarships, loan repayment, tuition assistance, stipends, and safety improvements in clinical settings, while also offering protections for workers facing retaliation. By targeting workforce shortages, HB 2024 addresses one of the most persistent barriers to care across Oregon.^{lxii}
- **House Bill 3321:** Directs **\$1 million** to the Alcohol and Drug Policy Commission to design and launch a *youth substance use prevention plan*. With youth in Oregon reporting higher-than-average rates of drug and alcohol use, this investment focuses on prevention and early education to curb future addiction and related mental health challenges.^{lxiii}

Taken together, these laws reflect a comprehensive strategy: **more treatment beds, clearer legal authority to intervene, stronger workforce pipelines, and early prevention initiatives**. While their long-term impact will depend on implementation, this package signals bipartisan recognition that Oregon's behavioral health system cannot wait for incremental fixes.

BOTTOM LINE

Reversing Oregon's long history of poor mental health outcomes is undeniably a challenging endeavor, but it is both achievable and imperative. The analysis in this report highlights that Oregon's behavioral health crisis is not due to one single failure, but a combination of high needs, systemic fragmentation, workforce strains, and historical underinvestment in key services.

The encouraging news is that Oregon has already begun to acknowledge and address these issues through increased funding, policy changes, and innovative local programs. The task now is to build on these efforts with a coordinated, evidence-based approach that stays the course.

The human stakes could not be higher. Every life lost to suicide, overdose, or untreated illness reflects the cost of inaction. But with sustained investment, better coordination, and a shared commitment to outcomes, Oregon has the opportunity to create a behavioral health system that reaches people earlier, responds more effectively in times of crisis, and supports recovery with dignity and equity.

Now is the moment to follow through.

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