Behavioral Health Initiatives Report

Per House Bill 3069 (2025)

November 1, 2026

Oregon Criminal Justice Commission

CJC Authors
William Ash-Houchen, Senior Research Analyst
Kim Phillips, Senior Research Analyst
Kaysea Beck, Behavioral Health Program Manager
Monica Benton, Research Analyst
Avery Sorensen, Operations and Policy Analyst
Jamie Pryde, Program Analyst
Lindsey Phillips, Program Analyst

OHSU-PSU SPH Authors
Elizabeth Needham Waddell, PhD
Sara Rainer, MPH
Erika Simeon, MPH
Alicia Feryn, MS

Ryan Keck
Executive Director

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) 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, the two programs are separate and distinct, each with its own goals, priorities, target populations, strategies for intervention, and outcome measures.

House Bill 3069 (2025) refined both grant programs, but initially the Oregon Legislature established the IMPACTS grant program 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] The Oregon Legislature subsequently established the BHD grant program in 2024 through House Bill 4002 to create community-based linkages to treatment and recovery services for individuals who may have substance use disorder and other behavioral health needs and who have heightened risk of entering the criminal legal system. [2]

For both grant programs, funding is available to Oregon counties and federally recognized Tribal governments. In the 2025-27 grant cycle, IMPACTS grant recipients represented 12 counties across the state and 4 federally recognized Tribal governments, and BHD grant recipients represented 27 counties and 8 federally recognized Tribal governments. The aim of each program is to serve individuals with behavioral health needs at various intercepts with the criminal legal system, thereby improving participants' health and legal outcomes. The outcomes explored in this report show how each grant program serves as a unique public safety intervention and the results of the interventions to date.

Key Findings:

Participants of both IMPACTS and BHD have complicated behavioral health service needs. *For both programs, co-occurring mental health and substance use disorders were common (56% in IMPACTS; 28% in BHD). The most used substance for IMPACTS enrollees (59%) was methamphetamine, followed by alcohol (44%). Methamphetamine was also the most frequently used substance by participants with a substance use disorder served by the BHD program (79%), followed by fentanyl (54%), and with 30% of participants using both. For IMPACTS enrollees with a mental health disorder, depression (34%) was often*

[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.

reported, as were trauma-related disorder (33%) and anxiety (32%). For BHD participants, depression (49%) and anxiety (47%) were reported most often.

The programs connect with participants at different points in the public safety continuum, with IMPACTS operating at several intercepts and BHD focusing on criminal legal system avoidance. *IMPACTS reaches individuals most often through jail (29%), behavioral health program referrals (17%), Community Corrections (14%), and law enforcement drop-off or referral (13%). For BHD, the law officer intervention pathway accounted for 73% of all deflection referrals; and, among all referrals to deflection, 68% occurred on the street or "on view," most often via law enforcement contact (71%).*

IMPACTS addresses unnecessary emergency healthcare utilization and criminal legal system involvement. *About 60% of participants reported a jail booking in the year prior to IMPACTS enrollment. Participants had an average of 2.7 jail bookings in the 12 months prior to IMPACTS, and among participants with 12 to 18 months of follow-up engagement, the average number of jail bookings since enrollment was 1.8. About 34% of participants reported an emergency department admission in the year prior to enrollment, and, of those with 12 to 18 months of follow-up engagement, 41% of participants had any admissions.*

BHD links individuals at risk of entering the criminal legal system to needed treatment and services. *Of all referrals to the program, 84% of deflection events were in response to a law enforcement encounter in which the participant would have faced a criminal charge (PCS only = 60%; no PCS charge but a quality-of-life charge = 5%; both PCS and quality of life or other co-charge = 8%). Among deflection events with completed service information, 58% of participants who entered the program received treatment for substance use disorder, and 11% received mental health treatment.*

Both IMPACTS and BHD participants engage in services designed to improve individual outcomes and quality of life. *For IMPACTS, both at enrollment and in the months of follow-up engagement, case management, peer support services or outreach, and care coordination were received most often by participants. For BHD, among the 940 deflection events in which participants completed the program, 865 (92%) experienced at least one identified need relating to housing, employment status, access to health care, or food security at the time of program entry. At program completion, improvement in one or more of these quality-of-life indicators was reported for 60%. Improvements to the housing situation was reported for more than 300 participants, 192 had reduced medical needs, 173 improved their employment status, and 137 had more food security.*

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.

Table of Contents

Executive Summary 2
Table of Contents 4
Table of Tables 5
Table of Figures 6
1. Introduction – Behavioral Health Initiatives 7
2. IMPACTS 9
2.1 Purpose of the Program 9
2.2 Funded Counties and Tribal Governments 9
2.3 IMPACTS Participants Served 11
2.4 IMPACTS Program Outcomes to Date 18
3. Behavioral Health Deflection 23
3.1 Purpose of the Program 23
3.2 BHD-Funded Counties and Tribal Governments 23
3.3 BHD Participation 26
3.4 Deflection Program Entry 28
3.5 BHD Participant Demographics and Housing 37
3.6 Assessments and Diagnoses among BHD Participants 39
3.7 Services Received by BHD Participants 43
3.8 Key Outcomes among Deflection Participants 45
4. Conclusion 50
A.1 2025-27 IMPACTS Funding by Program 51
A.2 IMPACTS Evaluation Data Notes 52
Appendix B: BHD Supplemental Information 53
B.1 2025-27 BHD County Funding by Program 53
B.2 2025-27 BHD Tribal Funding by Program 54
B.3 BHD Evaluation Data Notes 54
B.4 BHD Service Referrals and Outcomes 55

Table of Tables

Table 2.1. How Participants Connected to IMPACTS 11
Table 2.2. IMPACTS Participant Demographics at Program Entry 12
Table 2.3. Living Arrangements at IMPACTS Program Entry 13
Table 2.4. IMPACTS Participant Behavioral Health Conditions at Program Entry 14
Table 2.5. Type of Mental Health Disorder among IMPACTS Participants with MHD 15
Table 2.6. Type of Substance Use Disorder among IMPACTS Participants with SUD 16
Table 2.7. Public Safety and Health System Encounters in Year before IMPACTS 17
Table 2.8. Pattern of IMPACTS Participant Engagement 18
Table 2.9. Services Delivered to IMPACTS Participants 20
Table 2.10. IMPACTS Participants Diverted Once or More from Jail, Emergency Department, or Oregon State Hospital 21
Table 2.11. Number of Participants with Any Jail Bookings and Emergency Department Visits Before and During IMPACTS 22
Table 3.1. Deflection Events and Progression by County Program 27
Table 3.2. Description of Nationally-Recognized Deflection Pathways 28
Table 3.3. Officer Intervention Pathway: Program Eligibility and Entry by Handoff Type 31
Table 3.4. Active Outreach Pathway: Program Eligibility and Entry by Handoff Type 32
Table 3.5. First Responder and Officer Referral Pathway: Program Eligibility and Entry by Handoff Type 33
Table 3.6. Self-Referral Pathway: Program Eligibility and Entry by Handoff Type 34
Table 3.7. Criminal Charges at Time of Deflection Referral 35
Table 3.8. Reasons Potential Participants were Determined Ineligible for Deflection 36
Table 3.9. BHD Participant Demographics 37
Table 3.10. Participant Perceptions of Housing Stability and Safety at Program Entry 38
Table 3.11. Assessments and Screenings Provided to BHD Participants 39
Table 3.12. Behavioral Health Diagnoses among BHD Participants 39
Table 3.13. Type of Substance Use among BHD Participants with SUD 41
Table 3.14. Type of Mental Health Disorder among BHD Participants with MHD 42
Table 3.15. Services Most Commonly Received by BHD Participants 44
Table 3.16. Reasons Referred Services Not Received 45
Table 3.17. Criteria Most Frequently Satisfied to Complete a Deflection Program 46
Table 3.18. Reasons for Deflection Program Non-Completion 47
Table 3.19. Improvements in Social Determinants of Health among Participants who Completed Deflection 48
Table 3.20. Improvements among Participants with Incomplete Deflection Events 49

Table of Figures

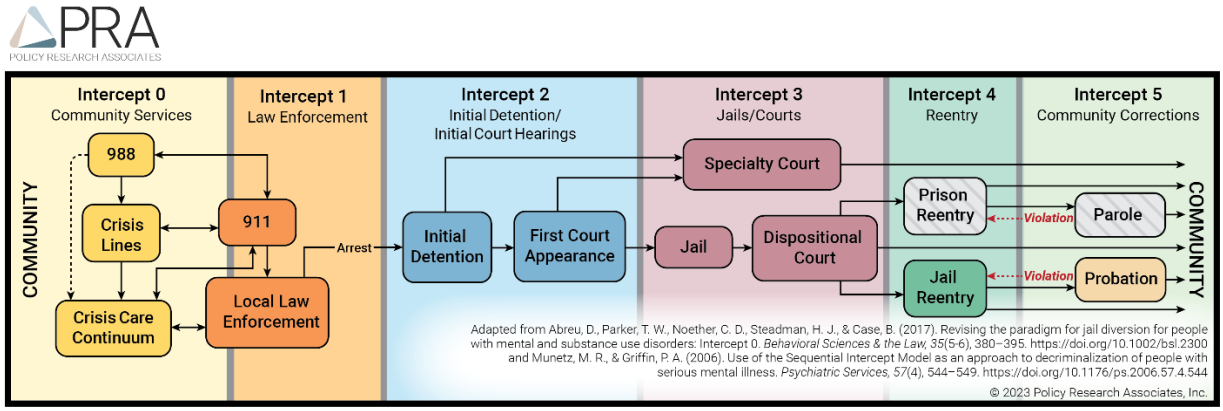
Figure 1. Sequential Intercept Model (SIM) 7
Figure 2. Map of Counties Receiving IMPACTS Funding in 2025-27 10
Figure 3. Map of Tribal Governments Receiving IMPACTS Funding in 2025-27 11
Figure 4. Most Common Living Situations at Time of IMPACTS Engagement 13
Figure 5. Type of Mental Health Disorder among IMPACTS Participants 15
Figure 6. Type of Substance Use Disorder among IMPACTS Participants 16
Figure 7. IMPACTS Participants Diverted Once or More from Jail, Emergency Department, or Oregon State Hospital 21
Figure 8. Map of Counties Receiving BHD Funding During the Reporting Period 24
Figure 9. Map of Tribal Governments Receiving BHD Funding in 2025-27 25
Figure 10. Progression of Participants through Deflection Events 26
Figure 11. Deflection Pathways Used Statewide 29
Figure 12. Location and First Point of Contact at BHD Referral 29
Figure 13. Handoff Type Used at Referral 30
Figure 14. Officer Intervention Pathway 31
Figure 15. Active Outreach Pathway 32
Figure 16. First Responder and Officer Referral Pathway 33
Figure 17. Self-Referral Pathway 34
Figure 18. Most Common Living Situations of at Time of Deflection Entry 38
Figure 19. Type of Substance Use Disorder among BHD Participants 41
Figure 20. Type of Mental Health Disorder among BHD Participants 42
Figure 21. Change in Living Situation from BHD Program Entry to Program Completion 48

1. Introduction – Behavioral Health Initiatives

Among the public safety grant programs that the Oregon Criminal Justice Commission (CJC) administers to improve the legitimacy, efficiency, and effectiveness of state and local criminal legal systems are two behavioral health initiatives: Improving People's Access to Community-based Treatment, Supports and Services (IMPACTS) and Oregon Behavioral Health Deflection (BHD). Both IMPACTS and BHD focus on individuals at the intersection of behavioral health and the criminal legal system, and each has distinct goals, priorities, target populations, strategies for intervention, and outcome measures.

The IMPACTS grant program targets individuals with behavioral health conditions who are high utilizers of criminal legal and emergency healthcare resources and provides them with community-based treatment, supports, and services. The goal is to reduce unnecessary frequent utilization of criminal legal and emergency healthcare resources. In contrast, the BHD grant program assists individuals suspected of or found in possession of user amounts of controlled substances by providing linkages to community-based services for substance use and mental health before they enter the criminal legal system.

Figure 1. Sequential Intercept Model (SIM)



Both of these behavioral health initiatives can be conceptualized using the Sequential Intercept Model (SIM), which maps how individuals with mental health and substance use disorders enter and move through the criminal legal system. [3] As shown in Figure 1, the model includes six intercepts, from Intercept 0 (Community Services) to Intercept 5 (Community Corrections and Reentry). Each intercept involves specific strategies to intervene or deflect individuals from the criminal legal system and support treatment and community (re)integration. Communities may use the SIM to visualize their criminal legal

[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).

and behavioral health systems and to identify service gaps, available resources, and opportunities to promote the use or expansion of evidence-based interventions. [4]

BHD takes place primarily at Intercept 0 and 1 with some extension into Intercept 2 among specific local program models in Oregon. The target population is individuals with behavioral health needs and low to moderate criminal risk. Individuals may be referred to the program during initial encounters with law enforcement, or they may be referred or self-refer as a preventive measure to avoid an emerging risk of criminal legal involvement. Importantly, BHD programs are intended to deflect individuals before any charges are filed.

IMPACTS targets higher need individuals, intervening with high system utilizers at every possible intercept. This includes, at Intercepts 2 through 5, strategies such as screening for behavioral health conditions at jail bookings, intensive case management and navigation through treatment courts, jail in-reach and reentry transition planning, and specialized community supervision.

Often at different stages and using distinct strategies to reach and serve individuals, the IMPACTS and BHD programs across the state help improve outcomes for Oregonians. This report satisfies the requirements set forth by the Oregon Legislature in House Bill (HB) 3069 (2025) to describe the outcomes of the IMPACTS program and BHD program, respectively.

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

2. IMPACTS

2.1 Purpose of the Program

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.

Individuals with a behavioral health condition who are high utilizers of criminal legal or emergency healthcare resources are the eligible target population of this grant. IMPACTS grant programs aim to reduce high utilizers' involvement with the criminal legal system and emergency medical services, including institutional healthcare placements, by increasing the availability of community-based supports and services.

Local IMPACTS programs vary widely in their implementation, including approaches for identifying eligible participants, engagement goals and strategies, and evidence-based services directly provided by program staff or referred out to local partners. This section of the report shares findings from grant recipient data reporting for IMPACTS participants served between July 1, 2023, and June 29, 2026.

In Practice

Examples of IMPACTS program implementation are included throughout the report in blue text boxes labeled "In Practice." These excerpts are drawn from program semi-annual reports and highlight illustrative program and participant experiences.

2.2 Funded Counties and Tribal Governments

The IMPACTS grant program received $10 million in the 2025 legislative session for use in the 2025–2027 biennium. The program has previously received a $10 million appropriation for each biennium consecutively, beginning in the 2019–2021 biennium. The project period for programs funded by the 2023-2025 appropriation extended through the end of December 2025, and a new solicitation process was completed to award available IMPACTS grant funds for the 2025-2027 biennium. The total amount of available funds for use in the 2025–2027 biennium was $11,118,000, including the 2025–2027 legislative appropriation and carryover funds from the 2023-2025 biennium. Less the 3% that, per

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

statute, was allocated to research and evaluation, there remained $10,784,160 available to applicants through a competitive process. After inviting consultation and input from Oregon's federally recognized Tribal governments in November 2025, the IMPACTS Grant Review Committee (GRC) met in December 2025 to determine that a minimum of ten percent of available funds would be set aside for Tribal applicants, matching that of each previous IMPACTS solicitation.

Two solicitations for grant applications were released in December 2025: one open to Oregon's federally recognized Tribal governments and one open to county governments. In total, four applications were received from Tribal governments and 11 were received from county governments, including a regional consortium application representing two counties. The total amount of funding requested exceeded what was available by approximately $3.98 million.

When the IMPACTS GRC convened in March 2026, funding requests from the four Tribal governments were awarded in full, and a 29.5% reduction was applied proportionally to funding requests received from county governments. The project period during which grant recipients may use these funds extends back to July 1, 2025, through September 30, 2027, aligning the IMPACTS grant program project period with that of other CJC grant programs funded during the 2025–2027 biennium. See Appendix A, Table A-1, for a table of the currently funded programs.

There are 15 IMPACTS high utilizer grant programs operating across the state, serving four of Oregon's federally recognized Tribes and 12 counties. Figures 2 and 3 represent where these programs currently operate, noting that Tribal jurisdictions are complex and cannot be accurately delineated by colonial-defined county boundaries.

Figure 2. Map of Counties Receiving IMPACTS Funding in 2025-27

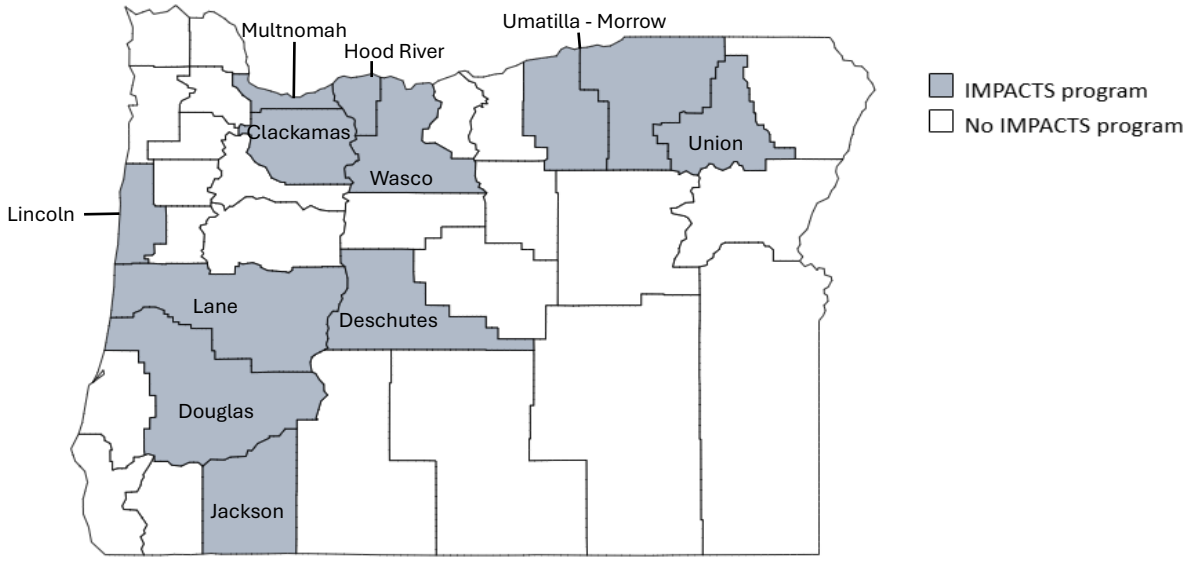
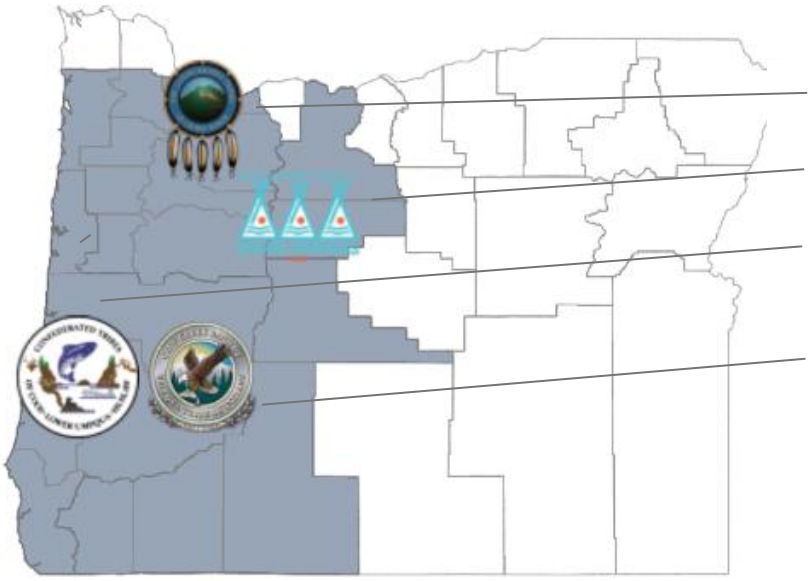


Figure 3. Map of Tribal Governments Receiving IMPACTS Funding in 2025-27



- Confederated Tribes of Grand Ronde
- Confederated Tribes of Warm Springs
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Cow Creek Band of Umpqua Tribe of Indians

Note. Participant data from Klamath Tribes, previously funded by IMPACTS, is included in this report.

2.3 IMPACTS Participants Served

Table 2.1 demonstrates the numerous ways in which local IMPACTS programs connect with participants. Most often, participants are reached through jail (29%), behavioral health program referrals (17%), Community Corrections (14%), and law enforcement drop-off or referral (13%).

Table 2.1. How Participants Connected to IMPACTS

Point of connection	Number	Pct
Jail	528	29%
Behavioral health program referral	307	17%
Community Corrections	259	14%
Law enforcement drop-off or referral	241	13%
Walk-in	224	12%
Community outreach	206	11%
Word of mouth or family referral	145	8%
Court	120	7%
Hospital	58	3%
Emergency department	45	2%
Prison	37	2%
Other	147	8%
Unknown	8	<1%
Total	**1,824**	**100%**

Note. Categories are not mutually exclusive; participants could connect through multiple avenues.

In Practice

Housing Need in IMPACTS

"The biggest need, from our team's perspective, is for places of residential care [and] support that are of low-to-middle intensity (i.e., adult foster homes, residential treatment homes, etc.) that are not secure or medically staffed but can provide ongoing support for persons with chronic severe mental illness (like schizophrenia)."

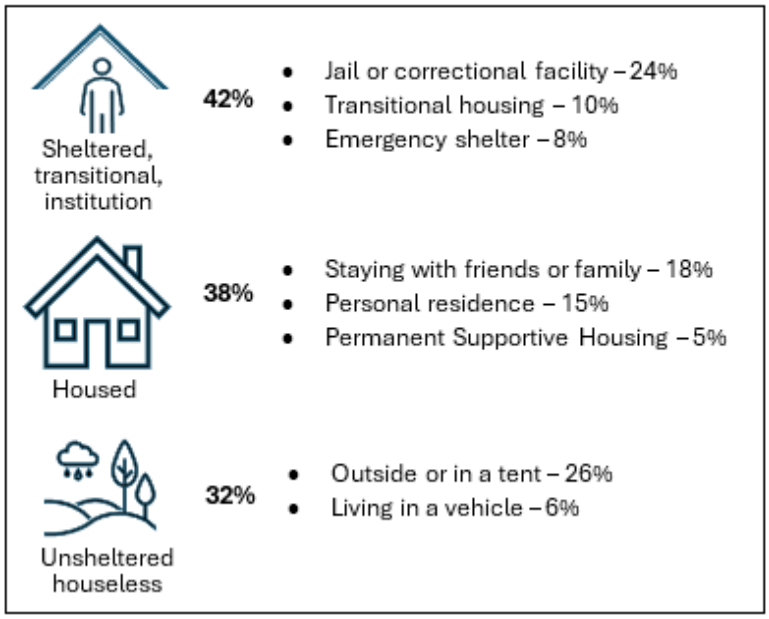
Table 2.2 summarizes demographic information for IMPACTS participants. Almost half (49%) of participants are aged between 35-54 years, and another 28% are 25-34 years. Two-thirds (67%) of participants are male. About 62% of participants are White, and 25% of participants are American Indian or Alaska Native.

Table 2.2. IMPACTS Participant Demographics at Program Entry

Demographic	Number	Pct
Age		
Under 25	148	8%
25 - 34	516	28%
35 - 54	893	49%
55 - 64	209	11%
65 and older	47	3%
Unknown	11	1%
Sex		
Male	1,220	67%
Female	593	33%
Unknown	11	1%
Race and ethnicity		
American Indian or Alaska Native	458	25%
Asian	14	1%
Black or African American	135	7%
Hispanic or Latino	84	5%
Native Hawaiian or Pacific Islander	19	1%
White	1,138	62%
Another race	20	1%
Unknown	30	2%
Total	**1,824**	**100%**

Note. Race and ethnicity categories are not mutually exclusive.

Figure 4. Most Common Participant Living Situations at Time of IMPACTS Engagement



At enrollment, participants reported multiple current living situations. Figure 4 and Table 2.3 illustrate the most commonly reported participant living situations at the time of their enrollment or engagement with a local IMPACTS program. The most frequently reported category (42%) was sheltered, transitional, or institution, including emergency shelter (8%), transitional housing (10%), or residing in a jail or other correctional facility (24%). Another 38% of reported living situations were housed, including staying with friends or family (18%) or a personal residence (15%). Just under one in three (32%) reported living situations at the time of engagement were unsheltered houseless, with just over one quarter (26%) living outside or in a tent.

Table 2.3. Living Arrangements at IMPACTS Program Entry

Living arrangement	Number	Pct
Living in a tent or outside	475	26%
In a jail or correctional facility	434	24%
Staying with friends, family, or others	336	18%
In a private residence (e.g., own house or apartment)	265	15%
In time-limited transitional housing or crisis residence	189	10%
Emergency shelter	141	8%
Living in a vehicle	111	6%
In permanent supportive housing	92	5%
In residential care (e.g., group home or rehab. center)	77	4%
Staying in a motel or hotel	55	3%
In an institutional setting (e.g., nursing home, psychiatric hospital, veterans' affairs hospital, state hospital)	37	2%
Other	66	4%
Unknown	45	2%
Total	**1,824**	**100%**

Note. Categories are not mutually exclusive.

Table 2.4 illustrates participant behavioral health conditions at program entry. More than half of participants were reported to have co-occurring mental health and substance use disorders (56%). A further 36% reported either a mental health disorder only or a substance use disorder only. IMPACTS programs, therefore, are reaching populations with complex behavioral health service needs with opportunities to tailor their programs to meet their target population's unique and diverse needs.

Table 2.4. IMPACTS Participant Behavioral Health Conditions at Program Entry

Behavioral health condition(s)	Number	Pct
Mental health disorder		
Yes	1,354	74%
No	127	7%
Unknown	343	19%
Substance use disorder		
Yes	1,353	74%
No	189	10%
Unknown	282	15%
Co-occurring disorders		
Co-occurring mental health and substance use disorders	1,021	56%
Mental health disorder only	333	18%
Substance use disorder only	332	18%
Neither mental health nor substance use disorder indicated	138	8%
Total	**1,824**	**100%**

In Practice

Complex Needs of the IMPACTS Population

"Additionally, the IMPACTS peers outreach efforts with the target population over the past several years have begun to show meaningful progress among individuals in the community who experience significant mental health symptoms. For some individuals, symptoms are being managed through Long-Acting Injectable medications when clinically appropriate and available in that form, determined by a psychiatrist. This approach is particularly important because many members of the population are houseless and may experience theft or loss of oral medications or may forget to take them. Although building rapport with these individuals has required a longer period of engagement, recent progress indicates a reduction in mental health symptoms. This progress is also creating opportunities to assist with cross-system placement, particularly for individuals who experience co-occurring developmental disabilities, traumatic brain injuries, and other complex conditions."

Table 2.5 shows the types of mental health disorder (MHD) experienced by participants at the time of IMPACTS engagement, and Figure 5 illustrates the most frequent categories and intersections among the types of MHD. Among the 73% of participants with an MHD, depression was the most reported diagnosis (34%), followed by trauma-related disorder (33%) and anxiety (32%). More than a quarter (27%) of participants with MHD had a schizophrenia or psychosis-related diagnosis. Among the common combinations of MHD diagnoses, bipolar spectrum disorder and anxiety co-occurred among 91 participants. Bipolar, anxiety, and a trauma-related disorder were reported for 79 participants.

Table 2.5. Type of Mental Health Disorder among IMPACTS Participants with MHD

MHD	Number	Pct
Depression	446	34%
Trauma-related disorder	434	33%
Anxiety	421	32%
Schizophrenia or psychosis	358	27%
Bipolar spectrum disorder	213	16%
Suicidal ideation	59	4%
Other mood disorder	59	4%
Substance-induced psychosis	57	4%
Personality disorder	49	4%
Other	168	13%
Unknown	211	16%
Total	**1,331**	**100%**

Note. MHD categories are not mutually exclusive.

Figure 5. Type of Mental Health Disorder among IMPACTS Participants

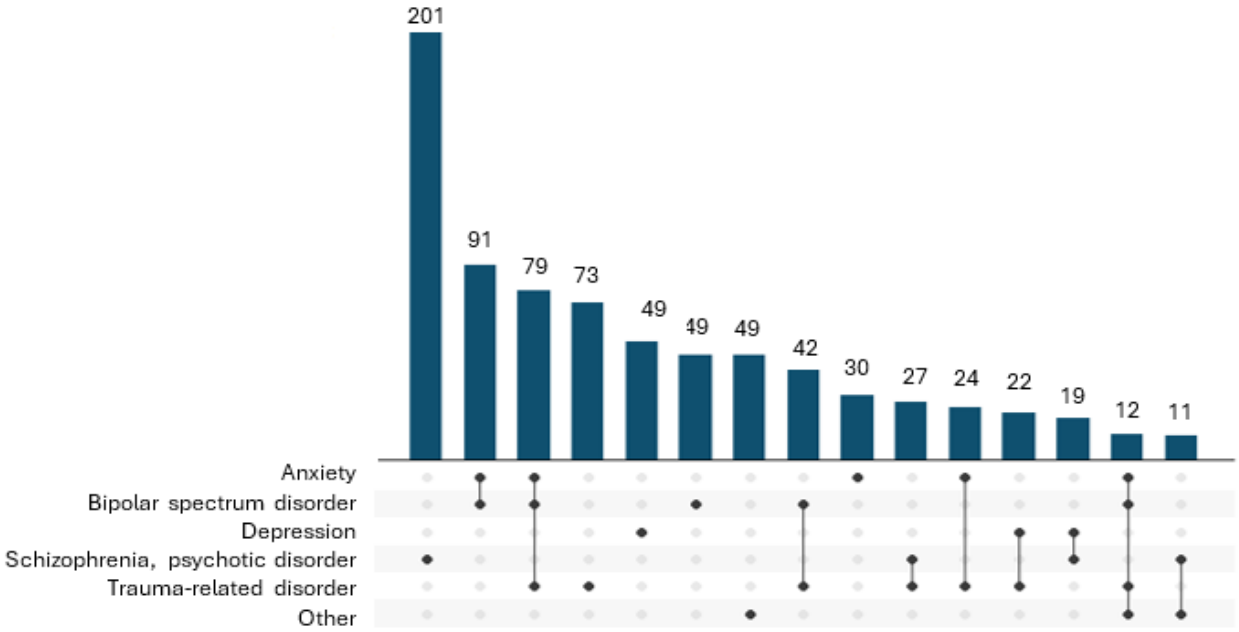


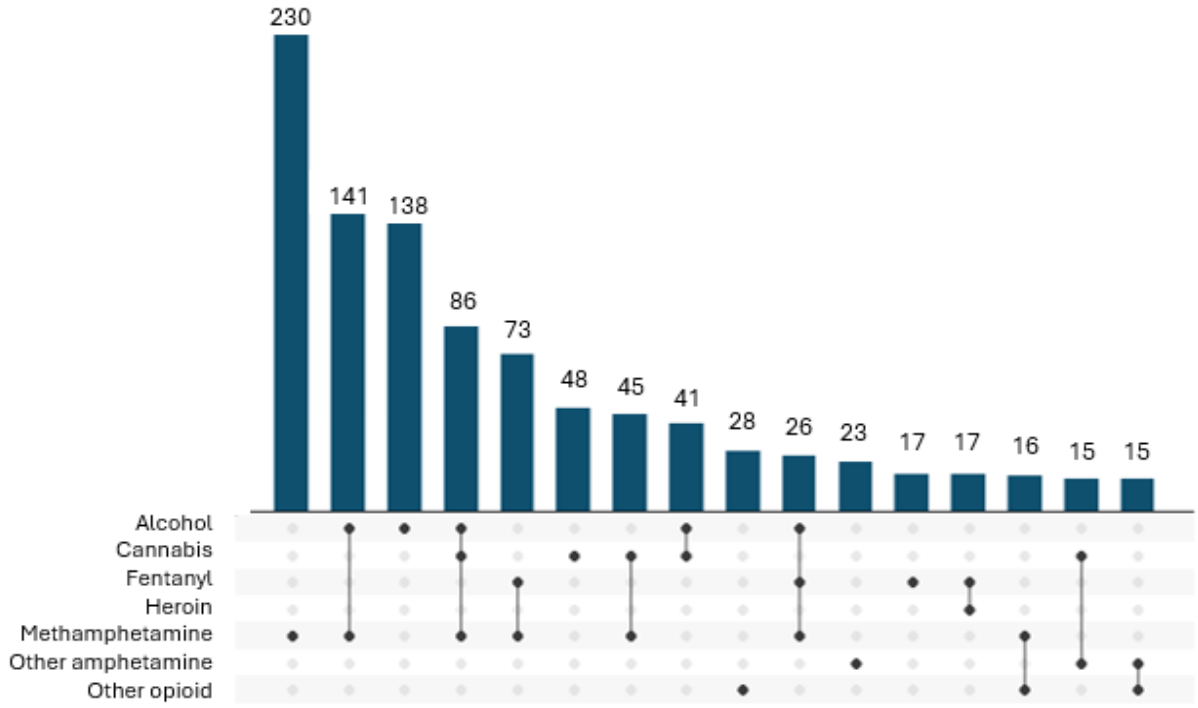
Table 2.6 shows the types of substance use disorder (SUD) experienced by participants at the time of IMPACTS engagement, and Figure 6 illustrates the most frequently observed categories and intersections among the types of SUD. Among the 73% with an SUD, most common (59%) was methamphetamine use, followed by alcohol (44%), and cannabis use (25%). Methamphetamine use alone was reported by 230 participants, with joint alcohol and methamphetamine reported by 141 participants, and alcohol alone by 138 participants. Alcohol, cannabis, and methamphetamine co-use was reported among 86 participants.

Table 2.6. Type of Substance Use Disorder among IMPACTS Participants with SUD

SUD	Number	Pct
Methamphetamine	782	59%
Alcohol	588	44%
Cannabis	337	25%
Fentanyl	224	17%
Other amphetamine	128	10%
Other opioids	116	9%
Heroin	97	7%
Other	67	5%
Unknown	103	8%
Total	**1,329**	**100%**

Note. SUD categories are not mutually exclusive.

Figure 6. Type of Substance Use Disorder among IMPACTS Participants



IMPACTS participants are characterized by frequent utilization of public safety resources in the year preceding program enrollment. Table 2.7 describes utilization of public safety and health services among participants with any encounters in the year prior to IMPACTS. Of this subgroup, most (71%) had at least one jail booking in the year preceding enrollment, and among those, the average was 4 bookings a year. Over half (58%) of participants in this subgroup had at least one encounter with local law enforcement. Among those, the average was 4.7 encounters. About 41% of participants were on community supervision in the year prior to engagement.

In Practice

Meeting Needs During Reentry

"IMPACTS staff began building a relationship through written communication before release and met with the participant shortly after returning to the community. Together, they identified immediate needs and developed a plan to reduce barriers while the participant waited for …benefits and backpay. IMPACTS provided temporary assistance with housing expenses and legal transportation, helping the family remain stable during this critical transition."

Table 2.7. Public Safety and Health System Encounters in Year before IMPACTS

	At least one encounter (among participants with any encounters)		How many encounters (among participants with at least one)	
Encounter type	**Number**	**Pct**	**Average**	**Range**
Jail bookings	1,088	71%	4.0	1 - 26
Local law enforcement	893	58%	4.7	1 - 50
Emergency department	629	41%	5.0	1 - 57
Parole or probation	627	41%	--	--
Hospital admission	254	17%	2.3	1 -31
Incarceration	179	12%	1.4	1 - 12
Inpatient mental health services	178	12%	1.8	1 - 10
Inpatient SUD services	178	12%	1.4	1 - 12
Homeless shelter	164	11%	--	--
State hospital admission	123	8%	1.1	1 - 2
Stabilization or crisis center	122	8%	9.4	1 - 365
Other	27	2%	--	--
Total with any encounter	**1,529**	**100%**		

Note. Categories are not mutually exclusive. Of 1,824 participants, 1,529 or 84% had at least one encounter in the prior year.

Frequent utilization of healthcare systems is also common among IMPACTS participants with a history of public safety or emergency service use in the year prior to IMPACTS engagement. Table 2.7 shows 41% of these participants had at least one ED admission in the year prior to enrollment, with an average of 5 admissions per year. Hospital admission was reported by 17% of these participants, with an average of 2.3 admissions. Inpatient mental health services and inpatient SUD services histories were each reported for 12% of participants. Admission to the Oregon State Hospital was reported for 8% of participants.

2.4 IMPACTS Program Outcomes to Date

Expected length of participation in IMPACTS programming varies by program emphasis. In many cases, programs are structured to provide ongoing follow up services to participants who return for service in subsequent months beyond the month of enrollment, while other programming expected fewer interactions and refer directly to other services outside of the scope of their project.

Table 2.8 presents the average length of engagement among IMPACTS participants. Of the 1,824 enrolled participants, 1,284 (70%) have engaged in at least one additional month beyond their month of enrollment. On average, enrolled participants have engaged for 3.9 months, though the range spans 0 months to 35 months of follow up engagement.

Table 2.8. Pattern of IMPACTS Participant Engagement

	Number	Pct
Total enrolled	1,824	100%
Total with any engagement after enrollment	1,284	70%
Mean months engaged	3.9	
Median months engaged	2	
Range of months engaged	0 - 35	

Note. Months of engagement represent total months in which a participant had any follow-up contact; they are not necessarily consecutive.

In Practice

Repeated Engagement

"One individual accessed the [site] approximately 20 times during periods of behavioral health crisis. Although this person has a significant history of justice-system involvement, including more than 20 prior arrests in the county, only six arrests have occurred since the [site] opened in 2020. Despite ongoing life stressors, the individual continues to re-engage with stabilization services during times of acute need. Access to crisis de-escalation, behavioral health resources, and connection to care has provided a repeated alternative pathway to criminal justice involvement."

Minimally edited to protect anonymity

IMPACTS programs provide a variety of services to participants. Table 2.9 shows services received by IMPACTS participants at any time during their engagement, in their first month of engagement, and during months of follow-up services. At the enrollment stage, the most common services delivered include case management (46%), peer support services or outreach (44%), care coordination (30%), mental health services (22%), transportation (20%), and housing services (20%).

In Practice

Bringing Services to Participants

"By bringing behavioral health services directly to individuals where they already report, we aim to reduce barriers to accessing psychiatric care, increase engagement with treatment, and strengthen coordination between agencies. This integrated approach supports earlier intervention, promotes continuity of care, and aligns with our goal of reducing unnecessary emergency department utilization."

In follow-up months, 70% of participants received a service. Among those, the most delivered services are the same as the month of enrollment: case management (79%), peer support or outreach (70%), care coordination (68%), transportation (55%), mental health services (49%) and housing services (42%).

The volume and depth of ongoing, personalized support that grant recipients have provided to participants, such as the quality and quantity of time spent with a peer support specialist, may not be fully captured quantitatively. As prior work has shown, the value of IMPACTS is also demonstrated by integrated, person-centered services [6]. Programs not only strive to reduce high utilization of emergency health services and criminal-legal system engagement, but also to promote overall stability and fill gaps in existing community services.

[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.

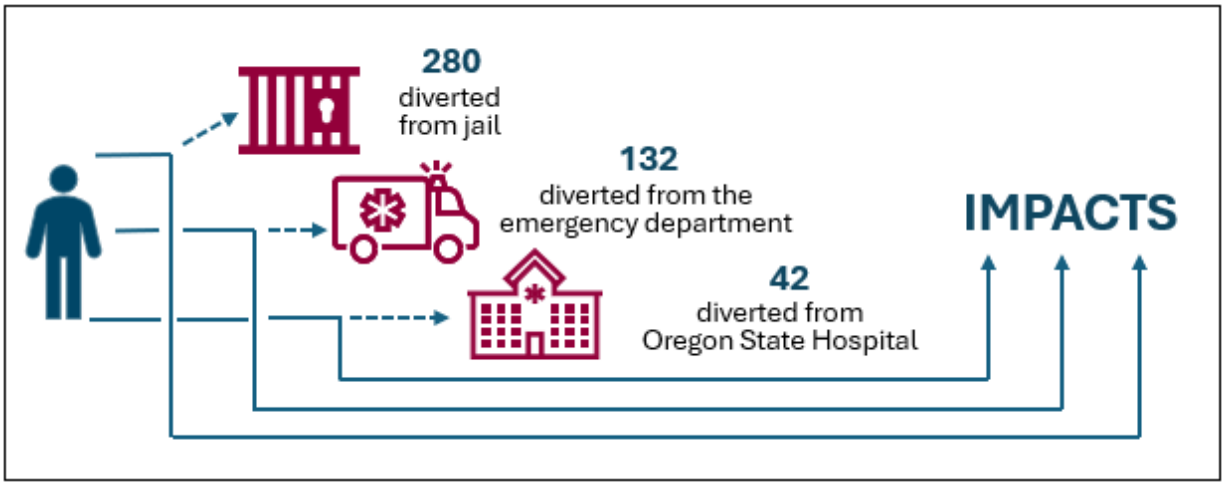
Table 2.9. Services Delivered to IMPACTS Participants

	Ever delivered		Delivered at enrollment		Delivered in any follow-up months	
Service	**Number**	**Pct of all participants**	**Number**	**Pct of all participants**	**Number**	**Pct of participants with any follow up**
Case management	1,272	70%	839	46%	1,007	79%
Food services	1,272	70%	260	14%	472	37%
Employment services	1,272	70%	61	3%	144	11%
Peer support or outreach	1,167	64%	796	44%	890	70%
SUD services	1,167	64%	244	13%	490	38%
Care coordination	1,060	58%	548	30%	869	68%
Transportation	849	47%	372	20%	706	55%
Mental health services	741	41%	403	22%	629	49%
Housing services	705	39%	358	20%	540	42%
Legal issues	705	39%	140	8%	303	24%
Health- or healthcare-related	417	23%	170	9%	354	28%
Applying for public benefits (e.g., SNAP, SSI)	288	16%	115	6%	210	16%
Help with activities of daily living	276	15%	112	6%	250	20%
Reentry support	258	14%	111	6%	191	15%
Utilities (e.g., heat, electricity, water)	201	11%	62	3%	169	13%
Enrollment in OHP or other insurance	162	9%	90	5%	83	7%
DMV assistance	160	9%	56	3%	122	10%
Childcare or other child-related issues	39	2%	14	1%	33	3%
Other	162	9%	144	8%	360	28%
None	210	12%	421	23%	--	--
Total	**1,824**	**100%**	**1,824**	**100%**	**1,276**	**100%**

Note. Categories are not mutually exclusive. Of 1,824 participants, 1,276 or 70% received any services after enrollment.

Figure 7 provides a view of diversion within IMPACTS; an important feature of program designs that helps reduce the severity of encounters with criminal legal or health systems.

Figure 7. IMPACTS Participants Diverted Once or More from Jail, Emergency Department, or Oregon State Hospital



As shown in Table 2.10, about 15%, or 280 enrolled participants, have been diverted from jail, 132 enrolled participants have been diverted from the emergency department, and 42 enrolled participants have been diverted from the Oregon State Hospital.

Table 2.10. IMPACTS Participants Diverted Once or More from Jail, Emergency Department, or Oregon State Hospital

Diversion type	Number	Pct
Any jail diversion	280	15%
Any emergency department diversion	132	7%
Any Oregon State Hospital diversion	42	2%
Total diverted	**341**	**19%**

In Practice

Diverting Individuals from Multiple Sources

"Efforts have focused on improving timely connections to services, increasing coordination across partner agencies, and ensuring the program is well positioned to engage individuals at the earliest appropriate intervention point."

Table 2.11 shows the percentage of participants with jail bookings and emergency department visits in the 12 months prior to enrollment and during their engagement in IMPACTS. About 60% of participants reported any jail bookings in the 12 months prior to enrollment. Among participants with 1 to 11 months of follow-up engagement, 30% had any jail bookings; 47% of participants with 12 to 18 months of follow-up engagement had any jail bookings. In addition to the reduction in the number of participants with any jail bookings, the average number of jail bookings was lower after IMPACTS enrollment. Participants had an average of 2.7 jail bookings in the 12 months prior to IMPACTS, and among participants with 12 to 18 months of follow-up engagement, the average number of jail bookings since IMPACTS enrollment was 1.8.

About 34% of participants reported an ED admission in the year prior to enrollment. Among participants with 1 to 11 months of follow-up engagement, 19% had any ED admissions; 41% of participants with 12 to 18 months of follow-up engagement had any ED admissions. Participants had an average of 2.3 ED admissions in the 12 months prior to IMPACTS, and among participants with 12 to 18 months of follow-up engagement, the average number of ED admissions since enrollment stayed roughly constant at 2.4.

Table 2.11. Number of Participants with Any Jail Bookings and Emergency Department Visits Before and During IMPACTS

	12 months prior to IMPACTS		During IMPACTS (by number of follow-up months)			
			1 - 11 months		12 - 18 months	
	Number	Pct	Number	Pct	Number	Pct
Jail bookings						
Any	1,088	60%	328	30%	101	47%
None	515	28%	704	64%	116	53%
Unknown	221	12%	67	6%	0	0%
Emergency department						
Any	629	34%	213	19%	88	41%
None	692	38%	754	69%	129	59%
Unknown	503	28%	132	12%	0	0%
Total	**1,824**	**100%**	1,099	100%	217	100%

Note. Table excludes participants with < 1 and ≥ 19 follow-up months. Table 2.7 shows similar information among participants with at least one encounter in the 12 months before IMPACTS.

3. Behavioral Health Deflection

3.1 Purpose of the Program

In 2024, Oregon House Bill 4002 newly classified possession of controlled substances (PCS) as a drug enforcement misdemeanor punishable by incarceration for up to 180 days or 18 months of supervised probation. The bill also established the Oregon Behavioral Health Deflection (BHD) Program to provide grant funds to Oregon 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, conviction, incarceration, and other engagement with the criminal legal system. As defined in HB 3069 (2025), deflection programs are collaborations between law enforcement agencies and behavioral health or social service entities, designed to create community-based pathways to treatment and needed services for people with substance use disorder, other behavioral health disorders, or co-occurring disorders.

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 needed assessment, treatment, and services for substance use and mental health disorders. Generally, deflection programs engage individuals who may be at risk of entering the criminal legal system due to a potential or actual PCS charge. Programs may also engage individuals without a suspected or active charge who may have a behavioral health condition or other service needs. Eligibility criteria for participation in deflection are determined by each funded jurisdiction to best meet community needs.

In Practice

Examples of BHD program implementation are included throughout the report in blue text boxes labeled "In Practice." These excerpts are drawn from program semi-annual reports and highlight illustrative program and participant experiences.

Existing deflection programs vary in the partnerships and strategies used to connect eligible individuals to community-based treatment and services. Counties collect and share data with the state to facilitate local and statewide monitoring and reporting of deflection program progress and outcomes. Key outcomes include connections to treatment and social services and criminal legal system avoidance. The remainder of this section (Section 3) describes the currently funded BHD programs and conveys statewide progress on county outcomes for the period of September 1, 2024, to June 30, 2026.

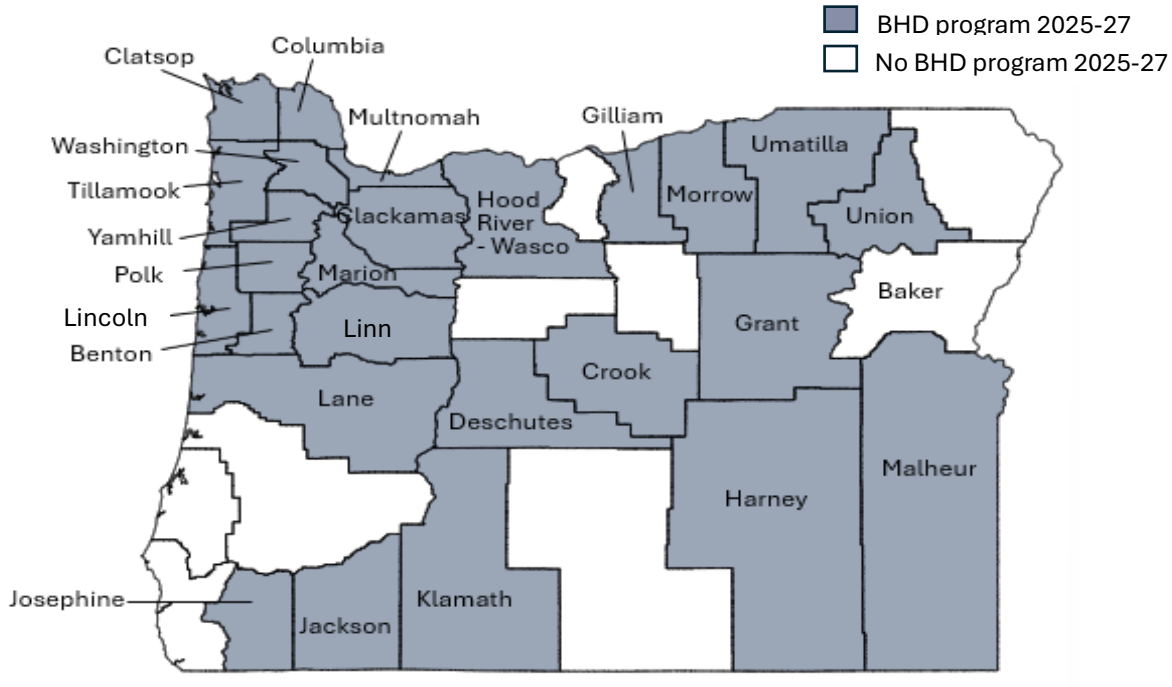
3.2 BHD-Funded Counties and Tribal Governments

The Legislature appropriated $40 million to Oregon's BHD grant program for use in the 2025-2027 biennium. After inviting consultation and input from Oregon's federally

recognized Tribal governments, the Commission determined that $2,618,920 was set aside for use by Oregon's federally recognized Tribal governments. House Bill 3069 (2025) mandated the distribution of approximately $37.3 million across four distinct parts. Per statute, the Commission retained 5% in total, including 3% for data collection and outcome evaluation and 2% for technical assistance. The remaining 95% was designated for county distribution, split between a 25% allocation tied to the 2023–2025 county formula share [7] and 70% allocated through a new formula [8] developed by the Commission based on county projections.

The Commission rolled out a two-phase grant solicitation process. Phase 1 required detailed program proposals to be approved by the Commission before distributing the 25% portion ($9,345,204) to applicants. In total, 27 Oregon counties applied, representing 26 grant programs including a Hood River and Wasco regional consortium. Through Phase 2, the remaining 70% ($26,166,572) was distributed based on a new formula developed by the Commission, as outlined in House Bill 3069 (2025). See Appendix B for additional details about the new formula and Phase 2 of the solicitation process. In December 2025, the Commission awarded funding requests for all 26 programs, which totaled $34,444,257. Refer to Appendix B, Table B-1 for a list of funded programs.

Figure 8. Map of Counties Receiving BHD Funding During the Reporting Period



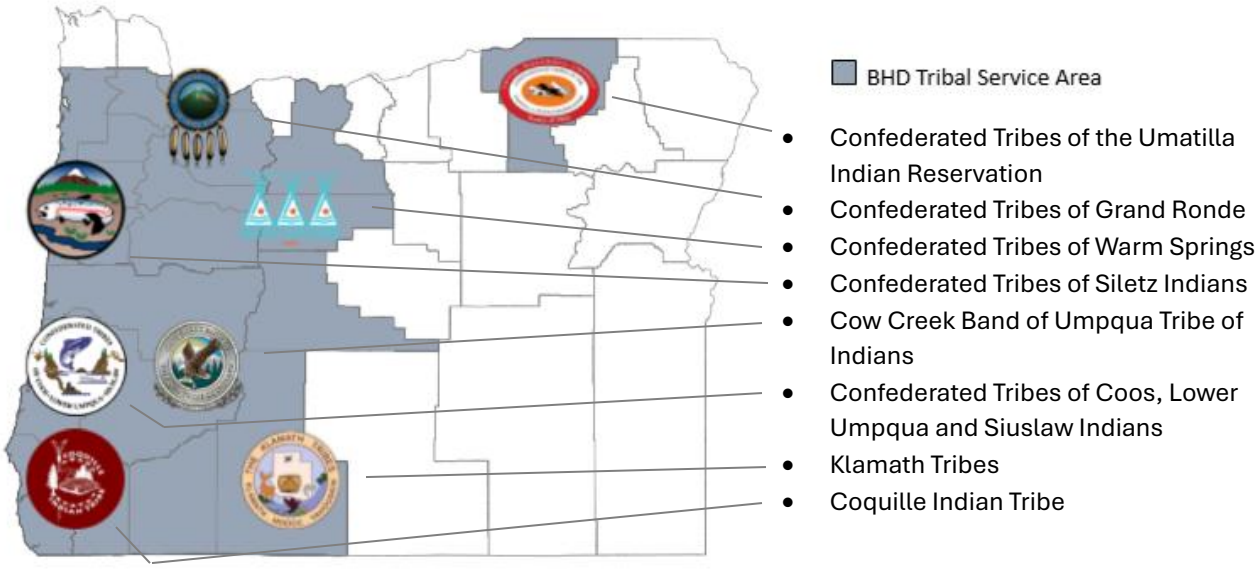
Note: Baker County had a funded BHD program in the 2023-25 biennium.

[7] The percentage formula derives from the county formula share employed by OHA's Oversight and Accountability Council established under ORS 430.388.
[8] The projections-based formula derives from ORS 430.430 and is further described in Appendix B-1.

The $2,618,920 set aside for use by Tribal governments in the 2025-2027 biennium anticipated that the six existing Tribal grant recipients in the 2023-2025 biennium would extend their project periods and maintain their current service levels for an additional year and included estimates for the three Tribal governments that previously opted out to access formula funding for a one-year grant. The proportion of funding available to each participating Tribal government was determined by first establishing a base allocation of $150,000, and then allocating remaining funds using the previous funding formula based on the 2024 Indian Health Serves User Population Data available.

Eight of Oregon's nine federally recognized Tribal governments applied for and received BHD grant funds (see Figure 9). The six existing Tribal BHD programs who had received funding in 2023-2025 biennium received extensions to their project periods through August 2027 and applied for additional funds. Two additional Tribal governments applied for 2025-2027 BHD funds for the first time. In total, $2,070,230 was awarded in grant funds to the eight Tribes. Refer to Appendix B, Table B-2.

Figure 9. Map of Tribal Governments Receiving BHD Funding in 2025-27

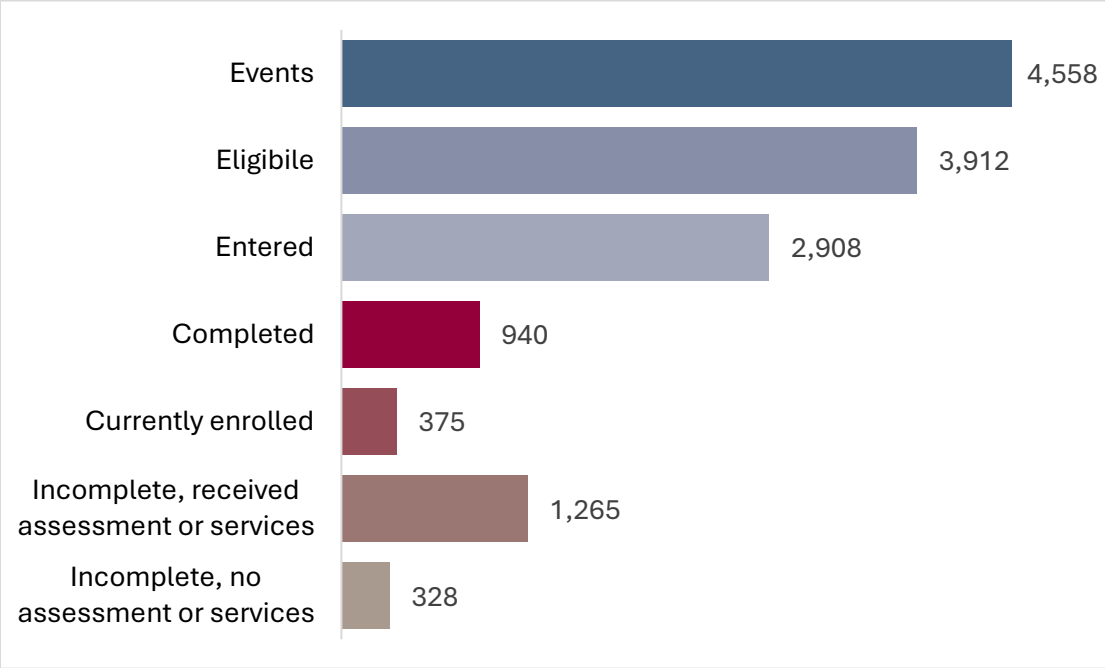


Tribal deflection program data are collected and maintained by Tribal governments. As the planning phase for Tribal deflection transitions to active programming, Tribal governments have just begun reporting de-identified, aggregate information, such as the number of participants served, to the CJC as part of its statewide monitoring and administration. Given Tribal governments' sovereignty and preferences, deflection program operations and results discussed in the remainder of this report focus solely on county deflection programs.

3.3 BHD Participation

As of June 30, 2026, funded BHD programs initiated 4,558 deflection referral events. Depending on jurisdictional criteria, an individual may have more than one deflection event. Figure 10 shows participant progression through deflection events. In 3,912 (86%) of these events, the referred individual was determined eligible to participate in the program. Each program establishes its own criteria for program eligibility, and reasons for ineligibility are summarized in Table 3.7 in subsection 3.4.2. In 2,908 events (74% of those in which the participant was determined eligible), the individual agreed to enter the program. In 375 events (13% of those in which the participant entered the program), the participant was currently enrolled as of June 30, 2026. In 940 events (32% of those in which the participant agreed to enter), the participant completed the program by meeting specific criteria defined at the jurisdictional level. These criteria are described in subsection 3.8.2. In 1,265 events (44% of those in which the participant agreed to enter), the participant did not complete the program but did receive an assessment, screening, or services, and in the remaining 328 events (11% of those in which the participant agreed to enter), the participant did not complete the program and did not receive any assessment or services. Table 3.1 summarizes participants' progression through deflection events that were initiated in each of the funded counties during the reporting period. For additional information beyond the reporting period, see the CJC's BHD dashboard. [9]

Figure 10. Progression of Participants through Deflection Events



[9] Behavioral Health Deflection Programs Dashboard | Tableau Public

Table 3.1. Deflection Events and Progression by County Program

Program	Events	Eligible		Entered		Completed		Exited without Completing			
								Rec'd assessment or services		No assessment or services	
	Number	Number	Pct of events	Number	Pct of eligible	Number	Pct of entered	Number	Pct of entered	Number	Pct of entered
Benton	49	46	94%	26	57%	6	23%	0	0%	1	4%
Baker	3	3	100%	3	100%	0	0%	0	0%	2	67%
Clackamas	292	282	97%	199	71%	142	71%	41	21%	8	4%
Clatsop	102	98	96%	89	88%	36	42%	32	37%	3	4%
Columbia	27	25	93%	16	64%	4	25%	5	31%	2	13%
Crook	95	35	37%	17	49%	0	0%	12	71%	5	29%
Deschutes	142	139	98%	113	81%	54	48%	39	35%	11	10%
Grant	6	3	50%	1	33%	1	100%	0	0%	0	0%
Harney	38	38	100%	35	92%	14	48%	9	26%	9	26%
Hood River – Wasco	87	68	78%	24	35%	6	25%	4	17%	8	33%
Jackson	277	277	100%	256	92%	126	49%	93	36%	35	14%
Josephine	192	190	99%	187	98%	81	43%	35	19%	61	33%
Klamath	221	96	43%	14	15%	8	57%	4	29%	0	0%
Lane	564	550	98%	549	100%	67	12%	321	59%	81	15%
Lincoln	173	159	92%	129	81%	45	35%	58	45%	15	12%
Linn	87	39	45%	18	46%	1	6%	2	11%	15	83%
Malheur	18	11	61%	10	91%	2	20%	5	50%	2	20%
Marion – LEAD	196	153	78%	113	74%	27	24%	70	62%	0	0%
Marion – Restore	64	63	98%	45	71%	0	0%	1	2%	1	2%
Morrow	22	20	91%	12	60%	7	58%	3	25%	0	0%
Multnomah	938	897	86%	646	72%	186	29%	400	62%	0	0%
Polk	103	67	65%	28	42%	12	43%	2	7%	1	4%
Tillamook	0	0	--	0	--	0	--	0	--	0	--
Umatilla	258	228	88%	51	22%	39	77%	5	10%	5	10%
Union	46	46	100%	45	98%	14	31%	1	2%	9	20%
Washington	270	159	59%	151	95%	49	33%	70	46%	5	3%
Yamhill	288	220	76%	134	61%	13	10%	53	40%	49	37%
Total	**4,558**	**3,912**	**86%**	**2,908**	**74%**	**940**	**32%**	**1,265**	**44%**	**328**	**11%**

Note. Baker County had a funded program in the 2023-25 biennium. Tillamook County data reporting is pending as of the preparation of this report.

3.4 Deflection Program Entry

Deflection program referrals take place through a variety of nationally-recognized pathways. Descriptions of the pathways used by Oregon BHD programs are adapted from the Police, Treatment, and Community Collaborative (PTACC) and provided in Table 3.2.

Table 3.2. Description of Nationally-Recognized Deflection Pathways

Officer Intervention	During routine activities of duty, including patrol or service calls, a law enforcement officer makes an arrest or identifies a basis for criminal charges and refers the individual to deflection.
First Responder and Officer Referral	As a preventive approach during routine activities of duty, a law enforcement officer or other first responder engages with an individual and provides a referral to deflection.
Active Outreach	A first responder or non-law enforcement professional or team reaches out to a potentially eligible individual in the community to offer engagement in deflection.
Naloxone Plus	A first responder reaches out to an individual who recently experienced an opioid overdose to refer them to deflection.
Self-Referral	An individual voluntarily initiates contact with a first responder, seeking referral to deflection, without fear of arrest.
Community Response	In response to a call for service, a community-based behavioral health team engages with an individual to de-escalate a crisis or resolve a non-crisis situation by referring to deflection.

Note. Adapted from the Police, Treatment, and Community Collaborative (PTACC).

In Practice

Cross-Agency Collaboration Supports a Person-Centered Approach

"…[O]ur team has strengthened cross-agency collaboration and created tools that bring the program's impact to life. We developed clear training materials for law enforcement and partner agencies, helping officers feel more confident in making referrals and understanding how deflection works in real-time situations. In addition, we introduced our "[progress] board," a visual display that tracks deflection participants as they move through engagement stages toward treatment— allowing staff, leadership, and partners to see growth and progress at a glance. Together [with HHS and the DA's office], we've streamlined communication so that referrals are supported quickly, charges can be paused when appropriate, and individuals have a direct pathway to treatment… These shared efforts continue to show that coordinated, person-centered approaches can shift outcomes in meaningful ways."

Figure 11. Deflection Pathways Used Statewide

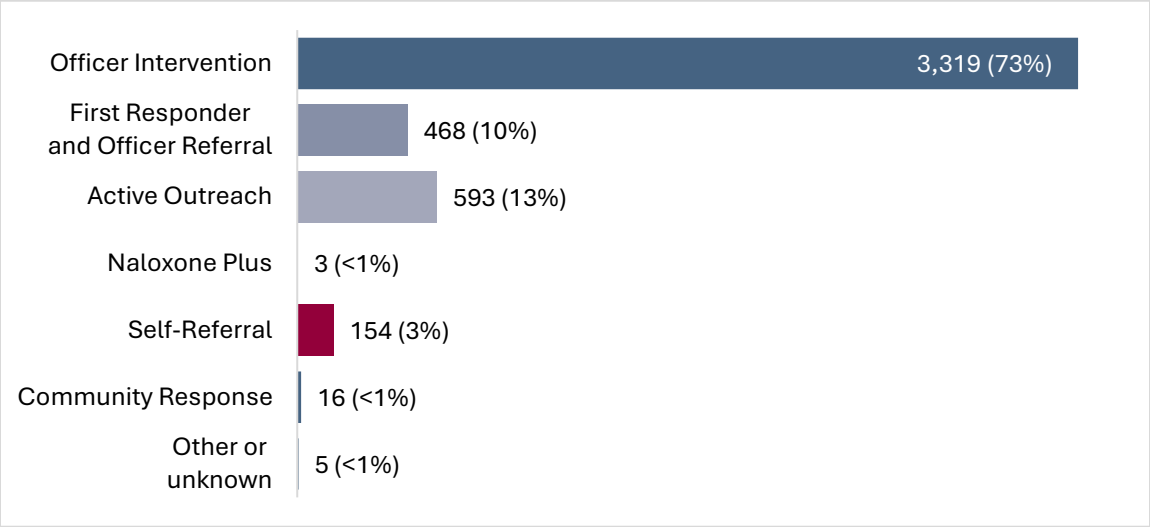
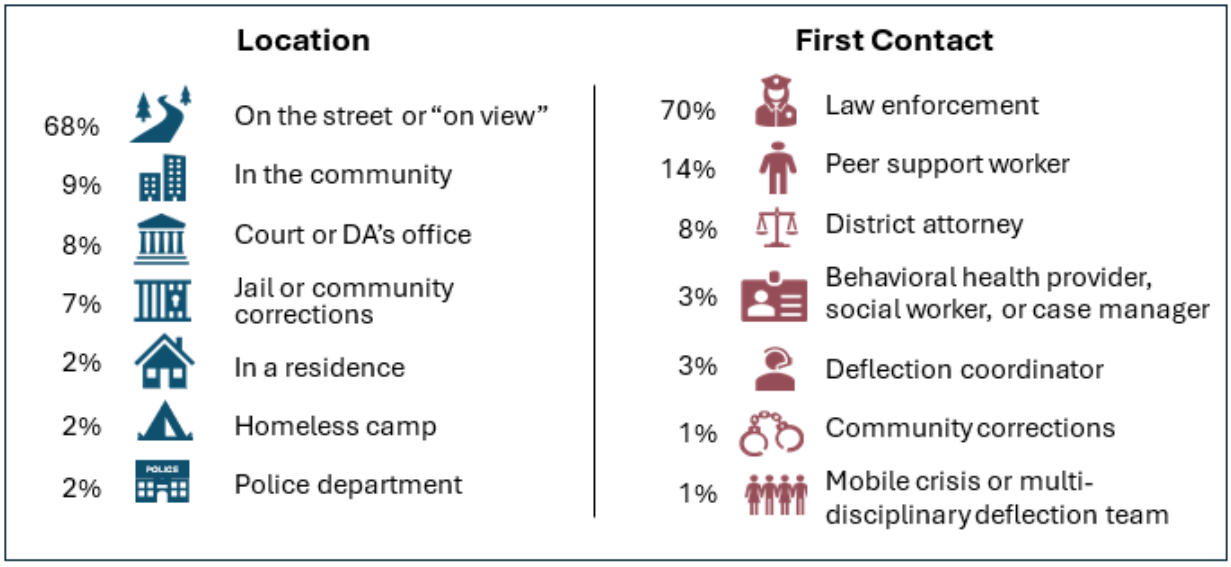


Figure 11 illustrates that the most commonly used pathway by Oregon deflection programs is Officer Intervention, which accounts for 73% of all deflection referrals through June 30, 2026. Next most commonly used were Active Outreach (13%) and First Responder and Officer Referral (10%). Participants used the Self-Referral pathway in 3% of events.

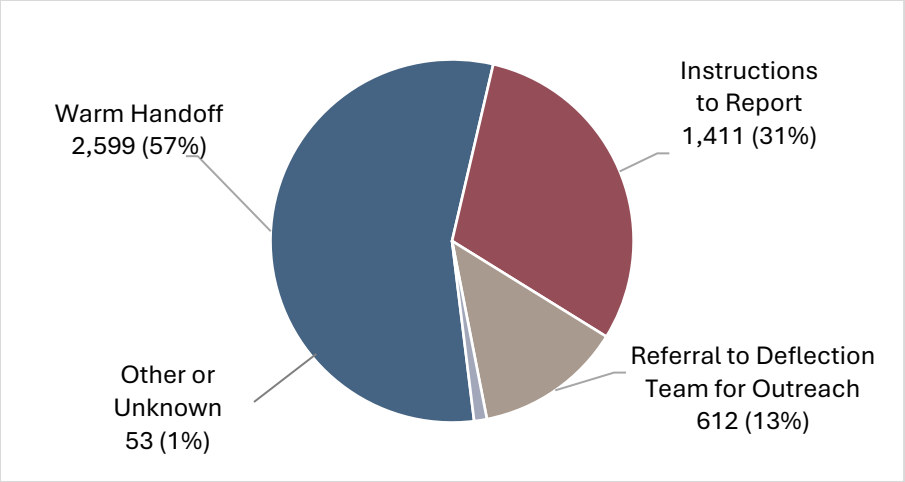
Most referrals to deflection (68%) occurred on the street or "on view," meaning in a public place like a park, during a traffic stop, or in a public establishment. Figure 12 illustrates the different locations in which deflection referrals were commonly made and the professional roles that typically served as potential participants' first contact. Most often, law enforcement was the first contact (70% of the time), followed by peer support workers (14%) and district attorneys (8%).

Figure 12. Location and First Point of Contact at BHD Referral



First contacts use various handoff types to connect potential participants with deflection, as illustrated in Figure 13. Warm handoffs were most used (57%) and included the real-time transfer of an individual to a deflection center (28%), a deflection navigator or case manager (20%), a peer support worker (7%), or a sobering or stabilization center (1%). Next most used were instructions to report to a particular person or place to initiate deflection (31%), including the deflection team or coordinator (19%), a behavioral health provider (9%), or community court (3%). About 13% of the time, a referral to deflection was issued, meaning the first point of contact provided the deflection team with contact information for subsequent outreach to an individual. A few programs reported sometimes (2% of the time) using more than one handoff type with a potential participant.

Figure 13. Handoff Type Used at Referral



The next sections provide more information, by pathway, about the first point of contact, where first contact occurred, and which handoff types were used when potential participants were first referred to deflection.

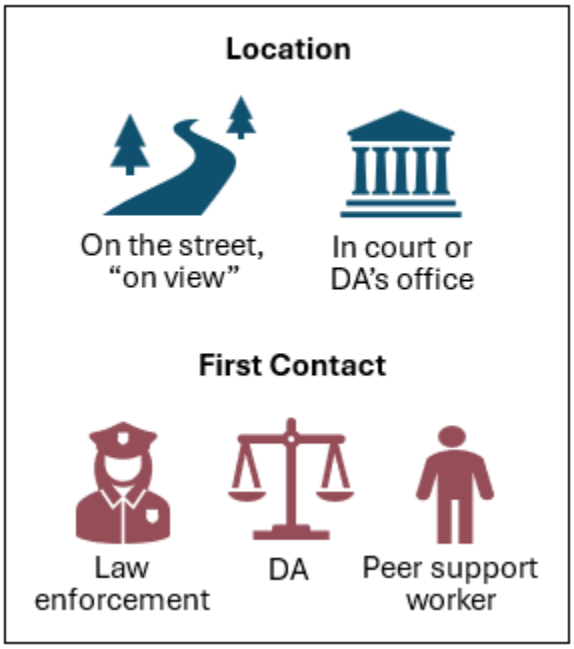
In Practice

Supplementing Officer Intervention with Additional Pathways

"One challenge our program experienced during this reporting period was a decrease in referrals through the Officer Intervention pathway. This appears to be largely related to ongoing changes in our community's response to homelessness and unsheltered camping, which have altered how and when law enforcement interacts with individuals who may otherwise qualify for deflection. While intervention referrals have decreased, we have maintained strong communication and collaboration with our law enforcement partners, who remain supportive of the program. At the same time, our non-citation pathways, particularly self-referral and outreach-based referrals, have helped ensure individuals can continue accessing services and support even when they are not entering the program through law enforcement contact."

3.4.1 Deflection Referral and Entry, by Pathway

Figure 14. Officer Intervention Pathway



About 73% of deflection events used the Officer Intervention pathway to refer potential participants to the program. Figure 14 shows that in this approach, individuals' first contact took place most often on the street or "on view" (82%). The next most common locations were at the DA's office (6%) or in court (4%). First contact was most often with law enforcement (84%), the DA (10%), or a peer support worker (3%).

Programs used a variety of handoff types with this pathway, most often involving warm handoff at a deflection center (36%); instructions to report to the deflection team or coordinator (22%); warm handoff to deflection staff or a case manager (15%); referral to the deflection team for outreach to the individual (13%); instructions to report to a behavioral health provider (11%); or instructions to report to community court (4%). Table 3.3 shows the percentage of Officer Intervention events in which individuals were eligible and entered deflection, by handoff type. A minority of events included more than one type of handoff.

Table 3.3. Officer Intervention Pathway: Program Eligibility and Entry by Handoff Type

	Referred		Eligible		Entered	
Handoff type	**Number**	**Pct**	**Number**	**Pct of referred**	**Number**	**Pct of eligible**
Warm handoff at deflection center	1,193	100%	1,154	97%	892	77%
Instructions to report to deflection team or coordinator	735	100%	434	59%	282	65%
Warm handoff to deflection staff or a case manager	486	100%	465	96%	427	92%
Referral to deflection team for outreach	419	100%	378	90%	224	59%
Instructions to report to behavioral health provider	354	100%	270	76%	179	66%
Instructions to report to community court	134	100%	81	61%	57	70%
Other	43	100%	37	89%	32	87%
Total	**3,319**	**100%**	**2,777**	**84%**	**2,062**	**74%**

Figure 15. Active Outreach Pathway



About 13% of deflection events used Active Outreach to refer potential participants to the program. Figure 15 shows that in this approach, individuals' first contact took place most often in the community, such as at a community-based organization, shelter, or treatment provider. The next most common locations were in jail or a correctional facility (20%), or on the street or "on view" (14%). First contact was most often initiated by a peer support worker (74%) or behavioral health provider (7%).

Programs used a variety of handoff types with this pathway, most often involving warm handoff to a peer support worker (46%) or to deflection staff or a case manager (27%); instructions to report to the deflection team or coordinator (10%); referral to the deflection team for outreach to the individual (7%); warm handoff at a sobering or stabilization center (5%); or instructions to report to a behavioral health provider (4%). Table 3.4 shows the percentage of Active Outreach events in which individuals were eligible and entered deflection, by handoff type. A minority of events included more than one type of handoff.

Table 3.4. Active Outreach Pathway: Program Eligibility and Entry by Handoff Type

	Referred		Eligible		Entered	
Handoff type	**Number**	**Pct**	**Number**	**Pct of referred**	**Number**	**Pct of eligible**
Warm handoff to a peer support worker	271	100%	253	93%	96	38%
Warm handoff to deflection staff or a case manager	158	100%	139	88%	118	85%
Instructions to report to deflection team or coordinator	62	100%	60	97%	59	98%
Referral to deflection team for outreach	44	100%	40	91%	27	68%
Warm handoff at a sobering or stabilization center	30	100%	30	100%	30	100%
Instructions to report to behavioral health provider	26	100%	26	100%	23	88%
Other	15	100%	15	100%	13	93%
Total	**593**	**100%**	**552**	**93%**	**352**	**64%**

Figure 16. First Responder and Officer Referral Pathway



About 10% of deflection events used the First Responder and Officer Referral pathway to refer potential participants to the program. Figure 16 shows that in this approach, individuals' first contact took place most often on the street or "on view" (59%). The next most common locations were at the police department (12%) or in jail or a correctional facility (9%). First contact was most often initiated by law enforcement (84%) or community corrections (5%).

Programs used a variety of handoff types with this pathway, most often involving warm handoff to deflection staff or a case manager (50%); referral to the deflection team for outreach to the individual (24%); warm handoff at a deflection center (12%); instructions to report to the deflection team or coordinator (8%); or instructions to report to a behavioral health provider (6%). Table 3.5 shows the percentage of First Responder and Officer Referral events in which individuals were eligible and entered deflection, by handoff type. A minority of events included more than one type of handoff.

Table 3.5. First Responder and Officer Referral Pathway: Program Eligibility and Entry by Handoff Type

	Referred		Eligible		Entered	
Handoff type	**Number**	**Pct**	**Number**	**Pct of referred**	**Number**	**Pct of eligible**
Warm handoff to deflection staff or a case manager	233	100%	212	91%	190	90%
Referral to deflection team for outreach	111	100%	103	93%	57	55%
Warm handoff at a deflection center	55	100%	55	100%	54	98%
Instructions to report to deflection team or coordinator	38	100%	36	95%	31	86%
Instructions to report to behavioral health provider	27	100%	27	100%	25	93%
Other	7	100%	6	88%	6	100%
Total	**468**	**100%**	**435**	**93%**	**360**	**83%**

Figure 17. Self-Referral Pathway



About 3% of deflection events used the Self-Referral pathway in which participants proactively expressed interest in the deflection program. Figure 17 shows that in this approach, individuals' first contact took place most often in the community at a community-based organization or treatment facility (49%). The next most common locations were on the street or "on view" (12%), or in a residence (7%). First contact was most often initiated by approaching a peer support worker (44%), the deflection coordinator (19%), a social worker or case manager (16%) or a behavioral health provider (13%).

Programs recorded a variety of handoff types with this pathway, most often involving warm handoff to a peer support worker (22%) or to deflection staff or a case manager (21%); warm handoff at a deflection center (19%); referral to the deflection team for outreach to the individual (18%); or instructions to report to the deflection team or coordinator (14%). Table 3.6 shows the percentage of Self-Referral events in which individuals were eligible and entered deflection, by handoff type. A minority of events included more than one type of handoff.

Table 3.6. Self-Referral Pathway: Program Eligibility and Entry by Handoff Type

	Referred		Eligible		Entered	
Handoff type	**Number**	**Pct**	**Number**	**Pct of referred**	**Number**	**Pct of eligible**
Warm handoff to peer support worker	34	100%	19	56%	18	95%
Warm handoff to deflection staff or a case manager	32	100%	30	74%	29	97%
Warm handoff at a deflection center	29	100%	29	100%	27	93%
Referral to deflection team for outreach	27	100%	20	74%	18	90%
Instructions to report to deflection team or coordinator	22	100%	21	95%	20	95%
Other	3	100%	3	100%	3	100%
Total	**154**	**100%**	**127**	**82%**	**119**	**94%**

3.4.2 Criminal Charges at Time of Referral

Most deflection referral events (84%) were in response to a law enforcement encounter in which the potential participant faced or would have faced criminal charges. See Table 3.7 for a summary of charges at referral and the proportion of events, by charge, in which the individual was determined eligible and agreed to enter deflection.

Table 3.7. Criminal Charges at Time of Deflection Referral

	Referred	Eligible		Entered	
Charge	Number	Number	Pct of referred	Number	Pct of eligible
PCS only	2,729	2,324	85%	1,680	72%
PCS plus others	243	152	63%	123	81%
No PCS but other charges	380	349	92%	297	85%
No charges	1,206	1,087	90%	808	74%
Total	**4,558**	**3,912**	**86%**	**2,908**	**74%**

Standalone PCS crimes (PCS only) were the most common charges facing participants in deflection referral events (n = 2,729, 60% of all referrals). About 98% of the time, events with PCS-only charges were referred through the Officer Intervention pathway. Participants with PCS-only charges were determined eligible for deflection 85% of the time and agreed to enter 72% of the time.

In 5% of deflection referrals, the participant faced no PCS charges but other quality of life charges, such as Criminal Trespass II, Failure to Appear, Theft II, and similar crime categories. Events with no PCS but other charges were referred through the Officer Intervention pathway 93% of the time. In 8% of deflection referrals, the participant faced both PCS and quality-of-life or other co-charges; these events were referred through the Officer Intervention pathway 96% of the time.

In 26% of referrals, the deflection event had no associated charges. Events with no associated charges were most common in the Active Outreach pathway (accounting for 95% of events in this pathway), the First Responder and Officer Referral pathway (accounting for 89% of events in this pathway), and the Self-Referral pathway (accounting for 95% of events in this pathway).

There were no significant differences, by charges faced, in the proportion of events for which the potential participant was determined eligible (Cramer's V = .19) or the proportion of events in which the eligible individual agreed to enter deflection (Cramer's V = .08). [10]

[10] Cramer's V is a chi-square statistic to assess the relation between two nominal variables. Cramér's V: Effect Size for Categorical Data — CASRAI

3.4.3 Reasons for Program Ineligibility

Each county program determines who is eligible to participate in deflection and defines its own exclusion criteria. Of 4,558 deflection referrals during the reporting period, 646 (14%) were determined ineligible for program participation. Table 3.8 lists the ineligibility reasons used by programs and why individual referrals were determined ineligible. Programs may specify more than one reason a potential participant is ineligible. As shown, the most common reasons for participant ineligibility were not attending a court appearance (27%), having a prior disqualifying conviction (26%), current community justice supervision (15%), and not being a resident of the county in which the deflection event occurred (11%).

Table 3.8. Reasons Potential Participants were Determined Ineligible for Deflection

Reason	Number of programs ever used the criterion	Number of events in which criterion was applied	Pct of events in which individual was ineligible
Did not attend court appearance	5	177	27%
Prior disqualifying conviction	13	168	26%
Community justice supervision	9	95	15%
Not a county resident	10	69	11%
Charged with other crime at time of deflection referral	9	60	9%
Pending warrant	7	28	4%
Previous deflection involvement	5	25	4%
Victim with potential restitution	3	7	1%
Other or unknown	13	44	7%
Total	**26**	**646**	**100%**

Note. Categories are not mutually exclusive (n = 54 had more than one reason for ineligibility).

In Practice

Success is Not Linear; Strong Partnerships Help

"We also have improved outcomes by working closely with law enforcement and the DA. We had an individual who was arrested on a new charge; we were informed of their arrest the same day. Due to this timely relay of information, we were able to meet with this individual in jail, attend the arraignment and coordinate their release. This improved trust between the deflection program and this individual. Upon release they were interested in going to detox and were able to be taken to detox within hours. Success is not linear and by creating multiple levels of care and connection we are seeing improved outcomes."

Minimally edited to protect anonymity

3.5 BHD Participant Demographics and Housing

Table 3.9 summarizes demographic information for county BHD participants. Most (65%) are 30 to 49 years old, and 60% are male. About 72% of participants are White, 7% are Hispanic or Latino, and 5% are American Indian or Alaska Native. About 16% of participants had at least one disability.

Logistic regression showed no statistically significant differences by age, race, ethnicity, or gender in the likelihood that an eligible participant would agree to enter deflection. Participants with a disability were more likely to enter the program than participants without ($z = 10.10$, $p < .001$). Related information is available in the CJC's 2026 report, *Examining Equity in the Recriminalization of Drug Possession in Oregon*. [11]

Table 3.9. BHD Participant Demographics

	Referred		Eligible		Entered	
Demographic	**Number**	**Pct**	**Number**	**Pct**	**Number**	**Pct**
Age						
18 – 29	930	20%	824	21%	619	21%
30 – 39	1,852	41%	1,579	40%	1,180	41%
40 – 49	1,092	24%	931	24%	693	24%
50 and older	684	15%	578	15%	416	14%
Gender						
Male	2,731	60%	2,324	59%	1,777	61%
Female	1,542	34%	1,370	35%	1,078	37%
Another gender	22	<1%	21	1%	17	1%
Unknown	263	6%	197	5%	36	1%
Race and ethnicity						
AIAN	231	5%	215	5%	178	6%
Asian	28	1%	26	1%	19	1%
Black	246	5%	228	6%	191	7%
Hispanic	337	7%	287	7%	232	8%
NHPI	46	1%	44	1%	37	1%
White	3,273	72%	2,839	73%	2,289	79%
Another race	43	1%	42	1%	31	1%
Unknown	547	12%	416	11%	105	4%
Has a disability	734	16%	691	18%	627	22%
Total	**4,558**	**100%**	**3,912**	**100%**	**2,908**	**100%**

Note. AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NHPI = Native Hawaiian or Pacific Islander. Race and ethnicity categories are not mutually exclusive.

[11] *Examining Equity in the Recriminalization of Drug Possession in Oregon*. Oregon Criminal Justice Commission (2026). http://2026-HB4002-Drug-Possession-Equity-Report%20(1).html

Figure 18. Most Common Living Situations of at Time of Deflection Entry

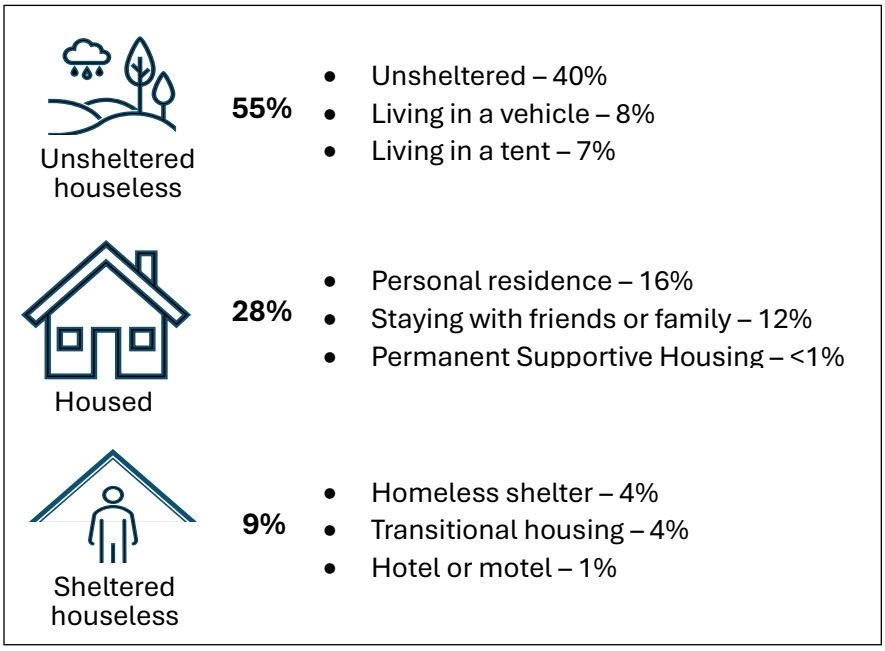


Figure 18 summarizes the most common living situations of participants entering deflection. More than half (55%) of deflection program participants were categorized as unsheltered, houseless. This means that when they entered deflection, the individuals lived in a vehicle (8%), a tent (7%), or unsheltered, outdoors, or somewhere else unfit for habitation (40%). Another 28% of participants were housed when they entered the program. This includes living in a personal residence (16%), staying temporarily or long-term with friends or family (12%), and a small percentage who lived in Permanent Supportive Housing (<1%). The next most common living situation, among participants entering deflection, was sheltered, houseless (9%). This means the individuals lived in a homeless shelter (4%), transitional housing (4%), or were temporarily sheltered at a hotel or motel (1%). Less common living situations at the time of program entry included a jail or correctional facility (2%) or a residential treatment facility (1%), or other (1%). In 5% of events, the participants' living situation was unknown or not recorded.

Regardless of where participants lived, deflection program staff also reported participants' perceptions of the safety and stability of their living situation when they entered the program. As shown in Table 3.10, a majority of participants had unstable (65%) or unsafe (54%) housing situations.

Table 3.10. Participant Perceptions of Housing Stability and Safety at Program Entry

	Number	Pct
Housing is stable	773	27%
Unstable	1,892	65%
Unknown	243	8%
Housing is safe	1,026	35%
Unsafe	1,577	54%
Unknown	305	10%
Total	**2,908**	**100%**

3.6 Assessments and Diagnoses among BHD Participants

Of 2,908 events in which participants entered deflection, participants received at least one assessment or screening in 2,353 events (81%). Table 3.11 shows that the most common were the American Society of Addiction Medicine Criteria (47%) which is used when determining an individuals' needed level of care for SUD treatment, or another type of SUD screening (ASAM.org, 2026).

Table 3.11. Assessments and Screenings Provided to BHD Participants

Assessment or screening type	Number	Pct
American Society of Addiction Medicine Criteria	1,363	47%
Substance use	1,375	47%
Mental health	1,260	43%
Social determinants of health	1,242	43%
Physical health	772	27%
No assessments	414	14%
Unknown	141	5%
Total	**2,353**	**100%**

Note. Categories are not mutually exclusive (n = 1,563 participants received more than one screening or assessment).

Mental health assessments or screenings were provided in 43% of events, as were screenings for social determinants of health (43%). Physical health assessment or screenings were less common (27% of events).

Participants in most deflection events (85%) were reported as having a substance use disorder (SUD), mental health disorder, or co-occurring disorders. In 84% of events, the entering participant had a known SUD; in 29% of events the participant had a known mental health disorder. Co-occurring mental health and SUD were identified in 28% of events; however, the prevalence of co-occurring disorders may be under reported. In some cases, deflection staff were aware of an SUD and reported uncertainty about mental health conditions. 3.12 summarizes the prevalence of known participant diagnoses.

Table 3.12. Behavioral Health Diagnoses among BHD Participants

Diagnosis	Number	Pct
Any diagnosis identified	2,479	85%
Substance use disorder	2,451	84%
Mental health disorder	847	29%
None identified	38	1%
Unknown	379	13%
Total	**2,908**	**100%**

Note. Diagnosis subcategories are not mutually exclusive (n = 819 participants had known co-occurring substance use and mental health disorders).

In Practice

Compassionate Support and the Possibility of Change

"This client is an unhoused individual… who has struggled with long-term substance use and unemployment… [T]he client was offered… and accepted the opportunity to engage in services. As part of the program, the client successfully entered a 90-day residential treatment facility and completed the program in full… The client shared that, without the deflection program, they do not believe they ever would have been able to get sober because they simply 'didn't know how.' They described themself as being 'personally and emotionally at the end of their rope,' explaining that they felt completely out of options and were struggling in every aspect of life. Since entering treatment and engaging with services, the client stated that they now have a renewed sense of hope and purpose. They reported that things are finally beginning to improve in their life. They have obtained employment and secured stable housing, which they described as life changing. The client expressed gratitude for what many people take for granted, including being able to take a warm shower, sleep in a bed each night, and wash their clothes whenever needed.

When discussing barriers to recovery, the client acknowledged that their biggest obstacles were their own mental barriers, the lifestyle they had been living, and their inability to hold themself accountable for their actions. They explained that [the program] approached them with compassion and support, [which] helped them begin believing that positive change was possible."

Minimally edited to protect anonymity

Of 2,908 deflection entries, 84% had an identified SUD. Table 3.13 shows the types of substances used by participants with a reported SUD, and Figure 19 illustrates the most frequently observed categories and intersections among the types of substances. Among participants with an SUD, polysubstance use was prevalent; use of two substances was most common (46%); followed by three substances (15%), and four or more (5%).

Among participants reported as having an SUD, the most frequent substance types used were methamphetamine (79%) and fentanyl (54%). About 20% of participants with an SUD (n = 478) used methamphetamine alone, 9% used fentanyl alone (n = 218), and 30% of participants used both methamphetamine and fentanyl (n = 740). Other common polysubstance use with methamphetamine included cannabis, fentanyl plus cannabis, and alcohol. Refer to Figure 19 for more information.

Table 3.13. Type of Substance Use among BHD Participants with SUD

SUD	Number	Pct
Methamphetamine	1,935	79%
Fentanyl	1,323	54%
Cannabis	542	22%
Alcohol	419	17%
Heroin	135	6%
Other opioids	111	5%
Other amphetamine	102	4%
Cocaine	59	2%
Psychedelics or hallucinogens	27	1%
Benzodiazepines	26	1%
Other or unknown	55	2%
Total	**2,451**	**100%**

Note. SUD type categories are not mutually exclusive. Of 2,908 deflection entries, 2,451 or 84% had an identified SUD

Figure 19. Type of Substance Use Disorder among BHD Participants

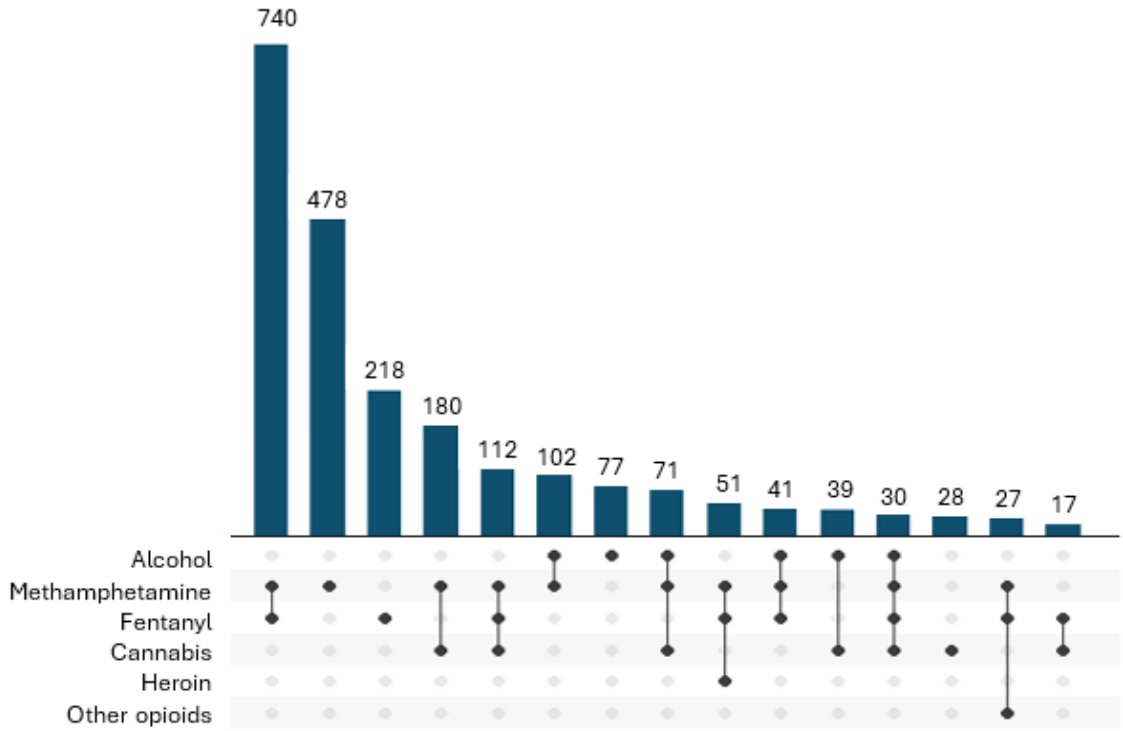


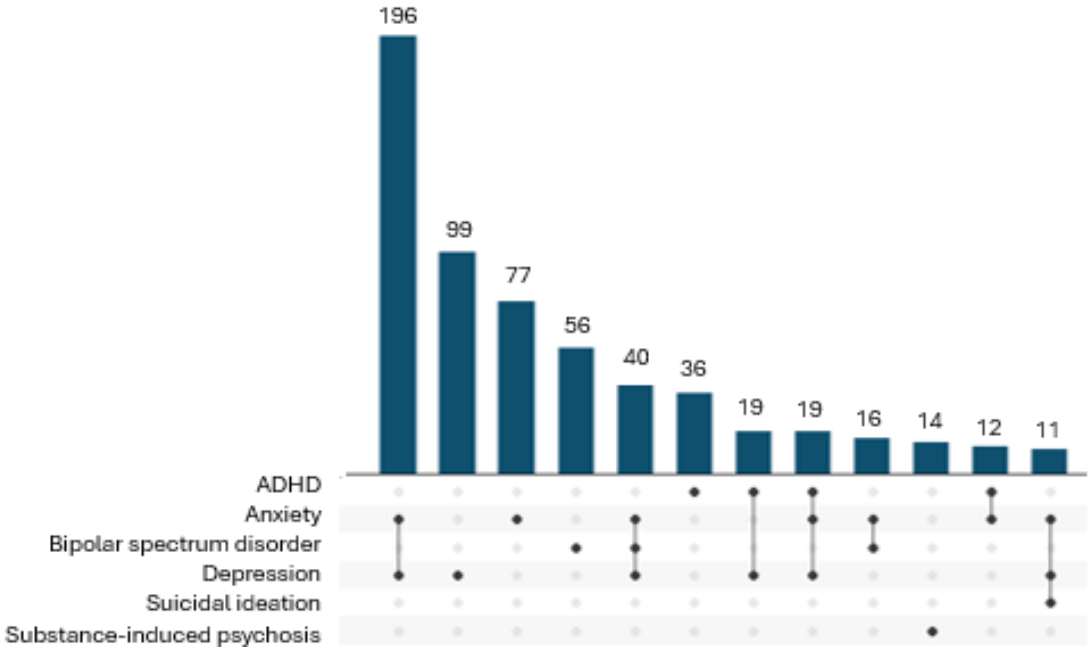
Table 3.14 shows the types of MHD reported for participants who entered deflection, and Figure 20 illustrates the most frequently observed diagnoses and intersections among the types of MHD. Among participants with any MHD, a single diagnosis was most common (42%). Two co-occurring MHDs were reported in 30% of cases; about 18% had three MHDs, 7% had four, and 3% had five or more.

Table 3.14. Type of Mental Health Disorder among BHD Participants with MHD

MHD	Number	Pct
Depression	416	49%
Anxiety	397	47%
Trauma-related disorder	313	37%
Bipolar spectrum disorder	142	17%
ADHD	103	12%
Schizophrenia or psychosis	101	12%
Other mood disorder	43	5%
Personality disorder	42	5%
Suicidal ideation	33	3%
Substance-induced psychosis	28	3%
Other or unknown	70	8%
Total	**847**	**100%**

Note. MHD categories are not mutually exclusive. Of 2,908 deflection entries, 847 or 29% had an identified MHD.

Figure 20. Type of Mental Health Disorder among BHD Participants



Among participants reported as having an MHD, the most frequent diagnoses were depression (49%) and anxiety (47%). Depression and anxiety co-occurred in 23% (n = 196) of cases and together with bipolar spectrum disorder in another 5% (n = 40) of cases. Bipolar spectrum disorder alone was present in 7% (n = 56) of diagnosed cases. ADHD occurred alone in 4% (n = 36) of cases or with anxiety (n = 12), depression (n = 19), or both (n = 19) in 6% of cases. Refer to Figure 20 for more information.

3.7 Services Received by BHD Participants

During deflection, participants are referred to different types of needed services. Services received by participants during their deflection events are summarized in Table 3.15. More detail about the prevalence of service referrals and service receipt status also appears in Appendix B, Table B-3. Data in Tables 3.15 and B-3 (appendix) reflect the subset of deflection entries with complete service referral records. Of 2,908 deflection entries during the reporting period, 2,619 (90%) had completed service information. Service information may be incomplete or pending when a participant is still currently active in the deflection program or when a participant recently completed or exited the program and staff are still working to enter or verify their service activities.

In 58% of deflection events with complete service information, participants received SUD treatment or services. The most frequent types of SUD services received were recovery support (39%), outpatient (32%), intensive outpatient treatment (14%), detoxification or withdrawal management (13%), harm reduction (13%), and medication for opioid use disorder (10%).

In 35% of deflection events with complete service information, participants received social and health-related services, including housing supports (24%), intensive case management (15%), items to meet basic needs such as clothing or hygiene products (12%), transportation assistance or other services or support needs (11%), and the provision of a cell phone to facilitate service coordination and access to other supports (10%).

In Practice

Essential Services Help a Participant Move Forward

"...[W]e received a referral... who was currently unemployed. The program was able to step in and provide them with a two-week motel stay, along with peer support to help them tackle some of the obstacles they were facing, like getting their birth certificate, ID, and OHP. They also decided to enroll in our internal [housing] program and our supportive employment program. They chose to keep engaged with these services because they believe they can really help them move forward."

Minimally edited to protect anonymity

In 11% of deflection events with complete service information, participants received mental health services, such as counseling (9%) or group therapy (6%). Culturally specific services such as interpretation, translated materials, or language concordant care were received by participants in 3% of deflection events with complete service information.

Table 3.15. Services Most Commonly Received by BHD Participants

Service type	Received by	
	Number	Pct
SUD services		
Recovery support	1,011	39%
Outpatient treatment	838	32%
Intensive outpatient treatment	371	14%
Harm reduction	350	13%
Detoxification or withdrawal management	341	13%
Medication for opioid use disorder	269	10%
Residential facility	179	7%
Contingency management	156	6%
Medication for stimulant use disorder	140	5%
Sobering services	75	3%
Medically managed inpatient treatment	70	3%
Medication for alcohol use disorder	34	1%
Subtotal	**1,510**	**58%**
Social and health-related services		
Housing supports	627	24%
Intensive case management	392	15%
Basic needs (e.g., clothing, hygiene products)	303	12%
Transportation	298	11%
Cell phone	270	10%
Employment supports	166	6%
SNAP enrollment or other food-assistance	131	5%
Legal assistance	104	4%
Oregon Health Plan enrollment	90	3%
Primary care	67	3%
Driver's license or identification	60	2%
Family services	50	1%
Other benefits enrollment	33	1%
Dental care	28	1%
Subtotal	**925**	**35%**
Mental health services		
Mental health counseling	228	9%
Group therapy	148	6%
Mental health medication	74	3%
Psychotherapy	37	1%
Hospitalization	16	1%
Subtotal	**300**	**11%**
Culturally specific care		
Culturally and linguistically specific care	68	3%
Interpreter services or translated print materials	16	<1%
Subtotal	**72**	**3%**
Total	**1,700**	**100%**

Note. Categories are not mutually exclusive. Of 2,619 deflection entries with complete service information, 1,700 or 65% received any services.

In Practice

Seeking Creative Solutions to Limited Treatment and Service Capacity

"…[L]imited treatment capacity, waitlists, and the lack of flexible services for participants with complex needs continue to create barriers to successful engagement. Our team remains committed to working collaboratively with community partners, identifying creative solutions, and advocating for additional resources that better support individualized care and long-term stability."

When deflection participants are referred to a service and do not actually receive the service, deflection staff indicate the reason(s) for service non-receipt. Across all service referrals in which the service was not received, the primary reasons are provided in Table 3.16. Most of the time (68%), when a referred service was not received, it was because the participant declined the service. The next most frequent reasons were that the referred service was not available in the program area (27%) and that program staff could not reach or contact the participant and were unable to follow up on their service referral (25%).

Table 3.16. Reasons Referred Services Not Received

Reason	Number	Pct
Participant declined the service	1,882	68%
Service not available in the area	745	27%
Unable to recontact participant for follow up	682	25%
Waitlist was too long	97	4%
Change to treatment plan	48	2%
Service no longer needed	31	1%
Coordinated Care Organization refused coverage	11	<1%

Note. Categories are not mutually exclusive.

3.8 Key Outcomes among Deflection Participants

3.8.1 Successful Completion of Deflection Events

During the reporting period, participants successfully completed their program in 940 deflection events (32% of events in which a participant entered the program). How long a participant remains in deflection before they may achieve completion status varies by program. Some programs have a minimum duration (e.g., 90 days) or specify that certain requirements must be met within a stated time frame (e.g., accessing services within 30 days or providing a series of negative drug tests). For other programs, criteria are not time-bound or may reflect more subjective assessments of an individual's progress, such as program engagement, reduced substance use, or improved quality of life.

County programs set their own completion criteria and report which criteria participants satisfy to finish the program. Because programs differ in philosophy and approach, they use different terms to describe what happens when core requirements are met. In many cases, the participant "completes" the program, or they may "graduate" or "move to alumni status." Programs that emphasize graduation or alumni status often do so to highlight that participants retain access to supports whenever needed.

Table 3.17 shows the most common criteria that participants met to complete or graduate from their deflection programs. Most often, the participant accessed services within a program-specified time frame (62%), completed an SUD assessment (58%), or continued to engage with a treatment plan for an established amount of time (54%). In just under half of completed events (47%), the participant completed required or agreed-upon treatment goals, and more than one-third of the time (38%), they engaged with a case manager.

Table 3.17. Criteria Most Frequently Satisfied to Complete a Deflection Program

Reason	Number of programs ever used the criterion	Number of events in which criterion was applied	Pct of events in which criterion was satisfied
Accessed services within specified time	22	586	62%
Completed a SUD assessment	21	547	58%
Continued engagement with treatment plan	23	509	54%
Completed treatment goals	22	445	47%
Engagement with case manager	17	358	38%
Improvement in quality of life	19	280	30%
Reduced substance use	18	251	27%
No new criminal activity	17	231	25%
Improvement in homelessness	14	172	18%
Reduction in recidivism	13	142	15%
Negative drug testing	11	121	13%
Increased harm reduction	11	103	11%
Improvement in employment status	10	79	8%
Reduced hospital or emergency dept. visits	6	46	5%
Total	**26**	**940**	**100%**

Note. Categories are not mutually exclusive (n = 737 satisfied multiple completion criteria).

When a participant does not graduate or complete their deflection program, BHD staff report one or more reasons why participation was incomplete. Most often (63%), the participant did not engage with the treatment plan, or they were lost to follow up (53%), meaning program staff could not reach or engage them. See Table 3.18 for more.

Table 3.18. Reasons for Deflection Program Non-Completion

Reason	Number	Pct
Did not engage with treatment plan	1,005	63%
Unable to contact participant or follow up	841	53%
Voluntarily left the program	202	13%
Declined housing support	107	7%
Substance use	107	7%
New criminal justice involvement	94	6%
Needs a higher level of care	22	1%
Other	35	2%
Total	**1,593**	**100%**

Note. Categories are not mutually exclusive (n = 621 had more than one reason for non-completion).

In Practice

Recognizing the Value of Second Chances

"…[O]ur deflection team has learned that recovery often requires more than one opportunity. Last year, an individual enrolled in the program but was unable to successfully complete treatment due to inconsistent attendance and limited engagement in the process. [Later], this individual reached out seeking another opportunity to participate in treatment. After careful consideration, we welcomed them back… Since re-engaging in treatment… [t]he individual has remained in regular contact with our team, has demonstrated a stronger commitment to the program, and is consistently attending treatment. This experience highlights the value of providing second chances and recognizing that readiness for change can develop over time."

3.8.3 Observed Change in Participant Circumstances at Program Exit

Deflection program staff reported on social determinants of health measures at the time of program entry and again at program completion. Among the 940 deflection events in which participants completed the program, 865 (92%) included at least one identified need relating to housing, employment status, access to health care, or food security. Table 3.19 shows that of these 865, 517 (60%) recorded participant improvement in one or more of these quality-of-life indicators.

Most often (63%), participants improved in access to health care. Among events in which participants entered and completed the program, 32% of the time participants entered needing basic or primary care, dental care, prescription medications, chronic condition management, or with other medical needs.

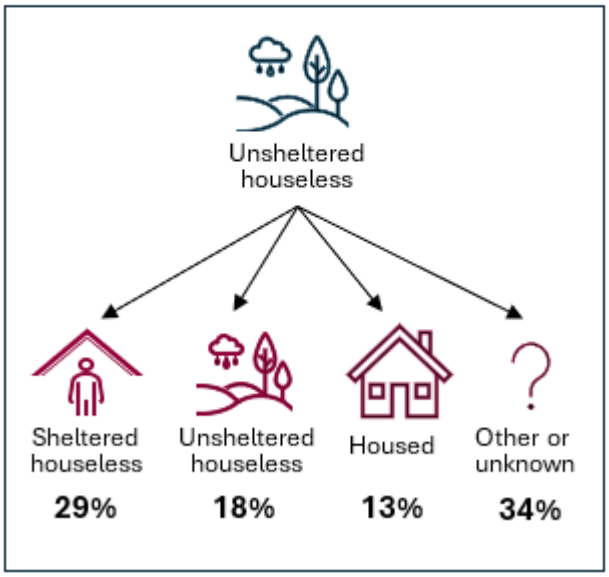
Table 3.19. Improvements in Social Determinants of Health among Participants who Completed Deflection

Social determinant of health	Need identified (among complete)	Improved from program entry to completion	
	Number	Number	Pct
Access to health care	304	192	63%
Housing	669	324	48%
Food security	358	137	38%
Employment	719	173	24%
Total	**865**	**517**	**60%**

Note. Categories are not mutually exclusive (n = 517 participants experienced improvement in more than one area).

Among completed events, 78% of entering participants were houseless or had unsafe or unstable housing, and 48% of them had improved living situations by program exit. Figure 21 illustrates changes in living situation from program entry to exit among participants who were unsheltered at the time of entry. Of those who were unsheltered at program entry, 29% were sheltered. 13% were housed, and 18% remained unsheltered at program completion. Another 34% had housing status unknown or not reported at program completion, which makes it difficult to accurately interpret any change in status. Of those who were housed at program entry, most (65%) remained housed at program completion. Some (11%) were sheltered houseless, and 18% had unknown living situations. Of completed participants who resided in a shelter at the time of program entry, most (60%) resided in a shelter at program completion; another 17% had unknown living situations, and 15% were housed.

Figure 21. Change in Living Situation from BHD Program Entry to Program Completion



Among completed events, 38% of entering participants needed access to food assistance. By program exit, 38% of those participants were receiving or no longer needed food assistance.

Regarding employment, among completed events, 24% had improved employment status. This includes 10% who had shifted from part-time to full-time work, 9% who had shifted from not employed to employed part-time, and 5% who had shifted from not looking to actively looking for work.

In Practice

The Right Services at the Right Time

"'S' entered the program through our Officer Prevention pathway at a time when they were experiencing significant mental health challenges… Through deflection, they were connected not only to substance use treatment but also to critical mental health services. The program also helped stabilize their immediate needs by securing housing, allowing them to focus on recovery. Once their individualized service plan was established, 'S' fully engaged with both the peer support specialist and counselors… After successfully completing the 30-day program, 'S' transitioned into a supportive apartment and continued participating in day treatment services. Since then, they have remained actively engaged in recovery, rediscovered their passion for creating artwork, and even had their work displayed publicly in a local art exhibit. Over time, they have built the confidence to participate in group activities—something that once felt impossible. [Their] continued progress demonstrates that recovery extends well beyond the initial 30-day intervention when individuals are connected to the right supports at the right time. Their journey illustrates how deflection can remove barriers, foster hope, and create lasting change."

Minimally edited to protect anonymity

Deflection staff also report observed improvements among participants who did not complete deflection. This information was not collected until 2026, so Table 3.20 shows emerging trends based on deflection events since that time. Of incomplete deflection events since January 2026, 26% included improvement in at least one category. The most common improvements reported were substance use reduction (15%), beneficial changes in housing situation (14%), and addressing medical needs (13%).

Table 3.20. Improvements among Participants with Incomplete Deflection Events

Observed improvement	Number	Pct
Reduction in substance use	58	15%
Housing situation	53	14%
Addressed medical needs	50	13%
Social relationships	38	10%
Mental health	30	8%
Employment status	23	6%
Quality of life	8	2%
Total	**99**	**26%**

Note. Categories are not mutually exclusive (n = 64 experienced more than one improvement).

4. Conclusion

IMPACTS and BHD each support Oregon's efforts to address behavioral health needs and reduce criminal legal system involvement. Through differences in programming and participant goals, priorities, target populations, approaches to service delivery, and outcomes, these program areas offer opportunities for counties and Tribal governments to intervene at one or more points in an individual's intersection with public safety and healthcare systems. IMPACTS provides supports for individuals with repeated health system and public safety system contacts at different points in the system, while BHD emphasizes earlier intervention and connection to community-based treatment and services.

The program areas' different positions within the SIM shape when and how individuals are referred, strategies for engaging those participants in treatment and other services, and associated outcomes. While BHD focuses on the early intercepts, IMPACTS can span the SIM, offering additional intervention opportunities for those with more extensive system contacts and histories.

These differences provide important context for interpreting results from each program. Findings in this report shed light on needs common to both programs, like housing instability, substance use disorder, and mental health conditions. Together, these programs fund local efforts to address behavioral health needs, create a more comprehensive continuum of care, and provide a greater range of intervention points to minimize involvement with the criminal legal system and reduce unnecessary emergency healthcare utilization.

IMPACTS and BHD 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.

Appendix A: IMPACTS Supplemental Information

A.1 2025-27 IMPACTS Funding by Program

Table A.1. 2025-27 IMPACTS Funding by Program

Grantee Name	Total Award
Clackamas County	$1,177,724
Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians	$103,976
Confederated Tribes of Grand Ronde	$579,788
Confederated Tribes of Warm Springs	$339,904
Cow Creek Band of Umpqua Tribe of Indians	$324,760
Deschutes County	$2,469,460
Douglas County	$1,071,020
Hood River County	$341,020
Jackson County	$640,328
Lane County	$2,225,880
Lincoln County	$324,680
Multnomah County	$377,312
Umatilla County & Morrow County*	$429,844
Union County	$185,016
Wasco County	$193,448

** Regional consortium*

A.2 IMPACTS Evaluation Data Notes

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 grant recipients, 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. 12

Client-level data for IMPACTS is reported by each program. Information is collected at time of enrollment, including demographics, behavioral health indicators, services provided in the first month of engagement, and system encounters in the year prior to engagement. Subsequent months of engagement are captured in an update form in REDCap®, including receipt of services and additional system encounters until participant attrition.

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) in 2024. 13 A cumulative second report detailing the second grant cycle is expected in November 2026.

The CJC is currently undertaking processes to identify and, in subsequent biennia, standardize best practices among IMPACTS programs operating in this state across relevant domains, such as identification of target population members, and using evidence-based approaches to treat and serve high utilizer populations.

---

[12] 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.

[13] 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.

Appendix B: BHD Supplemental Information

B.1 2025-27 BHD County Funding by Program

As part of Phase 2 of the solicitation, applicants developed projections of the number of individuals eligible for BHD in their jurisdiction (based on local criteria) and the number of individuals who likely would enroll in BHD. Then, the Commission determined the formula to calculate each county's share of the remaining available funds: 45% for projected enrolled participants; 5% for projected eligible participants; 40% for the percentage and number of individuals who had enrolled in deflection between January and June 2025; and 10% for the county's rate of enrollment. The 26 approved programs submitted budget projection details and funding requests that could not exceed their total formula share.

Table B-1. 2025-27 BHD County Funding by Program

Grantee Name	Total Award
Benton County	$431,355
Clackamas County	$1,283,630
Clatsop County	$943,057
Columbia County	$328,008
Crook County	$300,000
Deschutes County	$1,449,796
Gilliam County	$300,000
Grant County	$300,000
Harney County	$303,201
Hood River County & Wasco County*	$600,000
Jackson County	$2,508,775
Josephine County	$2,015,306
Klamath County	$413,911
Lane County	$4,579,771
Lincoln County	$1,341,909
Linn County	$750,714
Malheur County	$479,091
Marion County	$1,992,768
Morrow County	$277,542
Multnomah County	$6,671,870
Polk County	$736,827
Tillamook County	$416,499
Umatilla County	$530,772
Union County	$497,766
Washington County	$3,153,182
Yamhill County	$1,838,507

**Regional Consortium*

B.2 2025-27 BHD Tribal Funding by Program

Table B.2. 2025-27 BHD Tribal Funding by Program

Grantee Name	Total Award
Confederated Tribes of Coos, Lower Umpqua and Siuslaw*	$371,680.00
Confederated Tribes of Siletz Indians*	$867,556.00
Confederated Tribes of the Umatilla Indian Reservation*	$524,728.00
Confederated Tribes of Warm Springs Reservation*	$466,414.00
Coquille Indian Tribe	$218,766.00
Cow Creek Band of Umpqua Tribe of Indians	$273,882.00
Klamath Tribes*	$614,548.00
The Confederated Tribes of Grand Ronde*	$803,480.00

**Combined 2023-25 and 2025-27 awards*

B.3 BHD Evaluation Data Notes

HB 4002 (2024) outlines data collection and evaluation requirements for BHD programs. The CJC partners with the OHSU-PSU School of Public Health (SPH) to manage a statewide data system for deflection and engage with county BHD programs for data-related technical assistance and data quality monitoring. County programs report a common set of metrics using the statewide system, established by SPH in REDCap®. BHD program data informs the CJC's annual evaluation efforts, enables the identification of best practices, and offers an opportunity to provide feedback on program practices that are most likely to improve effectiveness and outcomes for BHD participants. The REDCap® data system applies to county BHD programs only; BHD Tribal programs report data separately with the CJC, according to negotiated government-to-government agreements.

County programs enter both identified and de-identified information into REDCap® and data are then securely shared from SPH to the CJC. De-identified program data includes demographic characteristics, screening and service provision, and outcomes such as changes in social determinants of health from program entry to program exit. Participant identifiers (e.g., name, date of birth) are stored and transmitted separately from de-identified program measures to preserve a level of anonymity. These data are used specifically for matching records with state administrative sources, such as criminal legal and public health data systems. This allows the CJC and contracted partners to examine a more robust set of outcomes, such as criminal legal involvement, recidivism, and healthcare utilization across relevant grantee and comparison group subpopulations.

B.4 BHD Service Referrals and Outcomes

Table B.3. BHD Service Referrals and Service Referral Outcomes

	Number			
Service type	**Referred**	**Received**	**Not received**	**Don't know if received**
SUD services				
Recovery support	1,252	1,011	206	35
Outpatient treatment	1,269	838	386	45
Intensive outpatient treatment	604	371	192	41
Harm reduction	404	350	23	31
Detoxification or withdrawal mgmt.	802	341	461	0
Medication for opioid use disorder	470	269	159	42
Residential facility	591	179	361	51
Contingency management	176	156	3	17
Meds for stimulant use disorder	217	140	50	27
Sobering services	106	75	13	18
Medically managed inpatient	213	70	93	50
Medication for alcohol use disorder	68	34	8	26
Social and health-related services				
Housing supports	928	261	34	40
Intensive case management	410	10	6	8
Basic needs (e.g., clothing, hygiene)	313	5	3	5
Transportation	310	4	6	8
Cell phone	280	3	6	7
Employment supports	199	22	9	11
SNAP or other food-assistance	161	20	9	10
Legal assistance	112	3	5	5
Oregon Health Plan enrollment	121	26	4	5
Primary care	99	18	9	14
Driver's license or identification	74	5	8	9
Family services	62	5	6	7
Other benefits enrollment	57	33	10	14
Dental care	51	28	23	0
Mental health services				
Mental health counseling	361	228	110	23
Group therapy	179	148	20	11
Mental health medication	135	74	42	19
Psychotherapy	72	37	17	18
Hospitalization	31	16	7	8
Cultural and linguistic services				
Culturally specific care	73	68	4	0
Interpreter or translated materials	17	16	0	1
Language concordant care	10	10	0	0
Total with any service referrals	**2,269**			

Note. Categories are not mutually exclusive, and many events include referral to multiple types of services. Of 2,619 deflection entries with complete service information, 2,269 or 87% were referred to any services.