Behavioral Health Initiatives Report

Per Senate Bill 973 (2019)
and House Bill 3069 (2025)

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Oregon Criminal Justice Commission

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The mission of the Oregon Criminal Justice Commission is to improve the legitimacy, efficiency, and effectiveness of state and local criminal justice systems.

Executive Summary

The Oregon Criminal Justice Commission (CJC) now administers two grant programs that fall under the agency's behavioral health initiative: the Improving People's Access to Community-based Treatment, Supports and Services (IMPACTS) grant program and the Oregon Behavioral Health Deflection (BHD) grant program. While both IMPACTS and BHD focus on individuals at the intersection of behavioral health and the criminal legal system, these two programs are separate and distinct, each with their own goals, priorities, target populations, strategies for intervention, and outcomes.

The IMPACTS grant program was established by the Oregon Legislature in 2019 through Senate Bill 973 to increase the availability of community-based supports and services to a target population of individuals with a behavioral health condition and frequent criminal legal system and/or emergency health services involvement.[1] Further, the Oregon Legislature established the BHD grant program in 2024 through House Bill 4002 to establish deflection programs designed to create community-based pathways to treatment and recovery for individuals before entering the criminal legal system.[2]

Both grant programs' funding is available to Oregon's counties and federally recognized tribal governments. In the 2023-25 grant cycle, IMPACTS grantees represented 11 counties across the state and five federally recognized tribal governments, and BHD grantees represented 28 counties and six federally recognized tribal governments. The aim of each program is to reduce the frequency with which persons served are involved with the criminal legal system. The outcomes explored in this report will showcase the similarities and differences between these two initiatives and will highlight the jurisdictional discretion afforded to grantees as they serve related but distinct target populations.

Key Findings:

The demographics of the populations served by IMPACTS and BHD are generally similar, but IMPACTS serves a higher proportion of participants who identify as American Indian or Alaska Native. IMPACTS and BHD participants are mostly white identifying (60 percent for IMPACTS and 70 percent for BHD). For IMPACTS, nearly one in three participants (30 percent) identifies as American Indian or Alaska Native (AI/AN), compared to four percent of BHD referrals. Six percent of IMPACTS participants identify as Black or African American, as did four percent of BHD referrals. Approximately one-third of BHD and IMPACTS participants identify as female.

IMPACTS and BHD programs report differences in how they most frequently encounter participants, which shows the necessity for varying points of interception. For IMPACTS, jail is the most frequent connection point into the program (30 percent)

[1] Oregon Laws 2019, chapter 563, section 1-14, available at https://olis.oregonlegislature.gov.
[2] Oregon Laws 2024, chapter 70, section 76, available at https://olis.oregonlegislature.gov.

followed by a behavioral health contact (15 percent). For BHD, law enforcement serves as the most common first point of contact (81 percent). Peer support navigators are the second most common point of contact (8 percent).

Individuals who qualify for IMPACTS are often deeply entrenched in the emergency healthcare and criminal legal systems. Sixty percent of IMPACTS participants had a jail booking in the year prior to engagement, with an average of four bookings. Thirty-six percent of IMPACTS participants had an emergency department visit in the past year, with an average of 5.1 visits.

Housing remains a prominent need among participants in both IMPACTS and BHD. The majority of participants in both programs were unstably housed when they enrolled. Roughly one in four participants in each program received or were referred to housing services and/or supports. Importantly, BHD participants with safe and stable housing upon program entry had higher rates of program completion. IMPACTS participants with stable housing at entry had higher rates of engagement in services over time.

Both IMPACTS and BHD reach individuals with behavioral health conditions. Among participants with known substance use disorders (73 percent in IMPACTS and 80 percent in BHD), programs report that roughly 60 percent of IMPACTS and nearly 75 percent of BHD participants use methamphetamine either alone or in combination with other substances. Across both programs, more than half of participants with known substance use disorders engage in polysubstance use. Over half of IMPACTS participants have co-occurring substance use and mental health disorders. With a focus on high utilizers of health systems, IMPACTS has higher rates of documented serious mental illness compared to BHD. To date, mental health status is less likely to be known among BHD participants at the time of program enrollment.

There are many different factors to client engagement among IMPACTS and BHD. An indicator of program success is client engagement. For IMPACTS, relationship-building is one of the program components that led to 69 percent of enrolled clients receiving services in follow-up month(s) after enrollment. For BHD, the type of entry into the program is an important component of engagement. Among those who were directly connected with program staff, 82 percent of individuals enrolled in a program, which is higher than other referral routes. Additionally, the highest completion rates are seen with those receiving a warm handoff from first responders (32 percent) or contacted by a deflection team via outreach (49 percent).

ORS 192.245(2):
A copy of the report may be obtained by contacting the Oregon Criminal Justice Commission at (503) 378-4830 or cjc@oregon.gov. The full report may also be accessed online at: https://www.oregon.gov/cjc.

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1 Introduction – Behavioral Health Initiatives

1.1 Background

As part of the work that the Oregon Criminal Justice Commission (CJC) does to improve the legitimacy, efficiency, and effectiveness of state and local criminal legal systems, the agency administers multiple public safety grants for the State of Oregon. In recent years, the CJC's grant administration portfolio has expanded to include two behavioral health initiatives: the Improving People's Access to Community-based Treatment, Supports and Services (IMPACTS) grant program and the Oregon Behavioral Health Deflection (BHD) grant program. While both IMPACTS and BHD focus on individuals at the intersection of behavioral health and the criminal legal system, these two programs are separate and distinct, each with their own goals, priorities, target populations, strategies for intervention, and outcomes.

The IMPACTS grant program targets a population of individuals with behavioral health conditions who are *high utilizers* of criminal legal and/or emergency healthcare resources and provides them with community-based treatment, supports, and services with the goal of reducing the frequency with which they are involved with those systems and resources. Alternatively, BHD programs intend to serve individuals suspected of or found in possession of user amounts of controlled substances by providing opportunities for early interventions and connections to community-based services for substance use and/or mental health disorders before entering the criminal legal system.

One way to compare the intervention focus of these two behavioral health initiatives is to use the Sequential Intercept Model (SIM). The SIM is a conceptual framework that maps how individuals with mental health and substance use disorders come into contact with and move through the criminal legal system.[3]

As shown in Figure 1.1 on the following page, the model includes six intercepts, from Intercept 0 (Community Services) to Intercept 5 (Community Corrections/Reentry). Each intercept of the model includes key elements used to inform community-based responses, such as strategies to intervene or deflect individuals from the criminal legal system and approaches to supporting treatment and community reintegration. The SIM may be used by communities to map their criminal legal and behavioral health systems, as well as to identify service gaps, available resources, and opportunities to promote the use or expansion of evidence-based interventions.[4]

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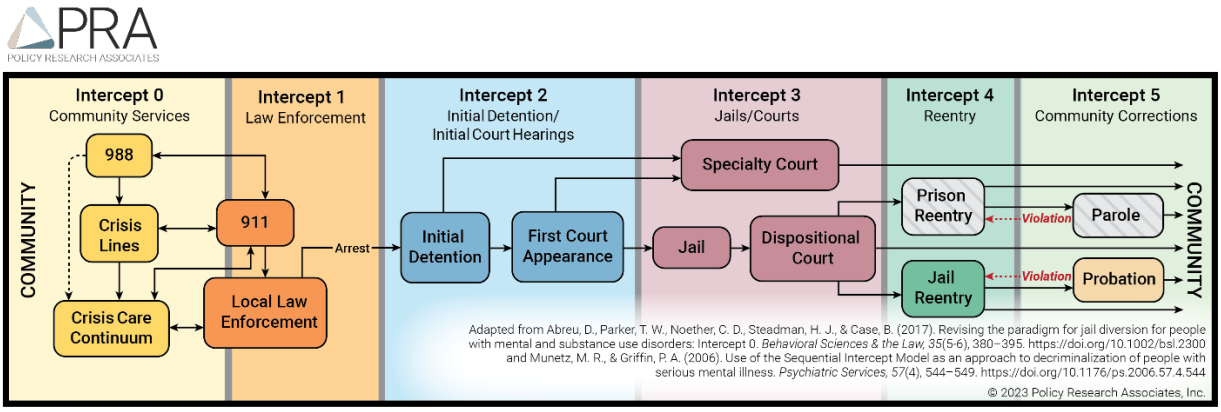
[3] "The Sequential Intercept Model (SIM)." Substance Abuse and Mental Health Services Administration, May 24, 2024, available at https://www.samhsa.gov/communities/criminal-juvenile-justice/sequential-intercept-model (last accessed October 7, 2025).

[4] "The Sequential Intercept Model." Policy Research Associates, available at https://www.prainc.com/sim/ (last accessed October 7, 2025).

Figure 1.1 Sequential Intercept Model (SIM)



Both IMPACTS and BHD include efforts that take place at Intercept 0 and 1, including mobile crisis outreach teams, co-response, and/or emergency department diversion. The strategies and intervention efforts of BHD programs primarily focus on the points before entering the criminal legal system – in lieu of or after citation or arrest – at Intercepts 0 and 1 with some extension into Intercept 2 among specific local program models in Oregon. IMPACTS programming expands to intervene with high utilizers of the systems at every possible intercept. These additional points of intervention for IMPACTS – Intercepts 2-5 – include strategies such as screening for behavioral health conditions at jail bookings, case management and navigation through treatment courts, jail in-reach and reentry transition planning, and specialized community supervision, all with the goal of reducing their utilization of the criminal legal and emergency healthcare systems.

With the shared goal of connecting individuals who are living with behavioral health conditions to community-based treatment, supports, and services in order to reduce involvement with the criminal legal system, the efforts of the IMPACTS and BHD programs across the state help improve outcomes for some of Oregon's most vulnerable populations. This report satisfies the requirements set forth by the Oregon Legislature in Senate Bill (SB) 973 (2019) to describe the outcome measures or the results of evaluations of the IMPACTS grant program to the Oregon Legislature in 2026, and that of House Bill (HB) 3069 (2025) to account for the progress of BHD grantees and evaluate their program outcomes by November 1, 2025.

2 IMPACTS Outcome Measures and Evaluation

2.1 Purpose

The Oregon Legislature established the Improving People's Access to Community-based Treatment, Supports and Services (IMPACTS) grant program in 2019 through SB 973 in recognition of the shortage of comprehensive community supports and services for individuals with mental health or substance use disorders that lead to their involvement

with the criminal legal system, hospitalizations, and institutional placements.[5] This program awards grants to Oregon's counties and federally recognized tribal governments, to establish evidence-based and tribal-based programs to provide these community-based supports and services.

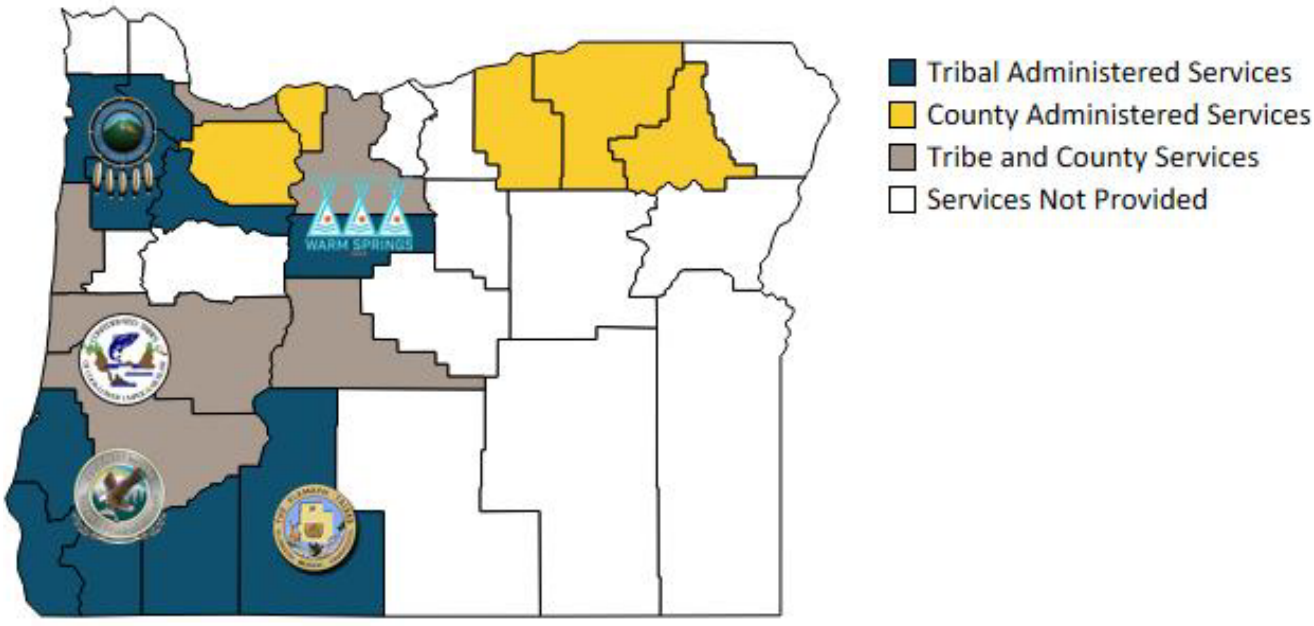
Those with a behavioral health condition who are high utilizers of criminal legal and/or emergency healthcare resources are eligible for the target population of this grant. IMPACTS grant programs share a common goal of reducing their high utilizer target populations' involvement with the criminal legal system and the frequency with which those individuals rely on emergency medical services, including institutional healthcare placements, by increasing the availability of community-based supports and services.

This section of the report will delve into several outcomes that have emerged from grantee data reporting and evaluation efforts.

2.2 Map of Counties and Tribal Governments Receiving IMPACTS Funding

There are a total of 15 IMPACTS high utilizer grant programs operating across the state, serving five of Oregon's federally recognized tribes and 11 counties. Figure 2.1 below represents where these programs operate, noting that tribal jurisdictions are complex and cannot be accurately delineated by colonial-defined county boundaries.

Figure 2.1 Map of counties and tribal governments receiving IMPACTS funding



[5]Oregon Laws 2019, chapter 563, section 1-14, available at https://olis.oregonlegislature.gov.

The IMPACTS grant program received $10 million in the 2025 legislative session for use in the 2025–2027 biennium. It has previously received a $10 million appropriation for each biennium consecutively, beginning in the 2019–2021 biennium. The current grant cycle utilizing 2023-2025 funds ends on December 31, 2025, and a new solicitation process is forthcoming. See Appendix A, Table A.1, for a table of the currently funded programs.

2.3 High Utilizers in Behavioral Health and Criminal Legal Systems

The target population for the IMPACTS grant program is unique to each local jurisdiction but shares the common criteria of having one or more behavioral health disorders. Other required criteria include those who are booked into jail an average of four or more times in a one-year period or are high utilizers of criminal legal resources, hospital or urgent healthcare resources, or institutional placements, as determined by the local program. Grantees have highlighted that this flexibility of who the program can serve and how they can serve those populations has contributed to success.

The Oregon Health and Science University – Portland State University School of Public Health's "Qualitative Insights from 15 Oregon IMPACTS Programs, 2024" report found that "flexibility to adapt service provision locally allows IMPACTS programs to base service delivery on individual circumstances – particularly when a client is not stable enough to engage in formal services."[6]

Moreover, this report found that IMPACTS works well in conjunction with the systems that are already in place by extending this jurisdictional discretion to the function of their programs. One site expressed as part of the "Qualitative Insights" report that "'IMPACTS has been a great addition to the teams we already have, and it really provides more flexibility for us in engagement and how, when, and honestly where we can provide services. There's a lot of rules governing mental health, psychiatric services and addiction, and IMPACTS [...] helps to work on the fringes of them and get people in the door effectively....'"[7]

Through allowing participants to enter the program in the absence of any formal criminal involvement, the program focuses heavily on preventative measures for future contact with the criminal legal system. While there may be past or current system involvement, IMPACTS allows counties and tribal governments to intercept at-risk individuals who are cycling through ats Intercept 0-1, as shown on the SIM map included in Section 1.1.

This program may also accept those with zero criminal legal system involvement who use significant healthcare resources. By allowing treatment to those who utilize the healthcare

[6] Sara Rainer, Inga Suneson, Eliza Haddeland, and Elizabeth Needham Waddell, "Qualitative Insights from 15 Oregon IMPACTS Programs," *Oregon Health and Sciences University – Portland State University School of Public Health* (2025): 4. https://www.oregon.gov/cjc/CJC%20Document%20Library/2025_7.10_IMPACTS_qualitative_report.pdf.
[7] Ibid, 3.

systems with a high frequency, intervention is again occurring early to alleviate higher levels of care. Since this population often crosses between behavioral health and criminal legal system utilization, IMPACTS has served as a mechanism to build partnerships across these often-siloed infrastructures to better fill service gaps.

Unlike many other programs, IMPACTS is unique in its flexibility with who, when, and how the program can serve individuals. By allowing this jurisdictional flexibility, IMPACTS can "provide holistic support extending beyond standard treatment or care, including reconnection with culture and traditions and family reunification," which may extend the positive effects past traditional modes of intervention.[8]

2.4 Explanation of Measures and Evaluation Efforts

The CJC partners with the Oregon Health and Science University – Portland State University School of Public Health (PI: Waddell), also known as OHSU – PSU SPH, to complete local formative evaluations for IMPACTS grantees, conduct data analysis, and provide technical assistance in data collection to local programs. A critical part of their efforts includes the development and maintenance of a web-based data system housed in the OHSU Research Electronic Data Capture (REDCap®) system.[9]

Deidentified, client-level data for the IMPACTS high utilizer program is reported by each county program using REDCap®, documenting participant information upon enrollment to create a baseline measurement and continuing to document program activities and engagement with health and public safety systems over time. The report includes data for IMPACTS participants engaged in services between July 1, 2023, and June 30, 2025. The baseline measurement includes a participant's demographics, behavioral health indicators, services provided in the first month of engagement, and encounters with public safety and health systems during the year prior to program engagement. Each subsequent month of engagement is captured in an electronic monthly update form in REDCap®, which

[8] Ibid., 14.

[9] Study data were collected and managed using REDCap electronic data capture tools hosted at Oregon Health & Science University (grant number UL1TR002369). REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture, 2) audit trails for tracking data manipulation and export procedures, 3) automated export procedures for seamless data downloads to common statistical packages, and 4) procedures for data integration and interoperability with external sources; Paul Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Jose Conde, "Research Electronic Data Capture (REDCap) – A Metadata-Driven Methodology and Workflow Process for Providing Translational Research Informatics Support," Journal of Biomedical Informatics 42, no. 2 (2009): 377-381, https://www.sciencedirect.com/science/article/pii/S1532046408001226?via%3Dihub; Paul Harris, Robert Taylor, Brenda Minor, Veida Elliott, Michelle Fernandez, Lindsay O'Neal, Laura McLeod, Giovanni Delacqua, Francesco Delacqua, Jacqueline Kirby, and Stephany Duda, "The REDCap Consortium: Building an International Community of Software Partners," Journal of Biomedical Informatics 95 (2019): https://www.sciencedirect.com/science/article/pii/S1532046419301261.

includes receipt of services and additional system encounters until participant attrition. The following sections include program data reported through REDCap®.

The OHSU – PSU SPH also published the "Qualitative Insights from 15 Oregon IMPACTS Programs, 2024" report detailing qualitative findings from interviews conducted with all 15 IMPACTS high utilizer programs.[10] The qualitative report provides programmatic context and themes across sites that the quantitative data alone cannot. Portions of the qualitative report are cited throughout as additional context alongside quantitative findings.

Additionally, the CJC partners with OHSU's Center for Health Systems Effectiveness (CHSE) for the purposes of a long-term evaluation project examining the statewide effects of IMPACTS program implementation. The CHSE completed an evaluation of the first grant cycle (July 2020 to June 2022), "IMPACTS Statewide Evaluation: Grant Cycle 1 Report," as seen referenced throughout this report.[11]

2.5 IMPACTS Participants Served

This section will explore who the IMPACTS program serves and their complex underlying needs, including how participants are connected to IMPACTS, what their criminal legal system and emergency healthcare resources utilization has been, and demographic data.

Table 2.1 How participants connected to IMPACTS

Point of connection (multiple response)	Count	Percent*
Jail	411	30%
Behavioral health program referral	214	15%
Walk-in	192	14%
Law enforcement drop-off or referral	191	14%
Community corrections	178	13%
Community outreach	168	12%
Other	126	9%
Word of mouth or family referral	125	9%
Court	52	4%
Emergency department	34	2%
Hospital	34	2%
Prison	29	2%
Do not know	0	0%
Total participants reported	1381	--

*Total percent may be greater than 100% on multiple response items.

Table 2.1 above illustrates the many ways in which IMPACTS participants were connected to their local program. Most often, they are connected via jail (30 percent) and/or behavioral health (15 percent). Other frequent paths to IMPACTS include walk-in (14

[10] Rainer, Suneson, Haddeland, Waddell, "Qualitative Insights from 15 Oregon IMPACTS Programs."
[11] Stephanie Renfro and Christina Charlesworth, "IMPACTS Statewide Evaluation: Grant Cycle 1 Report," *Center for Health Systems Effectiveness*, Oregon Health & Science University (2024). https://www.oregon.gov/cjc/impacts/Documents/IMPACTS_Statewide_Evaluation-Grant_Cycle_1_Report_Rev_04_2025.pdf.

percent), law-enforcement drop-off or referral (14 percent), community corrections (13 percent), and community outreach (12 percent).

The CHSE reports similar findings to this grantee-reported data in their recent study. They find that "72 percent of individuals who qualified for the target population in administrative data during [the years of 2018-2022] met criteria based on interactions with the criminal legal system… 23 percent qualified based on emergency department visits and hospital admissions… and three percent qualified based on an Oregon State Hospital stay."[12]

Table 2.2 below shows demographic information for the IMPACTS population. IMPACTS participants are mostly white identifying (60 percent), although nearly one in three participants identifies as American Indian or Alaska Native (30 percent). IMPACTS participants are about two-thirds male and about one-third female. About half (49 percent) of IMPACTS participants are between the ages of 35 and 54, more than one-third are younger than 35, and about 14 percent are age 55 or older.

Table 2.2 Participant demographic information at baseline

Demographic information	Count	Percent*
Race/ethnicity (multiple response)		
White	837	60%
American Indian or Alaska Native	412	30%
Black or African American	81	6%
Hispanic or Latino/a/x	51	4%
Do not know	23	2%
Other	17	1%
Native Hawaiian or Pacific Islander	16	1%
Asian	--	--
Middle Eastern/North African	--	--
Total participants reported	1384	
Counts censored when less than 11. Number of values censored: 4		
Sex at birth		
Male	918	66%
Female	460	33%
Total participants reported	1378	
Age group		
Under 18	--	--
18-24	102	7%
25-34	400	29%
35-54	672	49%
55-64	168	12%
65+	35	2%
Do not know	--	--
Total	1386	100%
Counts censored when less than 11. Number of values censored: 4		

* Total percent may be greater than 100% on multiple response items. Censored values are included in total counts.

[12] Ibid., 16.

Participant living arrangements in the year prior to program engagement, as reported by grantees, are illustrated in Table 2.3 below. Most IMPACTS participants (54 percent) were unstably housed upon first engagement (data not shown). In the year prior to program engagement, or baseline, participants were most often reported to be sheltering in a tent or outside (25 percent), in a jail or correctional facility (23 percent), and/or staying with friends, family, or others (19 percent).

Table 2.3 IMPACTS participant living arrangements at baseline

Baseline living arrangement(s)	Count	Percent*
Living arrangements at baseline (multiple response)		
Living in a tent/outside	349	25%
In a jail/correctional facility	324	23%
Staying with friends/family/others	263	19%
In a private residence, such as their own house/apartment	221	16%
In time-limited transitional housing or crisis residence	127	9%
Emergency shelter	113	8%
Living in a vehicle	85	6%
In permanent supportive housing	79	6%
In residential care, such as a group home or rehabilitation center	51	4%
Other	50	4%
Staying in a motel/hotel	49	4%
Do not know	35	3%
In an institutional setting (e.g., nursing homes, psychiatric hospital, veterans' affairs hospital, state hospital)	15	1%
Living in a foster home/foster care	5	0%
Total participants reported	1,386	

*Total percent may be greater than 100% on multiple response items.

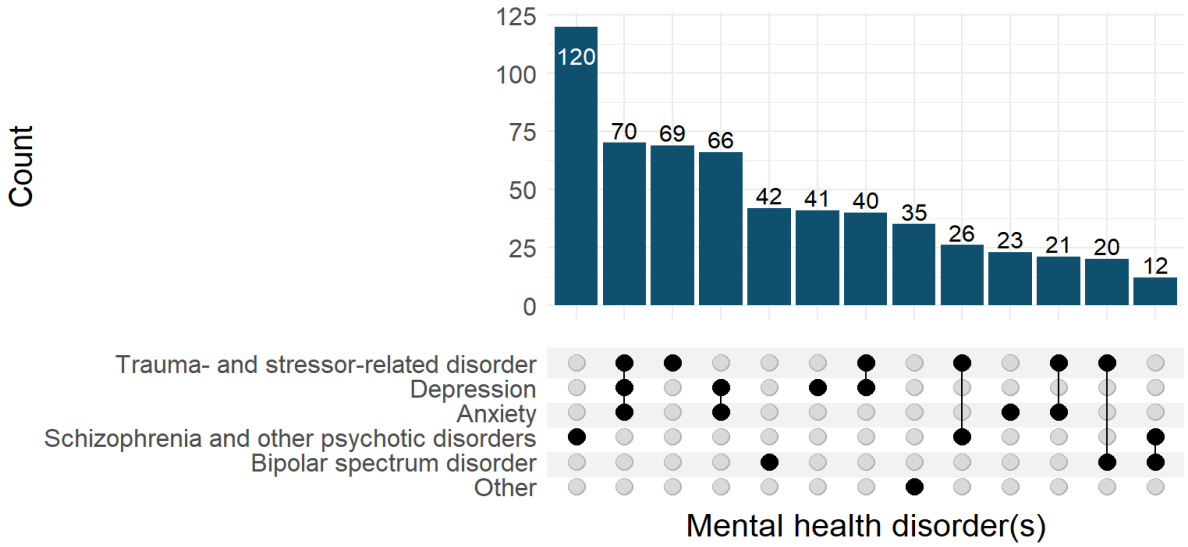
Table 2.4 IMPACTS participant behavioral health conditions at baseline

Behavioral health condition(s)	Count	Percent
Mental health disorder		
Yes	1,009	73%
No	97	7%
Do not know	281	20%
Total	1,387	100%
Substance use disorder		
Yes	1,009	73%
No	140	10%
Do not know	237	17%
Total	1,386	100%
Co-occurring disorders		
Co-occurring mental health and substance use disorders	751	54%
Mental health disorder only	257	19%
Substance use disorder only	258	19%
Neither mental health nor substance use disorder indicated	120	9%
Total	1,386	100%

Table 2.4 on the previous page illustrates the behavioral health conditions of IMPACTS participants at baseline. Approximately three in four participants (73 percent) had a reported mental health disorder, and the same proportion of participants (73 percent) had a reported substance use disorder. Over half (54 percent) of IMPACTS participants have co-occurring mental health and substance use disorders.

The CHSE corroborates this through administrative data sources and finds that about 65 percent of individuals that qualify for the IMPACTS target population statewide have a co-occurring mental health disorder and substance use disorder.[13] Local IMPACTS programs, therefore, are keenly situated to handle this type of high system utilization through tailoring their programs to meet their target population's unique and diverse needs. The "Qualitative Insights" report also supports this finding. Through grantee interviews, the report surmises that "IMPACTS programs meet participants in the moment with flexibility and responsivity to the needs of the day," recognizing that it is constantly changing for those with co-occurring disorders.[14]

Figure 2.2 Most common combinations of IMPACTS participant mental health disorder(s) reported at baseline



Note: This figure shows only common combinations. Supplementary data, including full counts, for Figure 2.2 provided in Technical Appendix, Table B.1.

Figure 2.2 above displays the most frequently reported combinations of mental health disorders among participants, omitting those that are unknown or combinations of mental health disorders that contain fewer than twelve individuals. Grantees reported type(s) of mental health disorder(s) for 1,003 participants total. Of those IMPACTS participants for

[13] Ibid., 19.

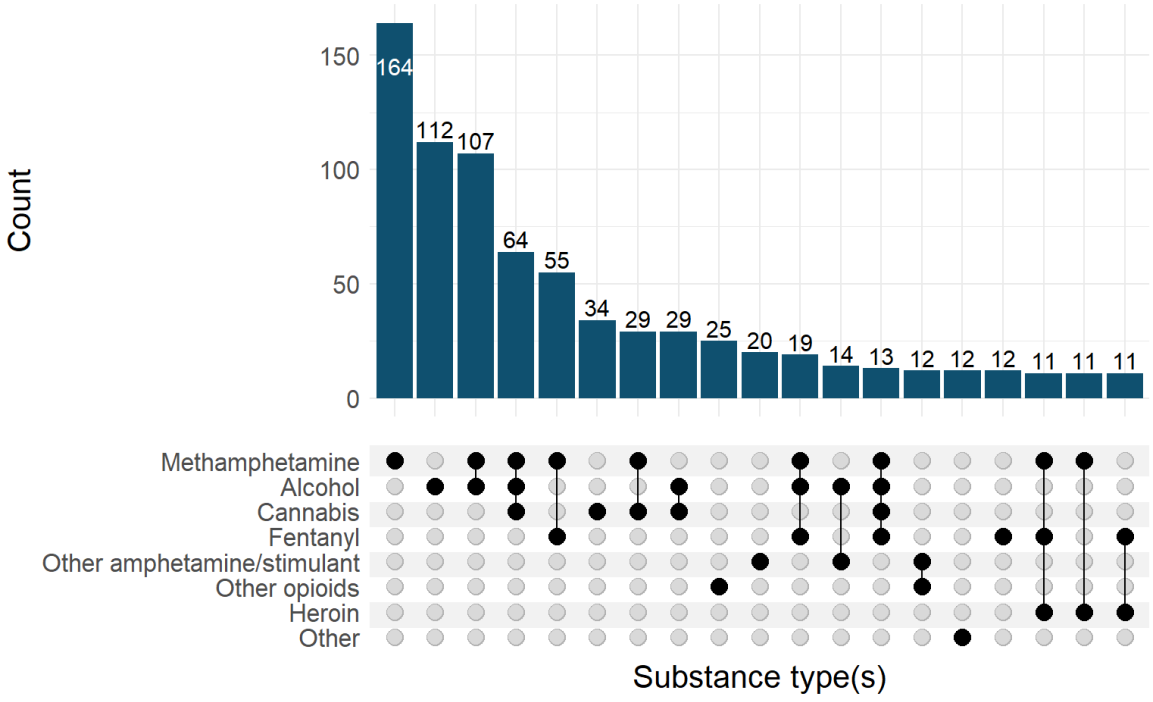
[14] Rainer, Suneson, Haddeland, Waddell, "Qualitative Insights from 15 Oregon IMPACTS Programs," 14.

whom mental health disorder(s) are known, the most commonly reported combination of mental health disorders was schizophrenia and other psychotic disorders alone (120 participants, or approximately twelve percent). This category accounted for 50 more individuals than the second highest combination of mental health diagnoses – trauma, depression, and anxiety combined (70 participants).

However, trauma-related disorders (such as post-traumatic stress disorder, or PTSD), were the most common type of disorders present in the IMPACTS population overall, with a total of 385 participants (38 percent) reporting a diagnosis, either in combination with another disorder or alone. After trauma-related disorders, depression was the most common with 367 participants (37 percent) reporting a diagnosis, followed by anxiety (337 individuals, or 34 percent), schizophrenia and other psychotic disorders (237 individuals, or 24 percent), and bipolar spectrum disorder (172 individuals, or 17 percent). More information on reported mental health disorders of this population can be found in Table B.1 in the Technical Appendix.

Figure 2.3 below illustrates the most frequently reported combinations of substance use disorders of IMPACTS participants at baseline, omitting those that are unknown, and combinations of substance use disorders that contain fewer than 11 individuals.

Figure 2.3 Most common combinations of IMPACTS participant substance use disorder(s) at baseline



Note: This figure shows only common combinations. Supplementary data, including full counts, for Figure 2.3 provided in Technical Appendix, Table B.2.

Among those IMPACTS participants for whom the type of substance use disorder (SUD) was known, the most common SUD combination at baseline was methamphetamine use alone (164 individuals), followed by alcohol alone (112 individuals), followed further by methamphetamine and alcohol combined (107 individuals). Fifty-nine percent of this population indicated polysubstance use (data not shown).

This aligns with the most commonly reported SUDs for the IMPACTS population overall, regardless of combination. Type(s) of SUD(s) were reported for 1,008 participants (Table B.2, Technical Appendix). Within this population, methamphetamine use was reported for 58 percent (588 individuals) and alcohol use was reported for 46 percent (466 individuals). Furthermore, grantees reported that 24 percent of IMPACTS participants (244 individuals) had SUDs involving cannabis at baseline, 17 percent (176 individuals) were reported to use fentanyl, and eight percent (84 individuals) were reported to use heroin. More information on the substance use disorders of this population can be found in Table B.2 in the Technical Appendix.

IMPACTS participants are characterized by frequent utilization of systems like public safety and healthcare, as exemplified in Figure 2.3 on the previous page and Table 2.5 below. Eighty-six percent of IMPACTS participants had at least one encounter with public safety or healthcare in the year prior to engagement. Three quarters (76 percent) of IMPACTS participants had at least one public safety encounter in the year prior to their engagement with the program, including jail booking (61 percent), law enforcement encounters (47 percent), probation/parole (34 percent), and/or prison (10 percent).

Table 2.5 Number and percentage of IMPACTS participants who had at least one public safety or health system encounter/admission in year prior to program engagement

Type of system encounter/admission (multiple response)	Count	Percent of enrolled (N=1,387)
Total number of participants who had at least one public safety encounter	**1,050**	**76%**
# with at least one jail booking	849	61%
# with at least one local law enforcement encounter	650	47%
# with at least one month on parole or probation	476	34%
# with at least one prison incarceration	132	10%
Total number of participants who had at least one health system encounter	**682**	**49%**
# with at least one emergency dept visit	495	36%
# with at least one hospital admission	206	15%
# with at least one inpatient mental health service encounter	143	10%
# with at least one inpatient substance use disorder service encounter	140	10%
# with at least one stabilization or crisis center encounter	108	8%
# with at least one state hospital admission	80	6%
Total number of participants who had any encounter (N=1,387)	**1,188**	**86%**

*Total percent may be greater than 100% on multiple response items.

Similarly, in the year prior to engagement with the program, nearly half (49 percent) of IMPACTS participants had at least one health system encounter, including emergency department visits (36 percent), hospital admissions (15 percent), inpatient mental health treatment (10 percent), inpatient substance use disorder treatment (10 percent), stabilization or crisis center encounter (eight percent), and/or state hospital admission.

Table 2.6 below summarizes the number of encounters and admissions in the past year for participants who had at least one encounter or admission. For those who experienced the most common public safety encounter, jail booking, the average number of bookings was four in the year prior to program enrollment. Similarly, the average number of law enforcement encounters the year prior to enrollment was 4.6 encounters. Visits to the emergency department were the most common type of health system encounter among IMPACTS participants at baseline, and the average number of emergency department visits in the year prior to enrollment was 5.1. Importantly, the majority of IMPACTS participants had more than one type of system encounter in the year prior to program enrollment, and encounters related to law enforcement were more common than healthcare encounters.

Of note, for those who had stabilization or crisis center encounters in the year prior to enrollment, the average number was high, at 10.3 encounters. This is due to outliers; at least one participant in this population had daily crisis center encounters in the year prior to IMPACTS participation. Also of note, for those with an Oregon State Hospital admission in the year prior to IMPACTS, none had more than two admissions. Lastly, the mode for number of months on parole or probation for this population was twelve, meaning that, of those who engaged with parole and probation in the year prior to IMPACTS participation, most often, participants were on supervision for the entire year prior to engagement.

Table 2.6 Number of public safety and health system encounters/admissions in year prior to program engagement, among participants with at least one encounter

	Number of participants reported	Min	Max	Mean/ Average	Mode/ Most frequent response
# Jail bookings	827	1	24	4.0	2
# Local law enforcement encounters	609	1	50	4.6	1
# Emergency dept visits	484	1	57	5.1	1
# Months on parole or probation	453	1	12	8.8	12
# Hospital admissions	199	1	12	2.3	1
# Inpatient mental health services encounters	143	1	10	1.8	1
# Inpatient SUD services encounters	134	1	12	1.5	1
# Prison incarcerations	129	1	12	1.4	1
# Stabilization or crisis center encounters	107	1	365	10.3	1
# State hospital admissions	76	1	2	1.1	1

Note: Supplementary data for Table 2.6 provided in Technical Appendix, Table B.3.

As reported by grantees, IMPACTS is uniquely situated to handle moments of crisis and transition because of its ability to fill service gaps. Some examples of this, outlined in the "Qualitative Insights" report, are aiding in clients' transition between service providers, assisting participants releasing from jail or prison to access housing, and meeting people where they are in the community to attend to urgent needs. The responsivity of IMPACTS programs to their clients' emergent needs helps to fill service gaps during these transitionary periods.[15]

After looking at who qualifies for the IMPACTS program, how that qualification materializes, and the demographics of that population and their complicating behavioral health disorders, this report will now dive into outcomes that local programs have realized or begun to realize. This includes services received and participant engagement data.

2.6 IMPACTS Program Outcomes to Date

Beginning at a statewide lens, the CHSE's evaluation of the first IMPACTS grant cycle revealed several important findings, including a reduction in the rate of convictions, for both misdemeanors and felonies, for areas of the state operating IMPACTS programs. Importantly, the unadjusted rates of conviction for areas without IMPACTS increased throughout the evaluation period. The unadjusted rates of conviction for this first grant cycle service areas saw overall decreases. This gap appeared to be widening at the end of the first grant cycle evaluation period.[16]

The statewide evaluation also found increased rates of both alcohol and other drug treatment and engagement in IMPACTS service areas. Additionally, the authors note, "These early results suggest enhancing community-based services may improve health and reduce criminal legal system involvement for a targeted population with behavioral health needs and history of intensive service use."[17] Furthermore, one grantee states in the "Qualitative Insights" report:

> Our mentally ill population are sicker than they've ever been. Before, stabilization used to be with drugs and alcohol, and it was getting them clean and sober. Right now, our first stabilization is really their mental health. And that is different than it has been in the past and takes more resources and time.[18]

This statewide evaluation and the local program data to come shows that community-based services that address high acuity service needs have the potential to offer more effective treatment and stabilization to the high utilizer target population.

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[15] Ibid., 14.
[16] Renfro and Charlesworth, "IMPACTS Statewide Evaluation: Grant Cycle 1 Report."
[17] Rainer, Suneson, Haddeland, Waddell, "Qualitative Insights from 15 Oregon IMPACTS Programs," 7.
[18] Ibid., 5.

Table 2.7 below compares the services received by IMPACTS participants at the beginning of their participation (baseline) and those received in follow-up months. This table shows that, overall, IMPACTS participants are receiving a broad scope of services, especially at follow-up visits.

Table 2.7 Distribution of services provided to IMPACTS participants at baseline and follow-up

Service (multiple response)	**# of baseline forms with service**	**% of baseline forms with service*** (N=1,064 forms)	**# of monthly follow-up forms with service**	**% of monthly follow-up forms with service*** (N=4,790 forms)
Case management	653	61%	3,234	68%
Peer support/outreach	566	53%	2,399	50%
Care coordination	399	38%	2,120	44%
Mental health services	325	31%	1,846	39%
Housing	276	26%	934	19%
Transportation	275	26%	1,922	40%
Substance use disorder services	207	19%	1,096	23%
Food	169	16%	893	19%
Medical care, medicine, medical supplies	118	11%	786	16%
Legal issues	103	10%	575	12%
Reentry support	95	9%	427	9%
Other	93	9%	420	9%
Applying for public benefits (WIC, SSI, SNAP, etc.)	82	8%	252	5%
Applying for health insurance/Oregon Health Plan	69	6%	61	1%
Help with activities of daily living	63	6%	612	13%
Employment	52	5%	272	6%
Utilities (heat, electricity, water, etc.)	49	5%	326	7%
DMV assistance	43	4%	116	2%
Childcare/other child-related issues	13	1%	99	2%
Total forms with service indicated	**1,064**		**4,790**	
N and % IMPACTS participants received at least one service (N=1387)	1,064	77%	957	69%

*Total percent may be greater than 100% on multiple response items.

**Other services provided included meeting basic needs (e.g., clothing, phone, ID card), providing pet care, and education support.

More than three quarters (77 percent) of IMPACTS participants received at least one service at baseline, and 69 percent received at least one service in follow-up month(s). Case management and peer support were the most common services received at baseline and follow-up. While the distribution of services at baseline compared to follow-up was

generally similar, there were some exceptions. Increases in intensive services among the 69 percent of returning IMPACTS participants suggest that participants with more complex needs were more likely to return. The provision of more intensive services such as care coordination, mental health services, help with activities of daily living, and transportation were proportionally higher at follow-up for those who continued services after baseline.

This may indicate that the number and breadth of services received by those who continued participating after baseline increased. This finding reflects the intent of the IMPACTS program to assist individuals with high needs; IMPACTS is an intensive program, and as such, those who qualify may need multiple types of services at many intervals. More information on the needs of IMPACTS participants and how this relates to their rates of engagement can be found in Table 2.9 and its corresponding text later in this report.

Grantees also emphasize the importance of relationship-building with the target population in the criminal legal sphere and in emergency health systems, which speaks to the high volume of clients returning for follow-up services. Grantees have reported that one way to accomplish this relationship-building is through multiple touchpoints. The "Qualitative Insights" report found that "IMPACTS staff build connections, rapport, and trust with high utilizers, even prior to engagement in services," and those pre-engagement services are crucial to interrupting the repeated jail bookings and emergency department visits.[19]

Not only do these repeated touchpoints lead to more successful outcomes, but the program allows for a wide range of service provision that contributes to participant stability. One grantee reported in the "Qualitative Insights" report:

> The other piece that I think doesn't get captured for IMPACTS-identified clients are the things that really help support people feeling "normal." It's not necessarily sitting with a therapist every day… we have coupons to go get your hair cut, take your peer support to go walk through the rock garden… things that are a little unique, but also capture the humanity in the need for connection for a lot of these folks.[20]

Some of the mechanisms that grantees use to help participants feel "normal," such as the quality and amount of time spent with a peer support specialist, may not be captured quantitatively. When discussing bridging service gaps, it is crucial to consider the full spectrum of activities that promote stability, because it speaks to the myriad of ways that IMPACTS fills service chasms.

[19] Ibid., 4.
[20] Ibid., 13.

IMPACTS participants are brought into the program from different systems through diversion efforts. Table 2.8 below illustrates diversions. About one in five (20 percent) IMPACTS participants were diverted at least once from jail, the emergency department, and/or the Oregon State Hospital. Sixteen percent were diverted from jail, eight percent were diverted from the emergency department, and two percent were diverted from the Oregon State Hospital at least once.

Table 2.8 Number and percent of IMPACTS participants diverted at least once from jail, emergency department, and/or Oregon State Hospital, July 2023-June 2025

Any diversion across baseline and follow-up	Number of IMPACTS participants diverted	Percent of IMPACTS participants diverted (N=1,387)
Any jail diversion	222	16%
Any emergency department diversion	105	8%
Any Oregon State Hospital diversion	32	2%
Total number and percent of participants with at least one diversion	272	20%

Rate of engagement may be a marker of participant success; the more often a participant returns for IMPACTS services, the more services they can receive. Service engagement is intended to mitigate factors that contribute to high utilization of criminal, legal, and/or healthcare systems. Rate of engagement in Table 2.9 on the following page was calculated by dividing the total number of months an individual engaged in IMPACTS services by the number of months that same individual was enrolled in an IMPACTS program. All but one of these comparisons are statistically significant.

Monthly engagement with services varied between different groups of IMPACTS participants. According to the comparisons in Table 2.9, non-white participants were significantly more likely to return for monthly follow-ups than their white counterparts, with a median rate of engagement of 33 percent.

Similarly, those identifying as female were significantly more likely to return for follow-up than their non-female counterparts; those with tribal affiliation had a significantly higher rate of engagement than those without a tribal affiliation; and those with an identified mental health disorder only had a higher rate of engagement than those without. The differences in engagement between those with and without mental health disorders suggest that programs are attracting and retaining individuals with intensive service needs. It is noteworthy that more than half of IMPACTS participants are known to have co-occurring substance use and mental health disorders.

Table 2.9 Median rates of monthly follow-up service engagement among IMPACTS participants through June 30, 2025

Group*	Number of participants	Median rate
White	655	17%
Not White	487	33%
American Indian or Alaska Native	358	33%
Not American Indian or Alaska Native	784	19%
Black or African American	73	55%
Not Black or African American	1069	22%
Female	374	33%
Not Female	768	20%
Male	710	19%
Not male	432	33%
Tribal affiliation	346	33%
No tribal affiliation	604	20%
Stably housed at baseline	466	33%
Not stably housed at baseline	611	18%
Co-occurring mental health and substance use disorders**	626	27%
Mental health disorder only	197	33%
Neither mental health nor substance use disorder indicated	93	0%
Substance use disorder only	226	14%

*Unless noted, differences between groups are statistically significant, $p < .05$
**Co-occurring mental health and substance use disorders vs mental health disorder only pairwise comparison not statistically significant (p=0.29)

This increased engagement for those with Tribal affiliation is supported in qualitative findings. The "Qualitative Insights" report details the following:

> Several Tribal grantees brought up their singular positioning to provide culturally specific, whole-person care to Tribal members. Activities like providing opportunities to practice traditional crafts, hosting social events, providing medicine items like smudges or participating in jail diversion that gets participants involved with the Tribe, ultimately help individuals to reconnect with their culture and traditions to provide meaning and fulfillment and help them be successful beyond standard substance use disorder or mental health services.[21]

This shows that, through IMPACTS, Tribal grantees have additional capacity to serve their members who qualify for the target population in multiple ways that may increase their engagement with supportive services. The range of those services, adhering to Tribal practices, allows healing beyond the criminal legal and behavioral health systems.

[21] Ibid., 14.

Additionally, Table 2.9 on the previous page illustrates a significant difference between rates of engagement for those who are stably housed at baseline compared to those who are not stably housed, with higher rates of engagement among those stably housed. IMPACTS programs offering services that may help participants become stably housed may not only be assisting those individuals with their immediate needs, but also their ability to access further assistance through follow-ups once their housing status improves.

These statistically significant rates of engagement are indicators for participant success in the ways shown above. Because local program goals heavily influence levels of participant engagement, future analyses over multiple program cycles could explore the interaction between specific program characteristics, rates of engagement, and longer-term trends in service needs, utilization, and engagement with the criminal legal and emergency healthcare systems to more accurately measure success across jurisdictions.

3 BHD Outcome Measures and Evaluation

3.1 Purpose

Four years after decriminalization by Oregon Ballot Measure 110 in 2020, possession of user amounts of a controlled substance (PCS) was again considered to be a criminal offense.[22] Oregon House Bill (HB) 4002 (2024) newly classified the offense type as a drug enforcement misdemeanor (DEM) effective September 1, 2024, and made it punishable by incarceration for up to 180 days or 18 months of supervised probation.[23] The Oregon Legislature established the Oregon Behavioral Health Deflection (BHD) Program through HB 4002 (2024) to provide grant funding to Oregon's counties and federally recognized tribal governments for deflection programs that assist individuals whose behavioral health conditions, including substance use disorder, lead to interactions with law enforcement, incarceration, conviction, and other engagement with the criminal legal system. As defined in HB 4002 (2024), deflection programs are collaborations between law enforcement agencies and behavioral health entities designed to create community-based pathways to treatment and recovery for people with a substance use disorder, other behavioral health disorders, or co-occurring disorders.[24]

The primary purpose of Oregon's BHD programs is to deflect individuals suspected of or charged with PCS away from the criminal legal system, before charges are filed, and to connect them to necessary assessment, treatment, and/or services for substance use and/or mental health disorder(s). Generally, deflection programs target individuals who may be at risk of entering into the criminal legal system due to a potential or actual PCS

[22] Oregon Secretary of State, "Drug Addiction Treatment and Recovery Act," https://sos.oregon.gov/admin/Documents/irr/2020/044text.pdf.
[23] Oregon Laws 2024, chapter 70, section 76, available at https://olis.oregonlegislature.gov.
[24] Ibid.

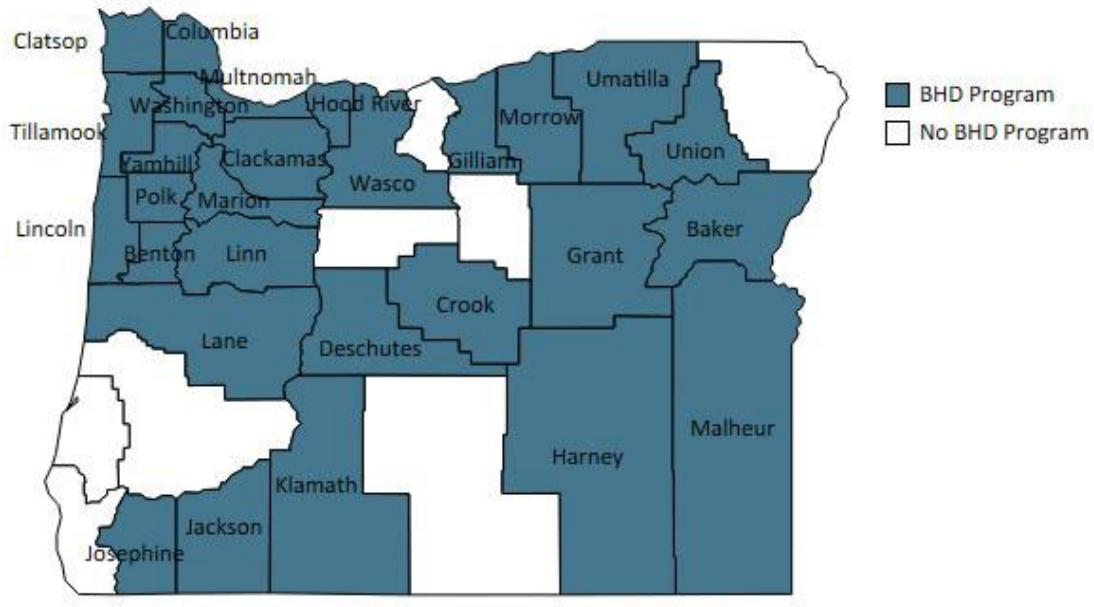
charge. Programming may also extend beyond those individuals suspected of or charged with PCS, including those who may have a behavioral health condition or other service needs, but eligibility criteria are at the discretion of each jurisdiction in order to best meet community needs.

There are currently many varying strategies, administering agencies, and referral pathways local jurisdictions use to connect eligible individuals to community-based treatment and services through deflection programming. Deflection outcomes, including connections to social services and criminal legal system avoidance, are captured by county-level data reporting. This section of the CJC's Behavioral Health Initiatives Report will explore the implementation of, early trends, and data for existing BHD programs approaching the first year of PCS recriminalization (September 1, 2024 – August 4, 2025).

3.2 Counties and Tribal Governments Receiving BHD Funding

In the first year of Oregon's BHD program, 28 of Oregon's 36 counties applied for and received 2023-25 BHD grant funding (see Figure 3.1 below). Two of these counties – Hood River County and Wasco County – joined efforts as a regional consortium to operate a single program.

Figure 3.1 2023-2025 Map of counties receiving BHD funding



In total, $20,708,200 was appropriated by HB 5204 (2024) to Oregon's BHD program for use in the 2023–2025 biennium.[25] Of that appropriation, $150,000 was allocated to evaluation efforts and ten percent ($2,070,819) was set aside for use by Oregon's nine

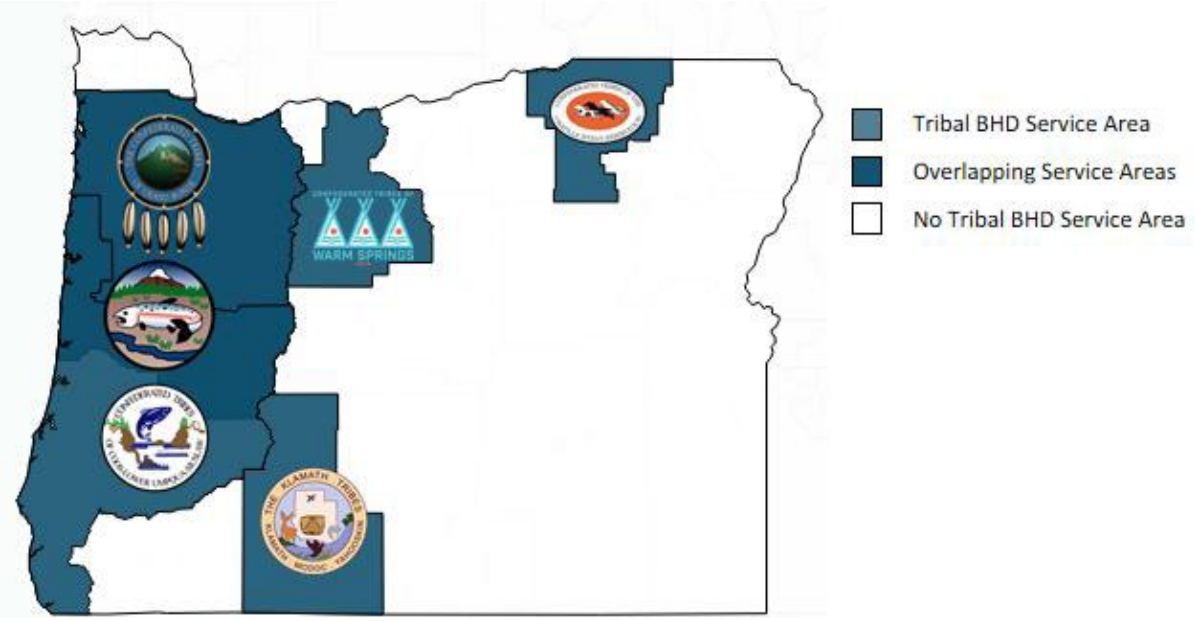
[25] Oregon Laws 2024, chapter 71, section 16, available at https://olis.oregonlegislature.gov.

federally recognized tribal governments. The remaining county share of that appropriation ($18,487,381) was allocated to the 28 counties who applied, funding 27 programs in total. Per HB 4002 (2024), the proportion of funds available to each county was determined based on the county formula share employed by the Oregon Health Authority's Oversight and Accountability Council, and no county program received less than $150,000.[26] See Appendix A, Table A.2, for a table of county BHD programs funded in the 2023–2025 biennium.

The first grant cycle extended from April 1, 2024, through September 30, 2025. The Oregon BHD program received an additional appropriation of $40 million in the 2025 legislative session for use in the 2025–2027 biennium.

Six of Oregon's nine federally recognized tribal governments applied for and received 2023-25 BHD grant funding to plan and begin implementation of deflection programs (see Figure 3.2 below). The tribal government share of the 2023-25 BHD appropriation ($2,070,819) was allocated to the six tribes that applied. After receiving input through consultation with Oregon's nine federally recognized tribal governments, the proportion of funds available to each tribe was determined based on Indian Health Services User Population numbers and no tribal program received less than $150,000. Tribal deflection programs are currently in a planning phase, so this report will focus solely on county deflection program operation and relevant data received to date. See Appendix A, Table A.3, for a table of tribal BHD programs funded in the 2023-25 biennium.

Figure 3.2 2023-2025 Map of tribal governments receiving BHD funding



[26] Oregon Laws 2024, chapter 70, section 76, available at https://olis.oregonlegislature.gov.

3.3 Deflection Pathways

Referral and entry to a deflection program can occur through a variety of pathways. As shown in Table 3.1 below, six deflection referral pathways have been identified as commonly used in deflection models across the United States.[27] These deflection pathways vary in number and in implementation strategy across local sites. For ease of understanding, we refer to the six conceptual names throughout this report, though this is not an exhaustive list of referral types.

Table 3.1 Deflection pathways

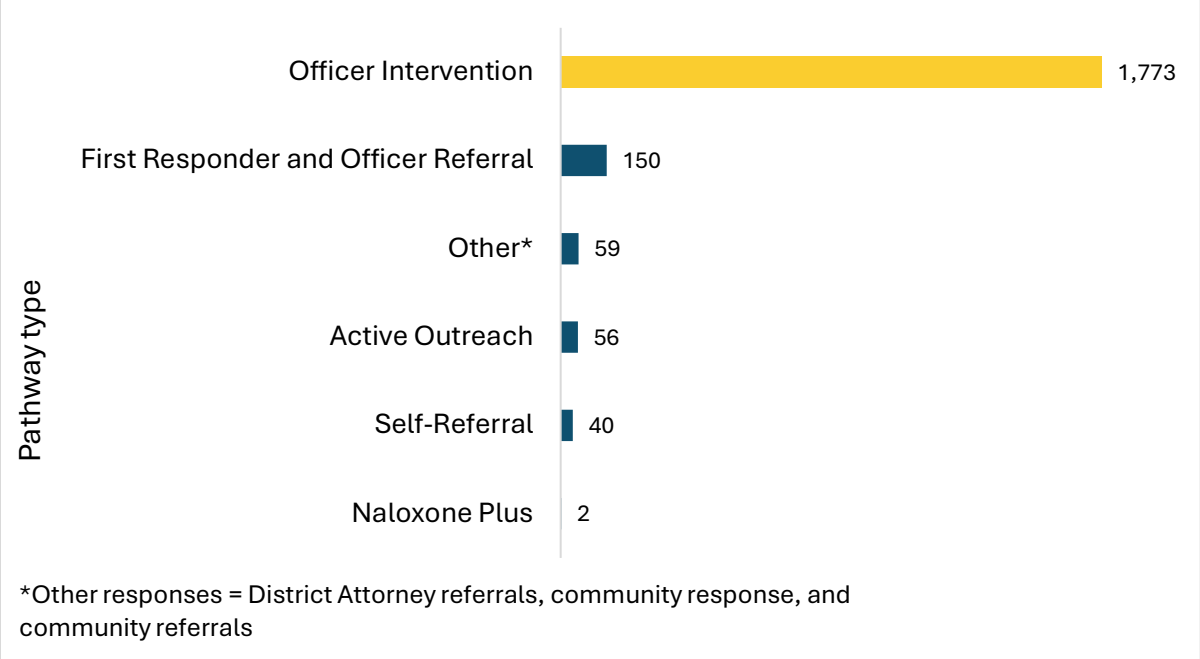
Pathway	Definition	Point of referral
Self-Referral	An individual voluntarily initiates contact with law enforcement or first responders, seeking treatment, without fear of arrest.	LE, fire, EMS, program staff
Active Outreach	LE officer, first responder, or non-LE agency seeks out or encounters known individuals in the community in need of treatment and services.	LE officer, fire, EMS
Naloxone Plus	LE officer, first responder, or crisis worker engages individuals as part of an overdose response, with rapid engagement to treatment and services. It also includes distribution of naloxone to people with SUD.	LE officer, fire, EMS, social worker, PSS
First Responder and Officer Referral (Officer Prevention)	LE officer or other first responder, alone or as a member of a co-response team, engages with individuals as a preventative measure, and provides referrals to treatment or to a case manager. This occurs as part of duties including on patrol or calls for service.	LE, co-responder (e.g., social worker, PSS, treatment provider)
Officer Intervention	LE officer, alone or as a member of a co-response team, makes an arrest or identifies a basis for a criminal charge, but no charges are filed if the program requirements are met. This occurs as part of duties including on patrol or calls for service and can include arrests with a warm handoff to a community-based responder.	LE, co-responder (e.g., social worker, PSS, treatment provider)
Community Response	A community-based behavioral health team engages with individuals to de-escalate crises and refer to treatment and services. LE may be involved when there are public safety concerns.	Crisis worker, clinician, PSS, program staff, LE

Sources: adapted from Oregon BHD Best Practices Report 2025 and Bureau of Justice Assistance 2023
Notes: EMS – emergency medical services; LE – law enforcement; PSS – Peer support specialist

[27] Erika Simeon, Inga Suneson, Sara Rainer, Eliza Haddeland, Daniel Hoover, Ruth Rowland, Faye Taxman, Elizabeth Needham Waddell, "Oregon Behavioral Health Deflection Best Practices Report," Oregon Health and Sciences University – Portland State University School of Public Health (2025): 4. https://www.oregon.gov/cjc/CJC%20Document%20Library/2025%20BHD%20Best%20Practices%20Report.pdf.

Among Oregon's BHD programs, utilization of the officer intervention pathway has emerged as an early trend. Since the inception of BHD data collection, officer intervention has been the most prevalent deflection referral pathway, utilized by nearly all BHD programs, as reported to the CJC. This high prevalence of officer intervention pathway utilization by local programs is also reflected in the number of referrals. Statewide, 85 percent of the 2,080 deflection referrals between September 1, 2024, and August 4, 2025, were received through the officer intervention pathway (see Figure 3.3 below).

Figure 3.3 Deflection pathways utilized statewide (N=2,080)



Note: Supplementary data for Figure 3.3 provided in Technical Appendix, Table B.4.

A key finding of the "Oregon Behavioral Health Deflection Best Practices Report," published in 2025, was that operation of multiple pathways to deflection extends program reach.[28] Many of Oregon's BHD programs began with a strategy to start small by operating a singular referral pathway – most commonly officer intervention – in order to build community trust, to gain buy-in from local law enforcement, and to be able to scale operation with time. By the end of the first grant cycle, however, the majority of programs had incorporated or had expressed interest in including other pathways into their operations. Presently, nearly all BHD programs operate multi-pathway approaches, and they continue to adapt their referral and service-connection strategies, as well as add capacity to their operations, through experience, streamlined internal processes, strengthened community partnerships, and expansion of participant eligibility criteria.

[28] Ibid, ii.

3.4 Explanation of Measures and Evaluation Efforts

HB 4002 (2024) outlines the data collection and evaluation requirements for BHD programs. The CJC partners with the OHSU-PSU School of Public Health (OHSU-PSU SPH) to manage the statewide data system for deflection, conduct data analysis, and engage with BHD programs for data-related technical assistance and data quality monitoring. Participant-level data for the BHD program is collected by local programs and reported in the statewide system built in REDCap® by the OHSU-PSU SPH. Data are intended to inform best practices, and this information can help programs improve outcomes for individual program participants.[29] This report contains information for county BHD programs; the CJC is working closely with tribal BHD programs and research partners at OHSU-PSU SPH to develop reporting requirements for when tribal BHD programs turn operational.

For county-led BHD programs, the statewide data system contains participant identifiers (e.g., name, date of birth), demographic characteristics, assessments and service provision, information on key points in the deflection process, and outcomes including pre/post social determinants of health measures at program entry and exit. Grantees enter data in real-time, as programs receive information about referrals to deflection and participant progress. The current report includes local county program data reported from September 1, 2024, through August 4, 2025. More detail is provided on these key points in the deflection process and outcomes throughout the remainder of this report.

In addition, the OHSU-PSU SPH published the "Oregon Behavioral Health Deflection Program Best Practices Report" in April 2025.[30] It includes a review of national literature and qualitative interviews with Oregon BHD county grantees to identify established and emerging best practices and how they relate to Oregon programs. Six core domains around the deflection process are discussed in detail in that report: coordinating agency, eligibility, deflection pathways, first point of contact, handoff to programs, and definitions of success.

HB 4002 (2024) directs the CJC to collect and analyze data relating to racial and other demographic disparities in enforcement. These data include locations of offenses, specific offenses, and demographic characteristics of those arrested, charged, or convicted for unlawful possession of a controlled substance and delivery of a controlled substance.[31] Beginning February 2026, the CJC shall make the results of this analysis available to the public in a clear and accessible format. In addition, the CJC shall produce the best practices and standards for deflection programs in Oregon based on information from the

[29] Oregon Laws 2024, chapter 70, sections 37, 75-76, available at https://olis.oregonlegislature.gov.
[30] Simeon, Suneson, Rainer, Haddeland, Hoover, Rowland, Taxman, Waddell, "Oregon Behavioral Health Deflection Best Practices Report."
[31] Oregon Laws 2024, chapter 70, section 75, available at https://olis.oregonlegislature.gov.

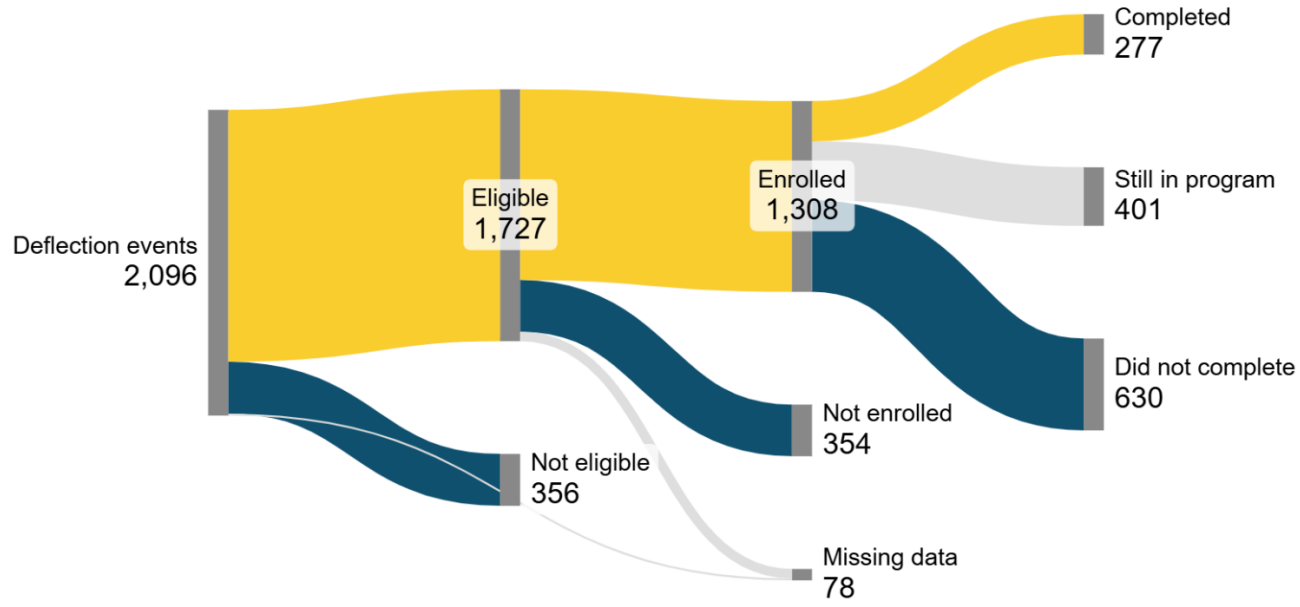
programs in February 2027.[32] Taken together, these efforts reflect substantive ongoing data and evaluation efforts for the BHD program at the local-program level and statewide.

3.5 BHD Participants Served

Each local BHD program sets specific eligibility and exclusion criteria and determines which deflection pathways are available. Key points exist in the programmatic flow – referral, eligibility and entry, assessment, service referral/receipt, and completion. Figure 3.4 below illustrates the flow of referred individuals as they progress through deflection programs statewide. More detailed data for each stage is provided below.

As of **August 4, 2025**, 2,096 deflection events have been recorded in the statewide data system. Of these, 1,727 individuals were determined to be eligible by a local program. 1,308 individuals entered a deflection program. Of those who entered a deflection program, 277 were completed successfully, 630 did not complete successfully, and 401 remain enrolled in a local program. These counts of deflection event entries and completions are updated monthly on the CJC's public-facing data dashboard.[33]

Figure 3.4 Deflection enrollment and completion patterns



Note: Supplementary data for Figure 3.4 provided in Technical Appendix, Table B.5.

[32] Oregon Laws 2025, chapter 557, section 12, available at https://olis.oregonlegislature.gov.

[33] Oregon Criminal Justice Commission, *Behavioral Health Deflection Programs Dashboard*, https://public.tableau.com/app/profile/cjcdashboards/vizzes (accessed October 24, 2025).

For each program, a breakdown of referrals, program qualification, program entry, and program completion are provided in Table 3.2 below. Deflection programs began operating at different points in time since September 2024, which is partly reflected in the variation in referral numbers. However, each county or consortium operates their deflection program, within their capacity, to meet the needs of their local jurisdiction.

Table 3.2 Number of program referrals and completions by program

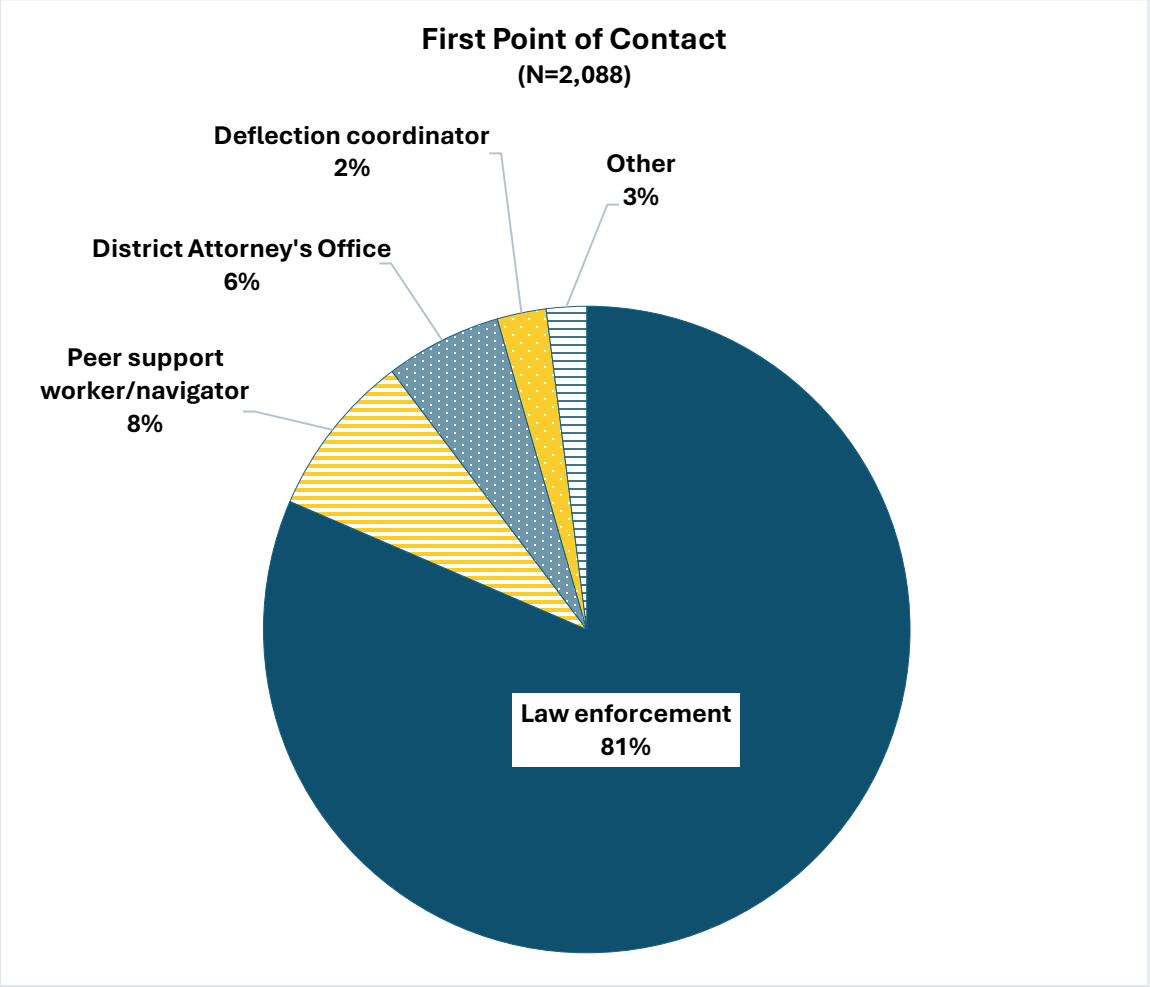
		Qualified for program			Entered program			Completed program		
County	**Referrals**	Yes	No	Total	Yes	No	Total	Yes	No	Total*
Baker	3	3	0	3	3	0	3	0	2	2
Benton	19	14	1	15	8	0	8	1	0	1
Clackamas	126	124	0	124	66	31	97	15	8	23
Clatsop	41	37	4	41	31	6	37	5	8	13
Columbia	3	3	0	3	2	1	3	1	0	1
Crook	25	17	8	25	9	8	17	0	4	4
Deschutes	79	79	0	79	70	9	79	28	18	46
Gilliam	2	2	0	2	2	0	2	1	0	1
Grant	4	1	3	4	0	1	1	0	0	0
Harney	11	10	0	10	10	0	10	2	3	5
Hood River/Wasco	5	4	1	5	4	0	4	0	1	1
Jackson	112	112	0	112	107	5	112	49	43	92
Josephine	83	82	1	83	81	1	82	28	45	73
Klamath	115	45	70	115	7	34	41	2	1	3
Lane	221	212	8	220	211	1	212	15	124	139
Lincoln	30	29	1	30	25	4	29	1	12	13
Linn	67	19	48	67	12	7	19	0	9	9
Malheur	7	5	2	7	5	0	5	1	3	4
Marion-LEAD	128	99	28	127	71	28	99	5	28	33
Marion-RESTORE	63	62	1	63	44	18	62	0	2	2
Morrow	0	0	0	0	0	0	0	0	0	0
Multnomah	568	519	49	568	359	160	519	89	222	311
Polk	33	20	13	33	2	4	6	2	0	2
Tillamook	0	0	0	0	0	0	0	0	0	0
Umatilla	38	26	12	38	14	10	24	4	5	9
Union	2	2	0	2	2	0	2	2	0	2
Washington	135	82	52	134	80	2	82	24	24	48
Yamhill	176	119	54	173	83	24	107	2	68	70
Total	**2096**	**1727**	**356**	**2083**	**1308**	**354**	**1662**	**277**	**630**	**907**

*The total includes individuals who have successfully completed a deflection program (Yes) and those who left the program prior to completion (No)

3.5.1 First point of contact

As BHD prioritizes Intercepts 0 and 1 in the SIM model described in Section 1 of this report, potential participants are most frequently encountered in the community. The "Deflection Best Practices Report" outlines the involvement of law enforcement or other first responders as the first point of contact (FPOC) to be a common practice nationwide.[34] This is seen in Oregon with law enforcement serving as the most common FPOC at 81 percent (see Figure 3.5 below). Peer support worker/navigators are the second most common FPOC (eight percent), followed by the District Attorney's Office (six percent).

Figure 3.5 Occupation of first point of contact with a potential participant



Note: Supplementary data for Figure 3.5 provided in Technical Appendix, Table B.6.

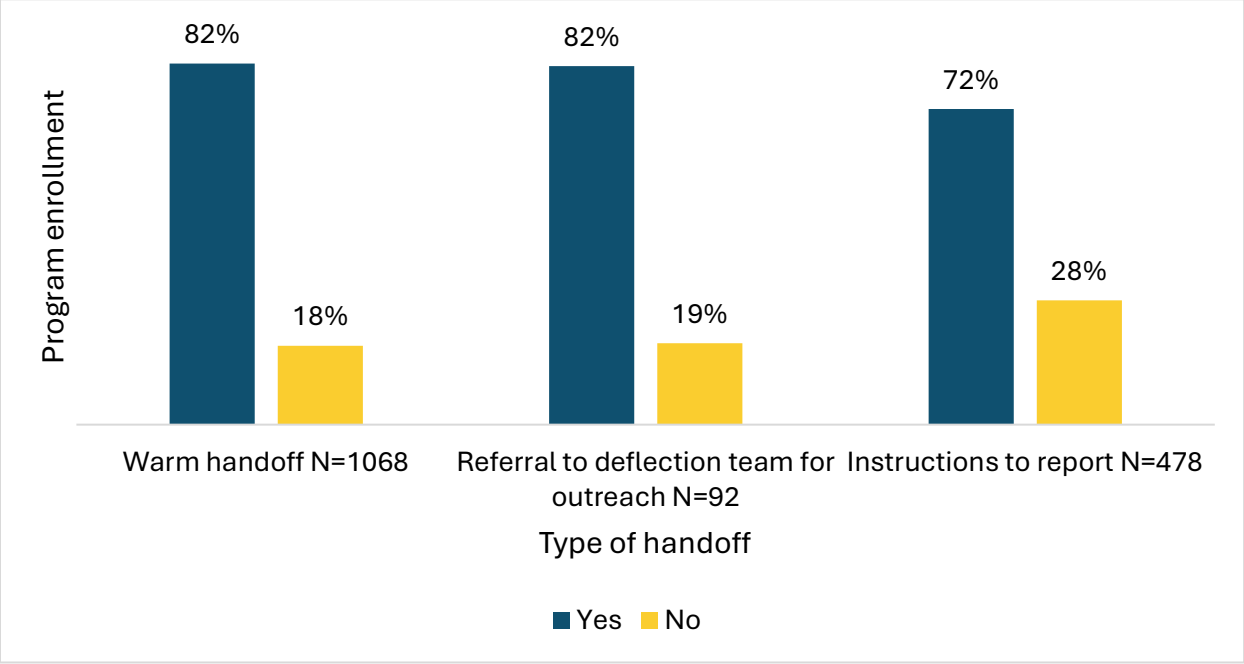
[34] Simeon, Suneson, Rainer, Haddeland, Hoover, Rowland, Taxman, Waddell, "Oregon Behavioral Health Deflection Best Practices Report."

3.5.2 Program handoff

As BHD programs aim to connect individuals to appropriate treatment and services, factors that affect the rate of program entry are important considerations. The "Deflection Best Practices Report" describes how 24/7 warm handoff availability has been cited as best practice for deflection and may improve the chance of individuals entering the program.[35]

Figure 3.6 below presents the percentage of eligible individuals who entered a program by type of handoff. Full details can be found in Table B.7 in the Technical Appendix. More than half of eligible individuals (65 percent) received some type of warm handoff, whether on scene with program staff or transportation by law enforcement to a drop off center. Almost one third (about 28 percent) received instructions to report to a particular location, such as court, often on a specific date. Roughly six percent received a referral to a deflection team for outreach, wherein the deflection team contacts the potential participant to consider program enrollment. Among those who received a warm handoff or a referral to a deflection team for outreach, 82 percent of individuals enrolled in a program. Among those who received instructions to report, 72 percent of individuals were enrolled.

Figure 3.6 Percentage of eligible individuals who entered a deflection program, by type of handoff (N=1638)



Note: Supplementary data for Figure 3.6 provided in Technical Appendix, Table B.7.

[35] Ibid.

3.5.3 Program eligibility

Each program establishes their own criteria for program entry as well as program exclusionary criteria. All programs screen referred individuals for program eligibility; however, this may occur at different stages. Reasons for program ineligibility are presented in Table 3.3 below. The most common reasons reported were not attending a court appearance (33 percent), prior disqualifying conviction (24 percent), and current community justice supervision (15 percent).

Table 3.3 Reasons people referred to deflection were not eligible for program entry

Reason for ineligibility (multiple response)	Count	Percent*
Did not attend court appearance	116	33%
Prior disqualifying conviction	87	24%
Community justice supervision	52	15%
Not a county resident	42	12%
Previous deflection involvement	26	7%
Other**	22	6%
Charged with other crime at time of deflection encounter	16	4%
Pending warrant	13	4%
Victim with potential restitution	1	0%
Don't know	7	2%
Total events reported	356	--

*Total percent may be greater than 100% due to multiple response items.
**Most of the "other" responses involve individuals with high acuity of some kind (e.g. criminal legal involvement, behavioral health needs, community safety hazard).

Nearly all county programs began implementation with limited participant eligibility criteria, such as only accepting those with standalone PCS charges, with the intent to assess capacity, gain buy-in, and potentially scale up operations by increasing eligibility criteria at a later date. It became clear through data reporting in the early months of implementation that referral numbers were lower than anticipated in some jurisdictions. Through technical assistance and inter-county collaboration, programs began to consider additional ways they could reach potential participants. By March 1, 2025, six months after the recriminalization of PCS, several county programs had expanded their eligibility criteria to include other PCS classifications, co-charges, or standalone quality of life crimes (Criminal Trespass II, Failure to Appear, Theft II, etc.), allowing for more potential deflection participants and fewer individuals being turned away from program entry. As BHD programs enter a new biennium of operation, many have further expanded their eligibility criteria and/or added accompanying referral pathways to their programs to try to reach more eligible individuals.

3.6 Characteristics of BHD Participants

Demographic information is collected by program staff for all individuals who are referred to a deflection program. Additional social determinants of health measures (e.g. housing, employment, food insecurity) are collected for those who are eligible and decide to enter programs. Most BHD referrals are male (58 percent), and gender identification is unknown in about eight percent of cases (see Table 3.4 below). Most BHD referrals are white (70 percent); about seven percent of referrals identified as Latino/a/x, while four percent of referrals each identified as American Indian or Alaska Native and Black or African American. The bulk of BHD referrals are adults between the ages of 26 and 54 (83 percent) with roughly equal percentages of referred individuals above and below this age range.

Table 3.4 Demographic characteristics of individuals referred to deflection

Demographic category	Count*	Percent**
Gender identification (multiple response)* **		
Male	1106	58%
Female	631	33%
Don't know	149	8%
Total reported	1901	--
Race/Ethnicity (multiple response)** **		
White	1336	70%
Latino/a/x	134	7%
Black or African American	80	4%
American Indian or Alaska Native	79	4%
Native Hawaiian or Pacific Islander	19	1%
Other	17	1%
Prefer not to answer	30	2%
Don't know	259	14%
Total reported	1901	--
Age group		
18 - 25	161	8%
26 - 34	644	34%
35 - 54	941	49%
55 - 64	140	7%
65 and older	31	2%
Total reported	1917	--

*Values less than 11 are censored but included in total counts.
**Total percent may be greater than 100% on multiple response items.
***Number of values censored: 14. Categories censored include - transgender man, transgender woman, non-binary, additional gender category, and prefer not to answer.
****Number of values censored: 4. Categories censored include - Asian and Middle Eastern/North African.

Housing is a prominent social determinant of health associated with known protective effects against recidivism, making housing supports an important inclusion in deflection program service offerings.[36] Upon enrollment, 64 percent of BHD participants were unstably housed (data not shown). Among participants for whom there is data, 38 percent were unsheltered, and 23 percent were living in a vehicle, tent or homeless shelter, which highlights the importance of access to housing supports for this population (see Table 3.5 below). Data related to housing is collected at program enrollment and completion. A comparative view of safe and stable housing at enrollment versus safe and stable housing at completion is provided later in the report.

Table 3.5 Housing situation at the time of deflection enrollment

Type of housing	Count	Percent
Unsheltered (or other place not fit for human habitation)	487	38%
Personal residence (house/apartment/dorm)	223	17%
Staying with friends or family (couch surfing)	153	12%
Living in a vehicle	127	10%
Living in a tent	105	8%
Homeless shelter	66	5%
Jail/correctional facility	25	2%
Transitional housing	21	2%
Hotel/motel	16	1%
Permanent supportive housing	8	1%
Other*	3	0%
Foster home/foster care	1	0%
Don't know	47	4%
Total events reported	1282	100%

* Other responses include residential treatment facility and transitional housing.

Nearly one in four participants is referred to housing assistance during their time in deflection programming (see Table 3.9 later in this report). Connection to housing – be it emergency, transitional, or long-term – can often be a critical first step towards stability which, in turn, aids in a path towards recovery. For individuals living with behavioral health conditions, stable housing can provide solid ground from which they can reliably connect to treatment and services while gaining self-sufficiency.

One particular deflection participant was houseless, sheltering in a tent, and living with an opioid use disorder when they encountered a patrol officer. That individual could have been arrested for PCS but, instead, the officer recognized them as a potential eligible candidate for their county's deflection program. The officer's referral deflected the

[36] Jon Ross and Bruce Taylor, "Designed to do good: Key findings on the development and operation of first responder deflection programs," *Journal of Public Health Management and Practice* 28, no. Supplement 6 (2022): S295-S301.

individual from the criminal legal system and, instead, linked them with a peer navigator who helped them connect to emergency housing and a residential treatment program. That individual recently graduated the county's deflection program in summer of 2025 and now lives in a recovery house, has reunited with their child, and is continuing to rebuild their life.[37]

3.7 Assessments and Behavioral Health among BHD Participants

Conducting behavioral health assessments is common in deflection programs nationwide and in Oregon.[38] Among deflection events where there is data, Table 3.6 below shows 46 percent of individuals received some type of mental health assessment and 33 percent received a physical health screening. Just under one third (32 percent) had an assessment classified as "other," which most often included a locally developed intake/screening tool.

Table 3.6 Screenings and assessments received by participants

Screening/assessment type (multiple response)	Count	Percent*
Mental health assessment	542	46%
Physical health screening	381	33%
Other assessment**	375	32%
SUD assessment	196	17%
Locally developed behavioral health assessment	10	1%
Social determinants of health screening	146	12%
No assessments administered	191	16%
Don't know	19	2%
Total events reported	1172	

*Total percent may be greater than 100% on multiple response items.

**Other assessment = most are a locally developed intake/screening tool.

Behavioral health conditions may be identified in a variety of ways other than formal assessments (e.g. self-report, previous documentation), which is illustrated by the fact that an SUD assessment was administered in just 17 percent of cases, but a substance use disorder was identified in 80 percent of cases where there is data (see Table 3.7 on the following page). While mental health disorders were identified in only 21 percent of cases, it is important to note that more than half were reported as not known.

[37] Ben Botkin, "A rebuilt life shows potential of Lane County deflection program," *Lookout Eugene-Springfield*, August 26, 2025, https://lookouteugene-springfield.com/story/government-politics/2025/08/26/in-lane-county-a-rebuilt-life-shows-the-potential-of-deflection-program/.

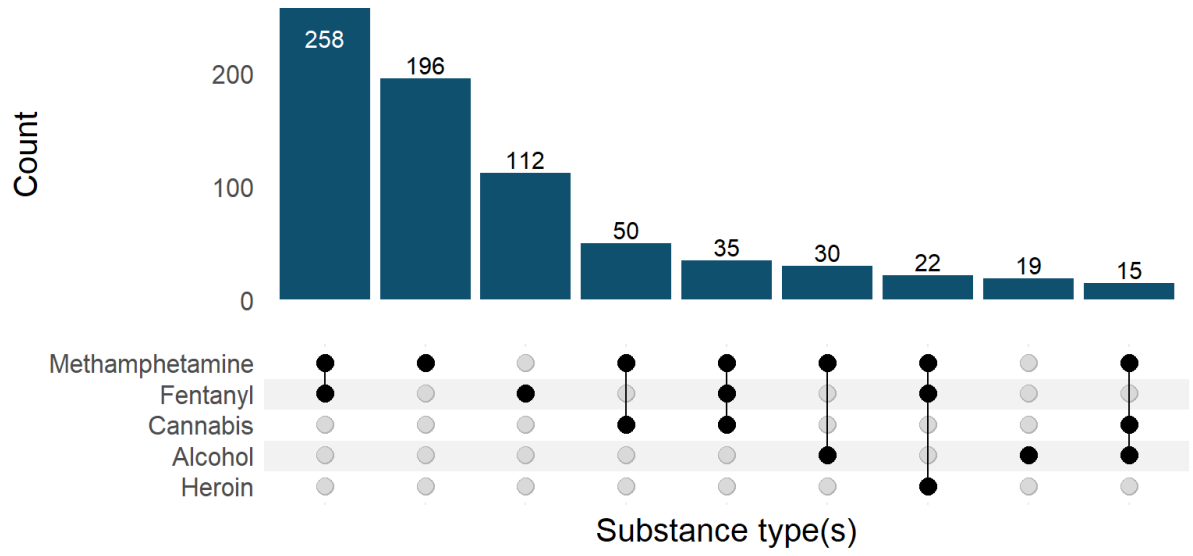
[38] Ross and Taylor, "Designed to do good: Key findings on the development and operation of first responder deflection programs," S295-S301.

Table 3.7 Behavioral health diagnoses for people enrolled in deflection

Behavioral health condition	Count	Percent
Was a substance use disorder identified?		
Yes	954	80%
No	18	2%
Don't know	214	18%
Total events reported	1,186	100%
Was a mental health disorder identified?		
Yes	247	21%
No	307	26%
Don't know	623	53%
Total events reported	1,177	100%

Among participants with a reported substance use disorder identified (N=949), the most common were methamphetamine (74 percent) and fentanyl (55 percent). Reports of heroin, cannabis, other opioids, or alcohol use disorders were quite low (see Technical Appendix, Table B.8). Sixty-one percent of those with at least one substance type reported (N=900) had multiple substances identified (data not shown). Figure 3.7 below summarizes the most common combinations of substances reported. Most often, methamphetamine and fentanyl are used together, followed by methamphetamine or fentanyl alone. There is a high prevalence of polysubstance use, most often methamphetamine with other drugs or alcohol.

Figure 3.7 Most common combinations of BHD participant substance use



Note: Supplementary data for Figure 3.7 provided in Technical Appendix, Table B.8.

Less data are available for mental health disorder diagnoses. However, among those for whom there is data, depression (44 percent), anxiety (42 percent), and trauma-related disorders (30 percent) were most frequent (see Table 3.8 below).

Table 3.8 Diagnosis type for participants with a mental health disorder

Mental health diagnosis (multiple response)	Count	Percent*
Depression	109	44%
Anxiety	104	42%
Trauma- and stressor-related disorder (includes PTSD)	73	30%
Other**	34	14%
Schizophrenia and other psychotic disorders (not substance-induced)	28	11%
Bipolar spectrum disorder	24	10%
Suicidal ideation/attempt/intentional self-harm	20	8%
Substance-induced psychosis	11	4%
Personality disorder	10	4%
Other mood disorder	6	2%
Don't know	21	9%
Total events reported	247	--

*Total percent may be greater than 100% on multiple response items.

**Other responses = ADD/ADHD and anger/rage disorders.

3.8 BHD Program Outcomes to Date

3.8.1 Service Provision among BHD Participants

Deflection participants receive service referrals based on their needs and assessment(s). Some participants receive more than one service referral. The general categories for services include SUD, mental health, culturally-specific care, and social services. Table 3.9 on the following page shows all service referrals, including counts in the second column, followed by the percentage of enrolled participants who were referred in the next column, and finally, subset counts of referred participants who received, who did not receive, and for whom receipt is unknown in the final columns. Among participants for whom there is data, 1,001 participants, or about 77 percent, were referred to at least one service. The most common services were in the SUD category: outpatient (39 percent), recovery support (33 percent), SUD counseling (27 percent), and detox/withdrawal management (25 percent).

Table 3.9 Referrals and services received by participants

Service type (multiple response)	Number of referrals	% enrolled referred* (N=1308)	Count		
			Referred/ Received	Referred/ Did not receive	Referred/ Don't know
Substance use disorder services					
Medically managed inpatient	85	6%	38	30	11
Detox/withdrawal management	331	25%	128	159	16
Residential facility	210	16%	59	119	13
Intensive outpatient	218	17%	122	56	16
Outpatient	504	39%	278	162	19
Medication for opioid use disorder	150	11%	101	24	7
Medication for alcohol use disorder	12	1%	11	0	2
Medication for stimulant use disorder	75	6%	57	12	3
SUD counseling	355	27%	277	47	16
Harm reduction	139	11%	122	8	6
Recovery support	435	33%	341	52	11
Mental health services					
Psychotherapy	15	1%	7	5	2
Mental health medication	44	3%	19	15	6
Hospitalization	7	1%	5	1	1
Mental health counseling	101	8%	63	26	8
Group therapy	41	3%	30	6	2
Culturally specific care					
Interpreter services	2	0%	2	0	0
Translated printed materials	2	0%	2	0	0
Language concordant care	3	0%	3	0	0
Culturally specific care	10	1%	8	1	1
Social services					
Housing supports	312	24%	184	84	21
Employment supports	65	5%	42	10	2
OHP enrollment	33	3%	27	3	1
SNAP enrollment/food assistance	57	4%	44	5	2
TANF enrollment	5	0%	2	0	0
At least one other service**	138	11%	109	13	0
Referred to at least one service	1001	77%	628	456	87

*This column indicates the percentage of people enrolled in deflection who were referred to each service. The total may be greater than 100% due to multiple response items.
**Other services = cell phone, transportation, document/legal assistance, and basic dental/medical needs.

3.8.2 Completion among BHD Participants

The length of time a participant is enrolled in a deflection program varies by program requirements. Some programs have a specified length of enrollment (e.g., 90 days) and/or other criteria to meet that are related to SUD treatment and criminal legal outcomes. Some of these criteria may be subjective assessments of an individual's progress, such as program engagement, changes in substance use, and quality of life.

Turning to specific program criteria in Table 3.10 below, most participants who successfully completed deflection had sufficient engagement with their treatment plan (99 percent) as deemed by deflection staff or behavioral health providers and completed an SUD assessment (62 percent), with other criteria being met in combination with these. Relatedly, when deflection is unsuccessful, the most common reason is a participant not engaging with their treatment plan (64 percent), followed by being lost to follow-up (46 percent), or voluntarily leaving the program (16 percent) (see Table 3.11 below).

Table 3.10 Criteria for successful completion of deflection programs

Program criteria (multiple response)	Count	Percent*
Substance use and treatment outcomes		
Sufficient engagement with treatment plan	271	99%
Completed an SUD assessment	171	62%
Reduction in substance use	44	16%
Increased harm reduction	14	5%
Criminal legal outcomes		
No new criminal activity	45	16%
Reduction in recidivism	25	9%
Completion of community service/restitution repayment	1	0.4%
Quality of life outcomes		
Improved quality of life (includes housing and employment)	46	17%
Reduction in hospital/ED visits	8	3%
Other	4	2%
Total events reported	275	--

*Total percent may be greater than 100% on multiple response items.

Table 3.11 Reasons why deflection program was not completed

Reason (multiple response)	Count	Percent*
Did not engage with treatment plan	402	64%
Lost to follow-up/unable to contact	291	46%
Voluntarily left program	99	16%
Substance use	44	7%
New criminal legal involvement	43	7%
Declined housing support	29	5%
Other	15	2%
Death (Not overdose related)	3	0.5%
Total events reported	630	

*Total percent may be greater than 100% on multiple response items.

Many factors may influence successful completion. Table 3.12 below presents some relevant programmatic factors – referral pathway, handoff type, and housing status – and how they relate to program completion. Counts are provided for the number of events in each category of referral, handoff and housing, and the corresponding percentage of deflections that were successful versus incomplete. Law enforcement intervention, by far the most common referral pathway, has a successful completion rate of 31 percent statewide. Higher percentages are seen in self-referrals and pathways classified as other; however, the numbers of events vary widely. As a result, these first-year findings cannot be generalized.

Handoff type is an important component of program engagement; the lowest rate of successful completion among handoff types was providing the individual with instructions to report to the deflection team (22 percent). Comparatively, higher completion rates are seen with those receiving a warm handoff (32 percent) or referral to a deflection team for team outreach to the participant (49 percent).

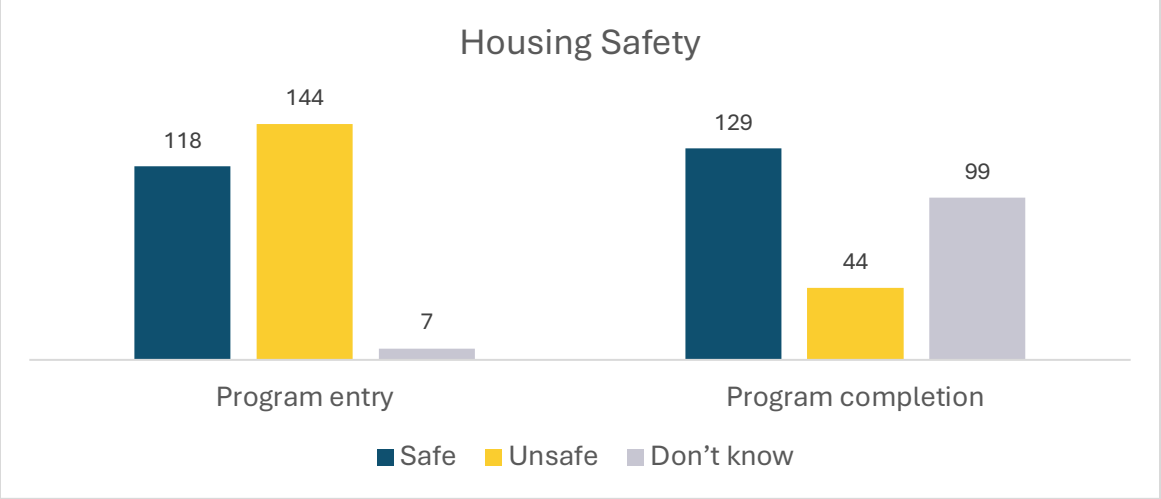
Table 3.12 Percent of successful deflections among individuals no longer enrolled

		% Successful completion	
	Total events	**Yes**	**No**
	907	31%	69%
Referral pathway (N=906)			
Other*	9	75%	25%
Self-Referral	10	50%	50%
Officer Intervention	813	31%	69%
Active Outreach	16	19%	81%
First Responder and Officer Prevention	58	16%	84%
Naloxone Plus	0	0%	0%
Handoff type (N=906)			
Referral to deflection team for outreach	35	49%	51%
Other	5	40%	60%
Warm handoff	671	32%	68%
Instructions to report	195	22%	78%
Stable housing at deflection (N=905)			
Yes	192	45%	55%
No	614	30%	70%
Don't know	99	7%	93%
Safe housing at deflection (N=907)			
Yes	288	42%	58%
No	505	29%	71%
Don't know	114	9%	91%

*Other responses = Community response and community referrals

Higher completion rates are also seen for participants who have safe (45 percent) and/or stable (42 percent) housing when they enter a deflection program indicating the supportive role that housing status can play in recovery. Housing is a prominent need for deflection participants, and many programs include some type of housing component to reduce barriers to treatment and program completion.

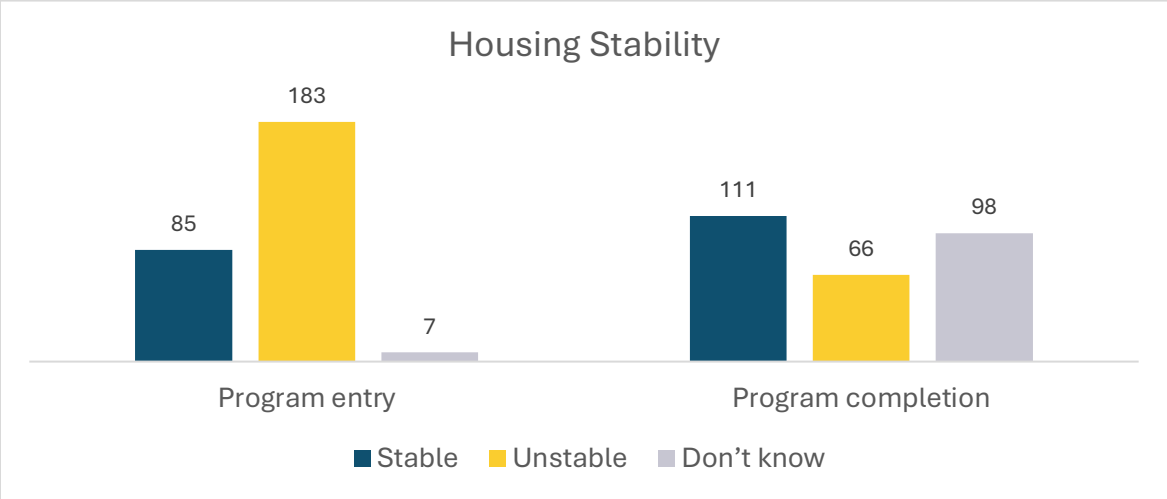
Figure 3.8 Safe housing, among participants who successfully completed deflection



Note: Supplementary data for Figure 3.8 provided in Technical Appendix, Table B.9.

Among participants successfully completing deflection, housing status is measured both at enrollment and at completion to assess any changes over time. The number of participants reporting safe housing at deflection increased from 118 to 129 at completion, and the number of participants with unsafe housing decreased from 144 to 44 (see Figure 3.8 above).

Figure 3.9 Stable housing, among participants who successfully completed deflection



Note: Supplementary data for Figure 3.9 provided in Technical Appendix, Table B.10.

Stable housing showed similar results – increasing from 85 at deflection to 111 at completion (see Figure 3.9 on the previous page). Unstable housing decreased from 183 to 66. While there is a trend for improvement in housing status for deflection participants, these preliminary data are descriptive and do not adjust for multiple factors that could also influence housing status. In addition, the number of unknowns increased substantially from program entry to completion.

4 Conclusion

The IMPACTS and BHD programs share a central objective to connect individuals with behavioral health needs to community-based treatment and services in order to reduce their involvement with the criminal legal system. However, while several goals of these programs align, their target populations and operational approaches differ in meaningful ways and reflect varied stages of system engagement and levels of need and acuity among participants. IMPACTS programs primarily serve high utilizers – individuals with high risk and high acuity who are deeply entrenched in the criminal legal and emergency healthcare systems – and intervene across all SIM intercepts, from crisis response and jail bookings to community reentry.

In contrast, BHD programs emphasize early intervention, engaging individuals at the earliest possible points of contact with law enforcement or crisis response and connecting them to services to prevent further system involvement. This distinction in timing and approach highlights the complementary nature of these two behavioral health initiatives: while BHD programs aim to deflect individuals before entering the criminal legal system, IMPACTS programs work to stabilize and support those who may already be moving through it.

Despite differences in target populations and points of entry, the individuals served by IMPACTS and BHD programs overlap with many key demographic and behavioral health characteristics, as well as share challenges such as unstable housing and high rates of substance use. Nearly half of the participants in both programs are between the ages of 35-54, commonly reporting polysubstance use and living with substance use disorder, mental health disorder, or co-occurring disorders.

Housing stability stands out as one of the most important factors in participant success across both programs and often correlates with higher engagement and completion rates. IMPACTS participants typically face more severe behavioral health conditions, including higher rates of mental illness and co-occurring disorders, and often require multiple attempts at engagement, whereas BHD participants require more timely intervention and connection to care through warm handoffs at the earliest possible intercept.

Together, these programs create a more comprehensive continuum of care and a greater range of intervention points for some of Oregon's most vulnerable populations at risk of

further involvement with the criminal legal and emergency healthcare systems. By meeting individuals where they are – whether during a moment of crisis or at the point of reentry into a community – and connecting them to needed treatment, supports, and services, these programs collectively bolster the state's capacity to improve public safety, reduce recidivism, and create opportunities for better health outcomes. The continued support, development, and evaluation of both the IMPACTS and BHD programs remain essential to advancing an integrative, evidence-informed approach to improving behavioral health and criminal legal outcomes statewide.

5 Appendices

A. Appendix

Table A.1 2019-2025 Funded IMPACTS Grantee Programs

Grantee Name	Total Award To-Date
Clackamas County	$983,396
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians	$400,805
Confederated Tribes of Grand Ronde	$1,228,059
Confederated Tribes of Warm Springs	$498,575
Cow Creek Band of Umpqua Tribe of Indians	$818,440
Deschutes County	$6,411,781.57
Douglas County	$4,263,337
Hood River County	$212,756
Klamath Tribes	$1,448,437
Lane County	$4,237,309
Lincoln County	$803,390
Multnomah County	$1,884,778
Umatilla County & Morrow County*	$962,808
Union County	$1,172,571
Wasco County	$374,566

* Regional Consortium

Table A.2 2023-2025 Funded BHD County Grantee Programs

Grantee Name	Total Award
Baker County	$150,000
Benton County	$258,430
Clackamas County	$1,060,853
Clatsop County	$453,888
Columbia County	$264,572
Crook County	$150,000
Deschutes County	$844,514
Gilliam County	$150,000
Grant County	$150,000
Harney County	$150,000
Hood River County & Wasco County*	$304,150
Jackson County	$1,281,288
Josephine County	$788,274
Klamath County	$412,114
Lane County	$2,120,517
Lincoln County	$341,256
Linn County	$531,486
Malheur County	$150,000
Marion County	$1,472,711
Morrow County	$150,000
Multnomah County	$4,313,852
Polk County	$239,314
Tillamook County	$163,548
Umatilla County	$390,303
Union County	$150,000
Washington County	$1,504,885
Yamhill County	$541,450

* Regional Consortium

Table A.3 2023-2025 Funded BHD Tribal Grantee Programs

Grantee Name	Total Award
Confederated Tribes of Coos Lower Umpqua and Siuslaw Indians	$184,702
Confederated Tribes of Grand Ronde	$404,726
Confederated Tribes of Siletz Indians	$431,474
Confederated Tribes of Umatilla Indian Reservation	$324,586
Confederated Tribes of Warm Springs Reservation	$423,884
Klamath Tribes	$301,452

B.Technical Appendix

Table B.1 Types of mental health disorders reported for IMPACTS participants at baseline

Mental health disorder type(s)	Count	Percent
Trauma- and stressor-related disorder (includes PTSD)	385	38%
Depression	367	37%
Anxiety	337	34%
Schizophrenia and other psychotic disorders (not substance-induced)	237	24%
Bipolar spectrum disorder	172	17%
Do not know	131	13%
Other	125	12%
Other mood disorder	49	5%
Suicidal ideation/attempt/intentional self-harm	47	5%
Personality disorder	45	4%
Substance-induced psychosis	45	4%
Total participants reported	**1,003**	--

*Total percent may be greater than 100% on multiple response items.

Table B.2 Types of substance use disorders reported for IMPACTS participants at baseline

Substance use disorder type(s)	Count	Percent
Methamphetamine	588	58%
Alcohol	466	46%
Cannabis	244	24%
Fentanyl	176	17%
Other amphetamine/stimulant	104	10%
Other Opioid	94	9%
Heroin	84	8%
Do not know	70	7%
Other	54	5%
Total participants reported	**1008**	--

*Total percent may be greater than 100% on multiple response items.

Table B.3 Number of public safety and health system encounters/admissions in year prior to program engagement

Encounter type(s)	Valid N	Minimum	Maximum	Mean	Median	Mode	Sum	Standard Deviation
# of jail bookings	827	1	24	4.0	3.0	2	3,304	2.98
# of local law enforcement encounters	609	1	50	4.6	3.0	1	2,802	4.98
# of emergency department visits	484	1	57	5.1	2.0	1	2,467	7.18
# of months on parole or probation	453	1	12	8.8	12.0	12	3,985	4.58
# of hospital admissions	199	1	12	2.3	1.0	1	453	2.16
# of inpatient MH service encounters	143	1	10	1.8	1.0	1	259	1.66
# of inpatient SUD service encounters	134	1	12	1.5	1.0	1	198	1.35
# of prison incarcerations	129	1	12	1.4	1.0	1	179	1.79
# of stabilization or crisis center encounters	107	1	365	10.3	2.0	1	1,099	37.11
# of state hospital admissions	76	1	2	1.1	1.0	1	82	0.27

Table B.4 Deflection pathways utilized statewide

Pathway type(s)	Count	Percent
Officer Intervention	1,773	85%
First Responder and Officer Referral	150	7%
Other*	59	2%
Active Outreach	56	3%
Self-Referral	40	2%
Naloxone Plus	2	0%
Total	**2,080**	**100%**

*Other responses = District Attorney referrals, community response, and community referrals

Table B.5 Deflection enrollment and completion patterns

	Count
Did they qualify for the deflection program?	
Yes	1727
No	356
Missing	13
Total	2096
Did they agree to enter the deflection program?	
Yes	1308
No	354
Missing	65
Total	1727
Did the participant complete deflection?	
Yes	277
No	630
Total	907
Currently enrolled	401

Table B.6 Occupation of first point of contact with a potential BHD participant

Occupation of first point of contact	Count	Percent
Law enforcement	1,693	81%
Peer support worker/navigator	171	8%
District attorney's office	121	6%
Deflection coordinator	51	2%
Other (includes categories below)	52	3%
Jail staff	13	1%
Social worker	12	1%
Multi-disciplinary deflection response team	7	0%
Other	6	0%
Community corrections staff	5	0%
Case manager	4	0%
First responder (EMS, Fire)	3	0%
Mobile Crisis/Crisis Response Team	1	0%
Behavioral Health treatment provider	1	0%
Total	**2,088**	**100%**

Table B.7 Number and percentage of eligible individuals who entered a deflection program, by type of handoff

	Did they agree to enter the deflection program?					
	Yes		No		**Total**	
	Count	Percent	Count	Percent	Count	Percent
Instructions to report	343	72%	135	28%	478	29%
Referral to deflection team for outreach to participant	75	82%	17	18%	92	6%
Warm handoff	876	82%	192	18%	1,068	65%
Total	1,294	79%	344	21%	**1,638**	**100%**

Table B.8 Types of substance use disorders reported for BHD participants

Substance use disorder type(s)	Count	Percent
Methamphetamine	700	74%
Fentanyl	520	55%
Cannabis	165	17%
Alcohol	114	12%
Heroin	58	6%
Do not know	49	5%
Other amphetamine/stimulant	39	4%
Other opioids	36	4%
Other	24	3%
Total participants reported	**949**	--

*Total percent may be greater than 100% on multiple response items.

Table B.9 Safe housing, among BHD participants who successfully completed deflection

	Is their housing situation safe at completion?			
Is their housing situation safe at deflection?	No	Yes	Do not know	**Total**
No	34	51	59	**144**
Yes	10	74	34	**118**
Do not know	0	4	6	**10**
Total	**44**	**129**	**99**	**272**

Table B.10 Stable housing, among BHD participants who successfully completed deflection

	Is their housing situation stable at completion?			
Is their housing situation stable at time of deflection?	No	Yes	Do not know	**Total**
No	57	54	72	**183**
Yes	9	54	22	**85**
Do not know	0	3	4	**7**
Total	**66**	**111**	**98**	**275**