# Oregon Behavioral Health Deflection Program Best Practices Report

*Per House Bill 4002 (2024)*

April 1, 2025

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Oregon Criminal Justice Commission

Ken Sanchagrin
Executive Director

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

# Produced for the Oregon Criminal Justice Commission

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# Executive summary

House Bill (HB) 4002 (2024) created the Oregon Behavioral Health Deflection (BHD) Program to provide grant funding for deflection programs that assist individuals whose behavioral health conditions, including substance use disorder, lead to interactions with law enforcement, incarceration, conviction and other engagement with the criminal legal system. As required by HB 4002, this report identifies best practices and funding recommendations through emerging evidence and common practices for deflection nationally and examines Behavioral Health Deflection (BHD) programs in Oregon. Data sources include: 1) comprehensive literature review, 2) consultation with national subject matter experts, 3) qualitative interviews with BHD grantees, 4) review of BHD grant applications, and 5) preliminary analysis of statewide program data submitted between October 2024 and March 2025.

This document provides a high-level overview of program models and findings at all points of the deflection process. It includes terminology, definitions, pathways, and model elements that are nationally recognized and evidence-based, providing a common framework with which to approach and discuss deflection.

## Program model key findings

The table below summarizes selected key findings for BHD model elements, emphasizing best practices and emerging evidence.

| Key findings | Strength of evidence | Report section |
|---|---|---|
| Broadening eligibility beyond stand-alone misdemeanor Possession of Controlled Substances extends the reach of deflection programs. | Emerging evidence | Program eligibility |
| The LEAD® model has been shown to produce certain positive deflection outcomes. | Best practice | Deflection pathway |
| Operating multiple pathways to deflection extends program reach. | Emerging evidence | Deflection pathway |
| Using co-responders can increase individuals' connection and engagement with services. | Emerging evidence | First point of contact |
| Utilizing warm handoffs increases deflection enrollment. | Best practice | Handoff to program |

| | | |
|---|---|---|
| In the absence of a warm handoff, conducting outreach as close as possible to the time of the deflection can lead to increased deflection enrollment. | Emerging evidence | Handoff to program |
| Conducting assessments in the field and supporting alternative modes of transportation can increase participant engagement and access to services. | Emerging evidence | Handoff to program |
| Collecting quality of life indicators and program engagement can be used as meaningful indicators of individual success. | Emerging evidence | Defining success |

To facilitate program support and growth, this report includes recommendations to the Oregon Legislature, which are summarized below.

## Recommendations

- Adopt a clear framework for program requirements while allowing flexibility to tailor programs by locality and clarify legislative expectations around deflection programming.
- Enable local programs to have access to funding that is adequate for their purposes, consistently available, and at a predictable cadence.
- Support a baseline training curriculum for use across the state to ensure consistent understanding of deflection principles to facilitate buy-in.
- Build an intentional connection between Coordinated Care Organizations/Medicaid and deflection teams and continue legislative efforts to increase the capacity of Oregon's behavioral health system.

Deflection is a complex and nuanced intervention with many moving pieces. Intensive coordination is required by multiple partners across varying sectors to effectively operate programs and ensure connections to appropriate services for all participants. Programs in Oregon are continually evolving and will take time to fully develop.

**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.grants@cjc.oregon.gov. The full report may also be accessed online at: https://www.oregon.gov/cjc.

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# Acronym list

**BHD –** Behavioral Health Deflection

**CIT –** Crisis Intervention Teams

**CJC –** The Oregon Criminal Justice Commission

**CLI –** Criminal Legal Involvement

**DA –** District Attorney

**ECHO –** Extension for Community Healthcare Outcomes

**ED –** Emergency Department

**EMS –** Emergency Medical Services

**HB –** House Bill

**LE –** Law Enforcement

**LEAD® –** Law Enforcement Assisted Diversion

**OHSU-PSU SPH –** Oregon Health & Science University-Portland State University school of Public Health

**ORPRN –** Oregon Rural Practice-Based Research Network

**PCS –** Possession of a Controlled Substance

**PSS –** Peer Support Specialist

**QRT –** Quick Response Team

**REDCap –** Research Electronic Data Capture

**SAMHSA –** Substance Abuse and Mental Services Administration

**SDOH –** Social Determinants of Health

**SUD –** Substance Use Disorder

**TA –** Technical Assistance

# Introduction

## Oregon Behavioral Health Deflection Program

Oregon House Bill (HB) 4002 (2024)[1] enacted drug enforcement misdemeanor provisions for possession of small amounts of controlled substances (effective September 1, 2024) that were previously decriminalized in the Oregon Drug Addiction Treatment and Recovery Act (effective February 1, 2020).[2] Under HB 4002 (2024), unlawful possession of user amounts of a controlled substance (PCS) is considered a drug enforcement misdemeanor and is punishable by incarceration for up to 180 days or 18 months of supervised probation.

Alongside these changes, HB 4002 (2024) created the Oregon Behavioral Health Deflection (BHD) Program to provide grant funding for deflection programs that assist individuals whose behavioral health conditions, including substance use disorder, lead to interactions with law enforcement, incarceration, conviction and other engagement with the criminal legal system. The Oregon Criminal Justice Commission (CJC) administers the BHD grant program and funds county and tribal governments. Local jurisdictions develop and implement programs that, in lieu of or after citation or arrest for PCS, offer individuals assessment, substance use disorder (SUD) treatment, and other services as an alternative to arrest or conviction. BHD programs throughout the state use a wide range of strategies to reduce drug-possession arrests, deflect individuals away from the criminal legal system, and refer people to substance use and/or mental health treatment services.[3]

This report satisfies the requirement set forth in House Bill 4002 (2024) to identify best practices and develop funding recommendations to the Oregon Legislature by April 1, 2025.

## Deflection 101

Throughout this report, deflection is defined as:

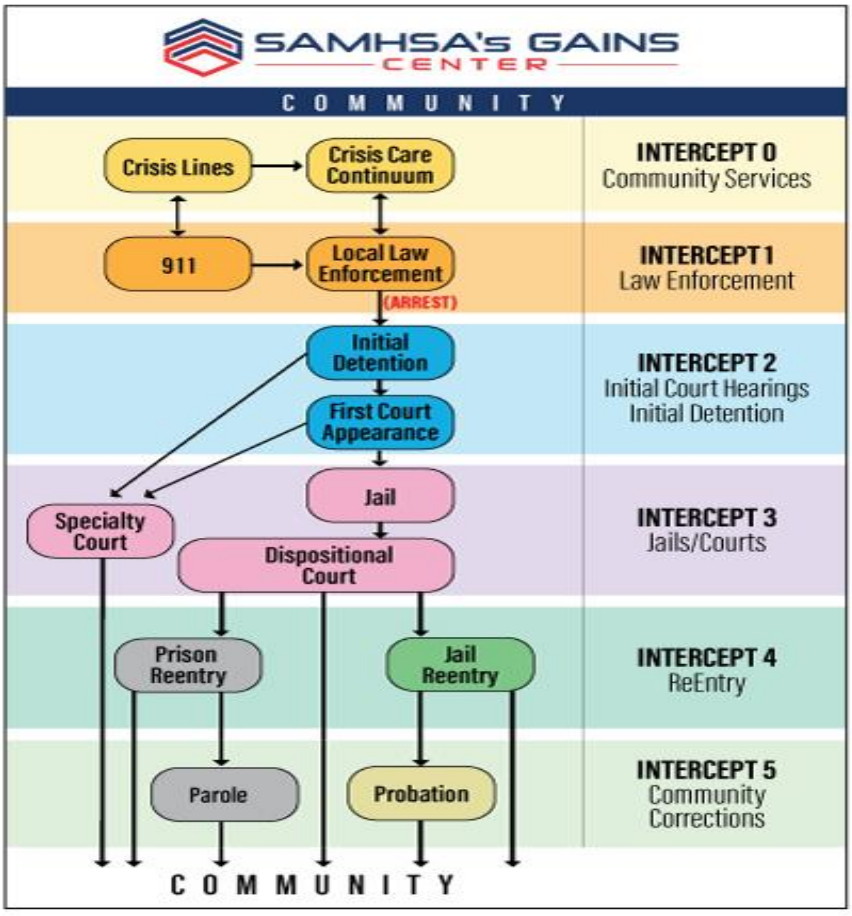
> ***"A collaborative intervention connecting public safety (e.g., police, sheriffs) and public health systems to create community-based pathways to treatment for people who have substance use disorders, mental health disorders, or both, and who often have other service needs, without their entry into the justice system."[4]***

Over the last fifty years, alternatives to entry into the criminal legal system for drug-related offenses have become more formalized. One such alternative is a deflection program that links individuals to services such as mental health or substance use treatment, case management, housing supports, or food assistance.[5] See Appendix A for a more detailed discussion of the deflection target population, including a profile of health status, service needs, and strategies to support appropriate referrals.

### The Sequential Intercept Model

There are different points within the criminal legal system at which deflection interventions may occur. The Sequential Intercept Model[6], illustrated in **Figure 1** below, maps how individuals with behavioral health disorders typically move through the system and identifies specific points when there is an opportunity to intervene with services such as behavioral health, housing, and employment.[7]

**Figure 1. The Sequential Intercept Model**




*Source: Substance Abuse and Mental Health Services Administration 2024*

Deflection refers to programs and services that are offered before the individual is formally involved in the criminal legal system but may include arrest (Intercepts 0-1).[6] Diversion refers to pre-plea options that exist through law enforcement, prosecutors, and courts before a guilty conviction has occurred (Intercept 2).[6] There are also post-plea diversion programs where individuals are offered options after a guilty conviction (Intercept 3).[6]

**Pathways to deflection**

People are referred to and enter deflection programs in a variety of ways. The circumstances can vary from encounters with law enforcement to first responders and community members. As shown in **Table 1** below, six pathways have been identified as commonly used deflection models nationwide.[8] All of the pathways except Officer Intervention can potentially be what is termed a "social referral," where no charges or potential charges are associated with the deflection encounter. Social referrals can be initiated by any deflection partner or community member. To date, more research is needed to assess the comparative impact of each pathway on deflection outcomes, e.g., reduced substance use or recidivism.[9]

The Law Enforcement Assisted Diversion (LEAD®) model, for instance, utilizes multiple deflection pathways.[10] LEAD® offers law enforcement officers latitude to refer deflection candidates at the time of arrest, or potential arrest, if eligible offenses are present, which could include offenses stemming from unmet behavioral health needs or poverty. In addition to pathways driven by law enforcement, the LEAD® model includes referrals by community partners that do not involve law enforcement or other emergency responders.[10] Examples of multiple standardized models that communities have implement can be found in Appendix B.

**Table 1. Deflection pathways**

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

*Sources: adapted from Bureau of Justice Assistance 2023[8]*
*Notes: LE – law enforcement; PSS – Peer support specialist*

### Role of law enforcement in deflection

The role of law enforcement in deflection is complex and varied. Decisions law enforcement make during initial encounters with a deflection candidate (e.g., arrest or citation) directly impact the timing of a deflection referral and at which point it is implemented in the criminal legal process (see SIM Map on page 2). The decision to arrest an individual in a particular circumstance is determined, in part, by law enforcement's observation of the individual's behavior and known history, the perceived severity of the offense, and the options available to officers in their locality.

Depending on the deflection pathway, interactions between law enforcement and a deflection candidate can range from providing information to individuals about seeking services, to linking with a peer support worker in the field, to transporting individuals directly into the care of behavioral health providers (e.g., crisis intervention center, therapeutic walk-in clinic).

Nationally, deflection programs have used law enforcement response in several different ways to best fit community needs and available resources. For example:

- All officers are trained in deflection and when to make referrals instead of arrests[11]
- Officers make social referrals when not part of a criminal incident[12]
- Any officer calls deflection-specific officers to make the referral[13]
- Police stations serve as self-referral sites, sometimes with additional navigators present to facilitate referral[9]
- Deflection-specific officers provide Active Outreach to people who recently experienced a non-fatal overdose[14]
- Community members initiate a social referral in collaboration with a law enforcement officer[15]
- Law enforcement co-responds with social workers or crisis workers[9]

**Resources:**

**First Responder Deflection Certification Course** 🔗
An eCourse from JCOIN that introduces deflection

**PTACC: Suite of Deflection and Pre-Arrest Diversion Resources** 🔗
Downloadable resources from the Police, Treatment, and Community Collaborative

# Oregon BHD grantees

Before diving into best practices, some context on Oregon's BHD grant programs and the process through which their program elements were synthesized is key. The BHD grant is administered by the CJC with award decisions made by the Improving People's Access to Community-Based Treatment, Supports, and Services (IMPACTS) grant review committee. Awarded funds may be used for expenses such as deflection program operation, law enforcement employees, deputy district attorneys (DDAs), behavioral health treatment workers, behavioral health workforce development, and capital construction of behavioral health treatment infrastructure. HB 5204, the companion funding bill to HB 4002 (2024), was signed into law in April 2024 to fund the BHD grant program and associated costs for evaluation and reporting.[16]

At a minimum, BHD deflection partnerships must include a district attorney, a law enforcement agency, a community mental health program and a provider from a Behavioral Health Resource Network. Partnerships may also include treatment providers, local mental health authorities, tribal government, peer support organizations, courts or local government bodies. BHD grantees are required to have a program coordinator, whose responsibilities include convening deflection program partners for program operations, managing grant funds awarded, and tracking and reporting data as required by statute.[1]

Twenty-eight counties applied for and received BHD grant funding for the period July 1, 2024, through June 30, 2025. Two of these counties formed a regional consortium to operate a single program. Nineteen of those counties applied early, so their project period began on April 1, 2024.

## Oregon county context through the lens of deflection

Nineteen county deflection program teams participated in interviews between July and November 2024 to describe their planning and implementation processes. Program team members interviewed included deflection program coordinators, law enforcement officers, behavioral health agency team members, corrections staff, members of district attorneys' offices, and other county-level staff. These interviews provided additional understanding about the types of programs counties were implementing and the variety of early successes and challenges they experienced.

Counties reflected on their previous experience with deflection-related activities and their motivations for starting a deflection program. They also described the unique

characteristics of their counties, and how these shaped their deflection programs. Their experiences shed light on the wide variation in Oregon counties in terms of community priorities, geography, and resources. Qualitative methods and a more detailed analysis of Oregon county context can be found in Appendix C.

## Oregon program descriptions

Within the guidelines described above, HB 4002 (2024) allowed grantees latitude to design their deflection program to best suit the needs and resources of their community. As grantee deflection models varied widely, the SPH data team leveraged multiple sources of information to gain a deep understanding of grantee goals, planning activities, and program characteristics. These included review of grantee applications, data collection meetings with grantees, and qualitative interviews.

To systematically compare Oregon programs, model characteristics were organized by six domains, based on a review of national literature and grantee qualitative data. These domains are described in more detail later in the Program Model Elements section.

- **Coordinating agency** – Where the deflection program and coordinator are housed
- **Eligibility** – Inclusion and exclusion criteria for entering program
- **Deflection pathway** – Nationally recognized deflection program pathways
- **First point of contact** – The person who first encounters the individual and initiates the referral to deflection
- **Handoff to program** – How an individual moves from referral to entering the program
- **Definition of success** – Criteria an individual must meet to complete the program

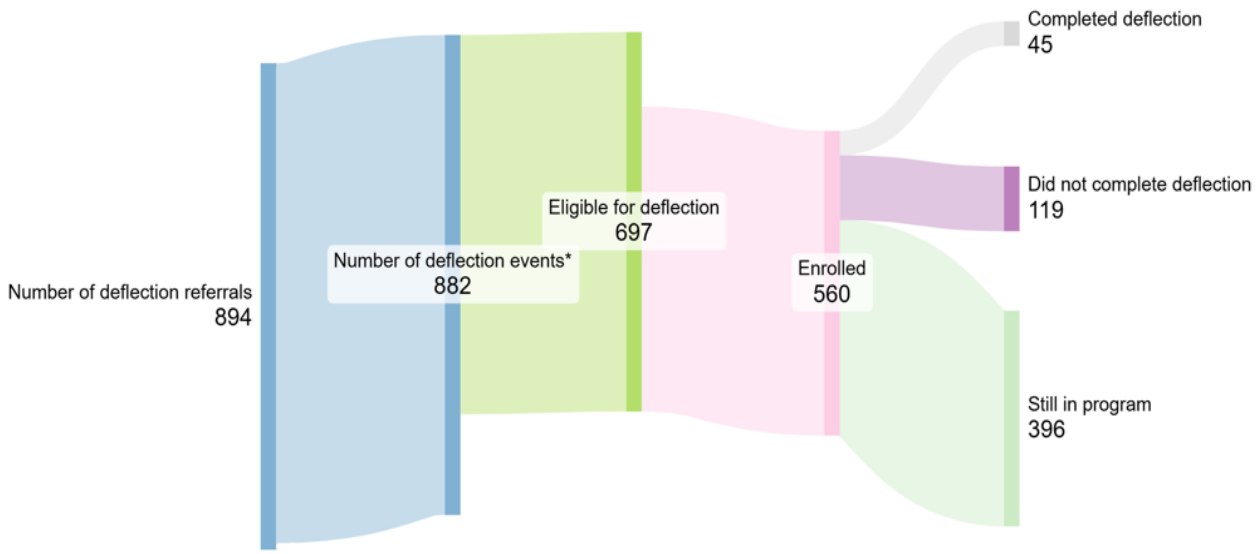
Many grantees changed elements of their program designs as they progressed through the planning and implementation process, expressing interest in continuing to find ways to increase program participation and access to services. This was in response to local contextual factors and receipt of technical assistance. Oregon BHD grantees were supported through planning and implementation by the OHSU implementation technical assistance team. While this support was optional, many took advantage of the opportunity to make model element decisions with help from subject matter experts and to attend training sessions. This assistance is ongoing and

is currently scheduled to continue through May 31, 2025. See Appendix D for a list of all technical assistance opportunities available to grantees through the OHSU implementation technical assistance team.

Oregon BHD programs report on clients and deflection events monthly in the statewide data system. An overall view of how deflection referrals move through programs toward completion is found below in **Figure 2**. Throughout the forthcoming Program Model Elements section, early findings from the statewide data system are presented to support and contextualize best practice findings. Presented in **Figure 2** below, between September 1, 2024, and March 3, 2025, grantees reported 894 referrals to deflection. Of those, 560 individuals were enrolled in the program, with 45 completing deflection and 396 still in the program.

**Figure 2. Overview of deflection referrals in Oregon**

*Data from September 1, 2024 – March 3, 2025*




*1 individual was recorded twice with 2 referrals in the same county; 3 individuals were referred in 2 counties.

**Resources:**

CJC Oregon Behavioral Health Deflection Programs Dashboard
Data dashboards and information pertaining to BHD programs

# Deflection program best practices

This section presents deflection program model elements, emphasizing evidence-based best practices and models with emerging evidence. The field of deflection is rapidly emerging as an area of study at the intersection of public health and the criminal legal system, with increasing opportunities to assess the impact of specific program elements on program outcomes. In addition to best practices and emerging evidence, common practices and strategies reported in the national literature are described in this report.

Throughout the national literature and evidence, three categories of practices emerge. First, ***best practices*** are program elements and practices with well-established associations with deflection outcomes, published in peer-reviewed literature or program evaluations. Practices with ***emerging evidence*** have less evidence but have been researched across multiple localities nationally, with evaluation results where efficacy is described but not measured. Finally, ***common practices*** appear frequently in the literature, but without current evidence of impact on program outcomes.

Each Program Model Elements section is organized as follows:

- **Key findings** – Significant best practices, practices with emerging evidence, and recommendations based on available evidence.
- **National landscape** – Information on national program model elements, with emphasis on best practices and practices with emerging evidence. Common practices are also presented where there is limited evidence.
- **Oregon programs** – Findings from qualitative interviews and data collection meetings with BHD grantees, grant application review, and statewide program data are also presented to provide additional local context and support decision-making around how national best practices might be applied in Oregon.
- **Resources** – Where available, links to literature, toolkits and other online resources are provided.

# Program model elements

## Coordinating agency

*Where the deflection program and coordinator are housed*

### Key Findings

- Most programs are housed in law enforcement agencies.
- Dedicated program staff at the coordinating agency, such as a coordinator or program manager, is a ***common practice*** to help bridge complexities of new and cross-sector partnerships.
- Deflection program coordinators have varying levels of job duties across programs.

**National landscape**

According to the 2020 national deflection survey, law enforcement lead about 75% of deflection programs (more than half by police departments and about 15% by sheriff's offices). Other types of agencies include behavioral health, public health, or social service agencies.[17]

Coordinating agencies can serve many functions in deflection programs. Below are some ***common practices*** observed in the national literature.

- **The coordinating agency houses the deflection program coordinator and serves as the primary agency or "backbone" for coordinating all deflection partners.** It may be responsible for a wide range of activities depending on the type of agency and its function within the deflection program. High-level functions may include activities such as convening workgroup and steering committee meetings, providing trainings and protocols, troubleshooting operational issues, and building relationships with partners. More direct service functions may include discussing new referrals, overseeing case management, and providing updates on participants' progress.[18]
- **Jurisdictions choose the appropriate coordinating agency for their program.** Existing resource infrastructure and how to coordinate and make services accessible should be considered in decision making. Law enforcement and

other first responders implement the majority of deflection programs,[17] but they do not directly provide treatment, case management, recovery support or other wrap-around services essential to support deflection efforts.[5] In some cases, agencies that provide these services may be more appropriate as the coordinating agency.

The deflection coordinator role is viewed differently depending on the program and how it is organized. Ultimately, the deflection coordinator is a critical position for the success of deflection programs.[17] ***Common practices*** for the role of coordinators reported by programs outside of Oregon include:

- **Operating at a high level within the program,** for example, overseeing program staff, managing operational issues, and building partnerships.[17]
- **Involvement with day-to-day operations** and working directly with program participants through program navigation, referrals to services, and participant tracking.
- **Functioning as an intermediary between deflection encounters,** connecting participants to treatment and other services.[14]
- **Serving as a navigator** "who takes ownership of assisting the participant in their journey through complex service systems and guides them so that they do not fall between various system cracks."[9]

### Oregon programs

During qualitative interviews, grantees reported that hiring a deflection program coordinator and deciding which agency should house them were early and important decisions deflection partners made. Counties were acutely aware of the importance of this role for the success of their program. For example, some noted that having a coordinator situated in a law enforcement setting often led to closer relationships and more efficient communications between the coordinator and law enforcement officers.

BHD coordinating agencies are required to designate a program coordinator, who is responsible for convening program partners in support of program operations, managing program funds, and tracking and reporting program data. BHD grantees coordinate their programs from varying agency types, with over half led by law enforcement or by behavioral health provider organizations. Other agencies used to coordinate BHD programs include district attorneys' offices, county agencies, and community corrections.

## Deflection program eligibility

*Inclusion and exclusion criteria for entering program*

**Key Findings**

- Deflection eligibility criteria are not standardized and must be developed to meet program goals within the context of budget and other local resources.
- ***Emerging evidence*** supports broadening eligibility beyond stand-alone misdemeanor PCS to extend the reach of deflection programs.

### National landscape

There is no one-size-fits-all deflection inclusion criteria. The six pathways of deflection are helpful for understanding broad inclusion criteria in terms of specific target populations who may benefit from a program.

- Broadly, a Self-Referral program will include adults with a SUD.[19]
- Active Outreach may be more expansive and include individuals with mental health disorders (in crisis or not), or those who are houseless.[19]
- The Naloxone Plus pathway typically reaches individuals with an opioid use disorder.[19]
- First Responder and Officer Referral (Officer Prevention) and Officer Intervention pathways generally include all of the populations described above, and they may also include individuals being deflected after theft or prostitution offenses.[19]
- Community Referral pathways are built for adults with mental health or substance use disorders, or situations that might involve houselessness or low-level conflicts.[19]

Restrictive eligibility criteria can pose barriers to expanding a program's reach, especially when criteria are implemented without considering individual cases.[15,20,21] ***Emerging evidence*** shows that programs have increased the number of appropriate referrals by expanding their eligibility criteria. Expanded criteria may include things such as permitting people on unsupervised probation to be enrolled or accepting

other potential charges such as property offenses, possession of drug paraphernalia, and specific, non-violent vandalism and theft.[13,15,22]

Examples of eligibility criteria that are ***common practices*** are listed below in **Table 2**. These should be developed while considering a wide range of factors including law enforcement capacity, available resources for referrals to services, budget, and local goals. These criteria vary across programs and may not suit every jurisdiction's specific needs and goals.

**Table 2. Common eligibility criteria used in national programs**

| **Sample inclusion criteria**[11-14,23-26] | |
|---|---|
| Misdemeanor charges involving substance use | Examples include being under the influence, possession of user amounts of controlled substances, or other drug activity including low-level dealing. |
| Low-level 'quality of life' offenses related to substance use misdemeanors | Examples include disorderly conduct, prostitution, vandalism, theft, and certain vehicle-based felony charges. |
| Disruptive behaviors and mental illness | Behaviors that may not result in charges to encourage referrals of people that are known to law enforcement or other outreach workers. |
| Overdose | Recent overdose or at high risk for experiencing an overdose. |
| **Sample exclusion criteria** [11-13,15,23,25,27-30] | |
| History of violent or person crimes | Examples include murder, arson, robbery, assault, kidnapping, sex offenses, and domestic violence. |
| Serious drug offenses | Examples include commercial drug trafficking or drug possession with the intent to distribute. |
| Other | Examples include outstanding warrants, previous deflection involvement, and safety risk. |

Careful consideration should be taken when developing local eligibility and exclusion criteria to avoid disparities in participation based on race, ethnicity, gender, or other sociodemographic characteristics.[15,17] A multi-site evaluation of LEAD® programs in North Carolina found that, "Black deflection candidates were more likely to have disqualifying criminal legal histories or probation status than their white counterparts,

which may have contributed to unintentional systematic exclusion."[15] Broadening program scope and continuously collecting participant demographic data helps to evaluate program reach and influence decision-making as needed.[17]

### Oregon programs

Most Oregon counties chose to start their programs with eligibility restricted to individuals with stand-alone PCS charges but left the door open to broadening criteria after seeing program results, noting frequent co-occurrence of PCS and other low-level crimes as possibilities. Several counties with newly operational programs were already contemplating expansions of eligibility criteria at the time of the interview. One county had yet to have any individuals qualify for its program despite several referrals, and others had fewer referrals than expected. These counties planned to reexamine exclusion criteria and consider adding new ways to make contacts with potential participants if numbers did not increase.

> *"…we'll meet again and we'll look at the data, we'll look at the referrals that we received, how they were disqualified or the citations that were just sent to the DA's office and why."*
> *(Deflection coordinator)*

Through grant applications and surveys, counties identified specific eligibility criteria for their programs. At the time of publication of this report, all counties include stand-alone PCS charges as eligible, with 18 opting to allow individuals with co-charges for low-level offenses to be enrolled in their program. Roughly half of counties exclude individuals with a previous deflection encounter and those on community supervision from the program. About two thirds of counties exclude individuals with previous higher-level charges or convictions, such as homicide or sex offenses.

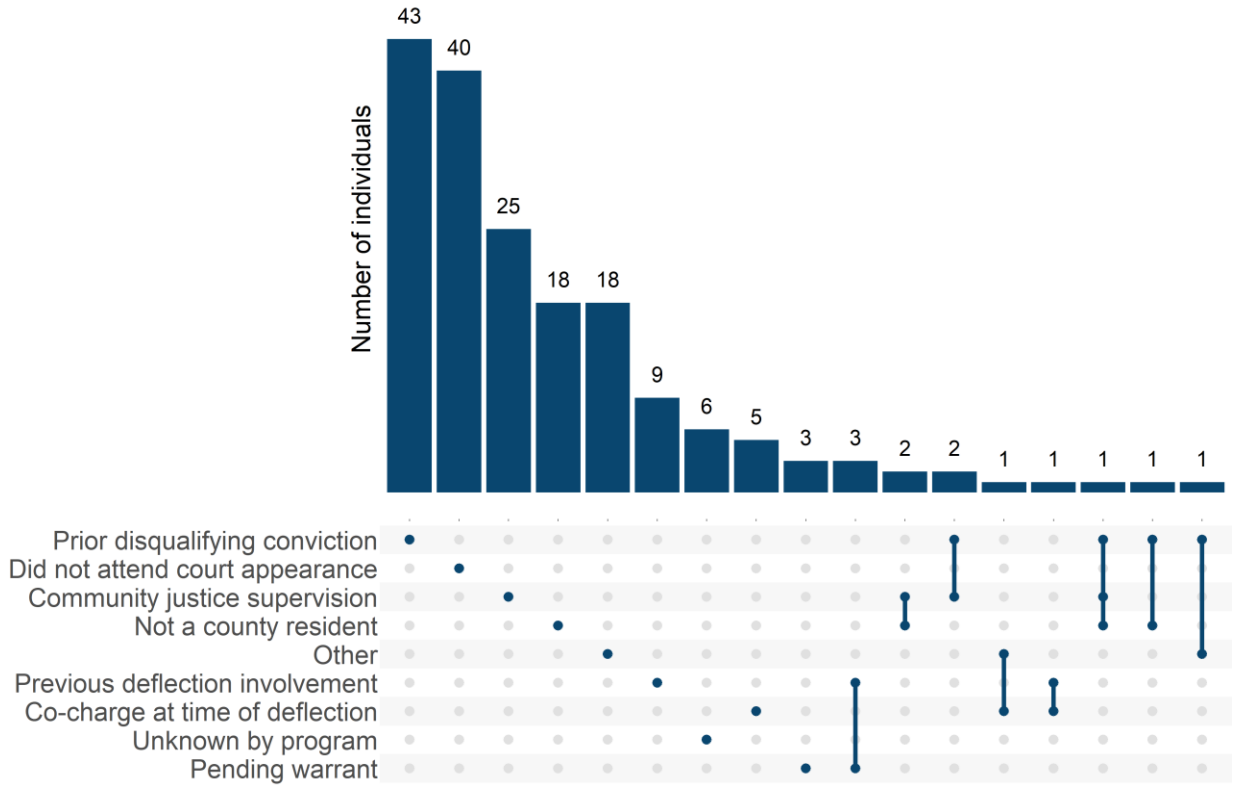
An early look at Oregon statewide data shows the reasons why deflection candidates who were referred to deflection were found to be ineligible, as illustrated in

**Figure 3** below. Some individuals had multiple reasons for ineligibility. The figure displays the combinations of exclusion criteria reported by Oregon programs. The first nine bars, moving left to right on the chart, display the number of individuals excluded for just one reason. For example, 43 individuals were ineligible due to a prior disqualifying condition, and 40 individuals did not attend a court appearance. The last eight bars show the number of individuals with more than one reason for exclusion. For example, three individuals had a pending warrant and prior deflection

involvement; two individuals were not county residents and were on community supervision.

**Figure 3. Reasons for ineligibility in Oregon BHD programs**

*Data from September 1, 2024, through March 3, 2025*




**Resource:**

Law Enforcement Assisted Diversion (LEAD) External Evaluation: Report to the California State Legislature 🔗 Report includes detailed eligibility and exclusion criteria for LEAD Seattle and LEAD Los Angeles County, including process for expanding eligibility criteria

# Deflection pathway

*Nationally recognized deflection program pathways*

**Key Findings**

- The LEAD® model, cited as utilizing ***best practices*** for Officer Intervention, has been shown to reduce substance use, reduce property crimes and recidivism, increase treatment utilization, reduce emergency room visits, and reduce arrests.
- There is ***emerging evidence*** to support operating multiple pathways for deflection to maximize the reach of programming.
- Social referral pathways are a ***common practice*** for many programs nationally.

### National landscape

**Table 3** below displays the distribution of deflection participants by pathway reported in the 2020 national deflection survey.[17] In the Western region, pathways to deflection at the participant level are fairly evenly distributed. About one in five participants come through Self-Referral, Active Outreach, Naloxone Plus, and Officer Prevention. About 15% enter deflection through Officer Intervention.[17] Communities should choose deflection pathways that align with specific community needs and resources available to address them. To maximize the reach of deflection programming, ***emerging evidence*** supports developing multiple pathways in local jurisdictions.

**Table 3. Proportion of cases for program pathway by national region**

| Pathway type | Northeast | Midwest | South | West |
|---|---|---|---|---|
| Self-Referral | 22.1% | 21.8% | 17.9% | 18.1% |
| Active Outreach | 19.3% | 18.5% | 18.6% | 19.3% |
| Naloxone Plus | 22.4% | 24.7% | 22.4% | 22.9% |
| Officer Intervention | 11.7% | 10.3% | 16.7% | 14.5% |
| Officer Prevention | 22.4% | 21.8% | 21.2% | 19.3% |
| Other | 2.1% | 2.9% | 3.2% | 6.0% |

*Adapted from: Report of the National Survey to Assess First Responder Deflection Programs in Response to the Opioid Crisis*[17]

The evidence base for specific deflection pathways is emerging, as the field continues to assess effectiveness of multiple pathways' impact on outcomes related to substance use and recidivism. The most comprehensive evaluations of deflection pathways have involved a variation of the Officer Intervention pathway, namely the LEAD® model, where law enforcement officers identify individuals in need, and outreach workers engage with the individual to initiate access to treatment and services.[11,31,32] These evaluations found positive outcomes supporting these types of models as a ***best practice***. A study of LEAD® in Seattle, Washington, found that the Officer Intervention framework increased treatment utilization, reduced emergency room visits, and reduced arrests.[11,31,32]

Social Referral pathways operating primarily outside of law enforcement (e.g., Self-Referral, some Active Outreach, Community Referral) are a ***common practice*** requiring more research.[9] The Self-Referral pathway takes a prevention approach, where individuals who currently use drugs may report to a local law enforcement or first responder agency without fear of arrest to receive an immediate referral to substance use treatment.[33] Self-Referral pathways are characteristically a walk-in model based in facilities that are open all the time. The goal is to provide rapid access to treatment without possibility of arrest, using minimal staffing and space. These programs are typically built around opioid use disorder, overdose, or polysubstance use.[9] Like Self-Referral programs, the Active Outreach pathway does not usually occur in the context of an arrest or possible arrest.[33]

The RAND Corporation evaluated six programs utilizing the Self-Referral pathway and found that if law enforcement were involved, the involvement ended after a hand-off to services, and they did not play a role in follow-up.[9] These programs identified the importance of partnerships and cooperation between stakeholders, having a high-profile champion, and involvement of people with lived experience as primary facilitators of their program success.[9] Self-Referral and Community Referral pathways have the potential to serve a broad range of participants who may not have contact with the criminal legal system, and more research is required to understand best practices for implementation.

### Oregon programs

Counties who participated in interviews revealed the following plans for pathway utilization:

- Although all interviewees were planning to implement or had implemented the officer intervention pathway at the time of the interviews, they **emphasized the importance of being able to intercept potential deflection participants at multiple entry points.**
- **Most counties interviewed reiterated the desire to start small**, perhaps with establishing a successful officer intervention pathway, before expanding to other pathways.
- Over **two thirds of counties offer or are planning to offer multiple deflection pathways for social referrals** that do not involve any formal charges.

From statewide data, **Table 4** below shows that while Officer Intervention is the most common pathway currently used in Oregon, grantees are also utilizing Active Outreach and Community Response alternatives, which allow for social referrals.

**Table 4. Deflection referral pathways used in Oregon BHD programs**

*Data from September 1, 2024, through March 3, 2025*

| Referral pathway | Participant Count |
|---|---|
| Officer Intervention | 151 |
| First Responder and Officer Referral | 16 |
| Community Response | 6 |
| Active Outreach | 5 |
| Total | 178 |

**Resources:**

First Responder Deflection Certification Course An eCourse from the JCOIN Training & Engagement Center (JTEC)

The Six Pathways: Frameworks for Implementing Deflection to Treatment, Services, and Recovery Bureau of Justice Assistance brief explanation of deflection pathways and how they work

## First point of contact

*The person who first encounters the individual and initiates the referral to deflection*

### Key Findings

- A ***common practice*** cited by deflection programs involves law enforcement or other first responders as the first point of contact.
- There is ***emerging evidence*** that the use of co-responders, such as peer support specialists or crisis workers, can help increase individuals' connection to and engagement with services.

**National landscape**

The first point of contact with a potential deflection participant may involve different types of first responders (law enforcement, emergency medical services, or firefighters) and other personnel who engage with an individual and may have the discretion to refer them to programs and services.

- **Involvement of law enforcement or other first responders as the first point of deflection program contact is cited as a *common practice*.** According to a national survey of first responder deflection programs, approximately 80% of deflection programs gave frontline staff deflection authority to decide whether to refer to treatment.[17]
- **There is *emerging evidence* that co-response helps facilitate connections to services.**[17,34] Co-response refers to having non-law enforcement staff either arriving on scene while law enforcement or another first responder is still present or travelling to the response site with them.[17] Deflection co-responders included peer support specialists, recovery coaches, case managers, social workers, crisis workers, and/or substance use disorder treatment providers.[14,17,22] According to a national survey of first responder deflection programs, co-response was cited as the most ***common practice*** for making initial contact in the Active Outreach and Naloxone Plus pathways.[17]

### Oregon programs

All local program models involve law enforcement as the first point of contact in the deflection process with over half indicating they also intend to utilize first responders, mobile crisis teams, or other community partners to refer individuals to the program. Statewide data in **Table 5** below shows who the first point of contact is for potential deflection participants. This data corroborates that, in Oregon, law enforcement serves as the first point of contact for the vast majority of deflections.

**Table 5. First point of contact in Oregon BHD programs**

*Data from September 1, 2024, through March 3, 2025*

| Role of deflection staff | Count |
|---|---|
| Law enforcement | 719 |
| District attorney's office | 70 |
| Peer support worker/navigator | 56 |
| Deflection coordinator | 20 |
| Social worker | 5 |
| Case manager | 3 |
| Other | 3 |
| First responder (EMS, Fire) | 2 |
| Mobile Crisis/Crisis Response Team | 1 |
| Jail staff | 1 |
| Community corrections staff | 1 |
| Total | 881 |

**Resources:**

Responding To Individuals in Behavioral Health Crisis Via Co-Responder Models ⛓ Details about the various co-responder models available

Critical Elements of Successful First Responder Diversion Programs ⛓ This article addresses core elements of first responder deflection programs, highlighting best practices of established programs

## Handoff to program

*How an individual moves from the point of referral to entering the program*

### Key Findings

- Warm handoffs to deflection programs are ideal and shown to be a ***best practice*** in deflection programs.
- If a warm handoff is not immediately available, ***emerging evidence*** shows that outreach as close as possible to the time of the deflection referral can lead to increased program engagement.
- There is ***emerging evidence*** that conducting assessments in the field and supporting alternative modes of transportation increase participant engagement and access to services.

**National landscape**

After a deflection candidate's first point of contact, a handoff to the deflection program occurs through referral to program staff, behavioral health providers, or community-based services.[13,23] Handoffs differ by type of deflection pathway. For Officer Prevention or Officer Intervention pathways, handoffs usually take place in the field, or the participant is dropped off at a program location (crisis center, department of health, police precinct, etc.).[13,15,35,22] In Active Outreach or Naloxone Plus pathways, programs seek out and locate individuals in need and directly connect them with treatment or other program services.[12,14] Self-Referrals could also resemble these outreach-based pathways where the participant presents themselves to law enforcement or program staff for an immediate handoff.[12]

More than half of the deflection programs who participated in the 2020 National Deflection Survey reported providing a personal introduction (also known as a warm handoff) to treatment case managers, and nearly two thirds reported providing transportation to an initial treatment or service provider appointment.[17] Deflection programs that used warm handoffs described the process as a meaningful and valuable component of their programs for law enforcement, deflection program staff, and deflection participants alike.[13,23]

Programs have cited several considerations when developing the handoff process.

- **24/7 warm handoff availability has been cited as a *best practice*** with case managers responding during business hours and mobile crisis responding after hours.[15]
- ***Emerging evidence* shows that timely handoffs may improve chances of referrals following through to treatment/services.** When individuals indicate readiness for treatment and support at the time of the encounter, they might not feel the same way if follow-up occurs later.[11,13] Deflection programs with low or no capacity for warm handoffs are more likely to lose participants between referral and follow up.
- **There is *emerging evidence* that programs with limited transportation or geographic barriers** should consider utilizing a participant's family or friends, trained volunteers, or grant funds for participant transportation to treatment and services.[27,28,30]
- **Conducting eligibility screenings in the field** via phone or at the location where assessments and services are delivered to facilitate connecting with individuals is supported by ***emerging evidence*.**[11,13]

### Oregon programs

During qualitative interviews, most grantees were still planning and had yet to implement their programs. They discussed potential barriers and facilitators to warm handoffs in their jurisdictions.

- **Most counties did not have adequate staffing to cover warm handoffs 24/7** but mentioned that as a desire for eventual program expansion.
- **Limited transportation in rural areas** also made reliable warm handoffs more difficult to implement.
- **A few counties were utilizing a crisis center** for their deflection programs, which may help facilitate participant handoffs due to expanded hours and staffing.

> *"Geography and resources are the two biggest challenges down here. Obviously, the gold standard would be they find someone with possession, law enforcement on the streets, we're right there with a peer mentor and can run them off to treatment, and they open the doors of treatment, and they walk them right in and get their assessment. But we just don't have those resources." (Deflection coordinator)*

**Table 6** below shows the prevalence of the various types of handoffs grantees use as seen in the statewide data. Over half of deflection program participants are receiving some type of warm handoff to services with the remaining receiving instructions to report to program staff.

**Table 6. Types of handoffs used in Oregon BHD Programs**

*Data from September 1, 2024, through March 3, 2025*

| Type of handoff | Count |
|---|---|
| Warm handoff at deflection drop-off center | 252 |
| Warm handoff on scene to deflection navigator/case manager | 206 |
| Instructions to contact or report to deflection team staff/coordinator | 144 |
| Instructions to report to behavioral health provider for assessment | 129 |
| Instructions to report to community court | 52 |
| Referral to deflection team for outreach to participant | 33 |
| Other | 26 |
| Don't know | 14 |
| Warm handoff to peer | 12 |
| Warm handoff at stabilization/sobering center | 8 |
| Total | 876 |

**Resources:**

Law Enforcement Assisted Diversion (LEAD): A multi-site evaluation of North Carolina LEAD programs Section 5.1 (page 41) Step-by-step walkthrough of hand off process

First Responder Deflection Certification Course An eCourse from the JCOIN Training & Engagement Center (JTEC)

## Defining individual success

*Criteria an individual must meet to complete the program*

**Key Findings**

- There is no standard definition of what a successful deflection looks like across different pathways and models.
- There is ***emerging evidence*** to support tracking an individual's success by collecting quality of life indicators and engagement with case management.

### National landscape

Determining what constitutes a "successful" deflection for individual participants can vary widely, often depending on the stated goals of the program. There is a gap in the literature regarding standard definitions of individual success or deflection endpoints. However, defining and tracking success is a critical component of every program, for participants, partners, and community members alike.

There is ***emerging evidence*** for programs to use an individualized approach to defining success, meaning there is no standard deflection plan or timeline with distinct progress markers.[11] Some program models, such as LEAD®, use a harm reduction approach and define individual success as any step taken to improve clients' quality of life (e.g., reduced substance use, connections with family and friends, and improvement in living situation).[23] Other deflection models, such as Quick Response Teams (QRTs), have an ultimate goal of connection to treatment, so participant engagement can be just one interaction.[12] Concrete measures and outcomes are needed to demonstrate program effectiveness beyond anecdotal information. Limited data reporting and barriers to information sharing across deflection partners can make it difficult to understand whether deflection programs are working at the national level.[35,36]

Specific progress indicators found in the literature include:

***Emerging evidence***

- Periodic assessment measuring change in quality of life[23]
- Receiving case management services[12]
- Completing required engagement with case management services[11,12]

***Common practices***

- Completion of an intake assessment[11,12]
- Connections to treatment[12]
- Tracking treatment attendance[12]
- Indefinite enrollment in program with no mandatory end date[15]
- Tracking completion of each phase of the program[19,37]

**Oregon programs**

Interviewees had wide variation in success criteria for individuals. Some programs required one engagement or post-assessment "step" toward an individualized plan, while others required multiple months of consistent program activity. Deflection teams were sensitive to public pressure for results, such as having participants complete treatment, while also cognizant of program limitations.

- About half of counties interviewed mentioned that an individual's **PCS citation is dismissed after meaningful program engagement, as determined by program staff,** as opposed to meeting a specific "completion" metric.
- **Several counties were still defining or discussing definitions** of individual success at the time of the interviews.
- Interviewees noted a **potential difference between what success means in terms of their deflection program and what success may mean to an individual** outside the scope of a deflection program, such as continued peer support.

> *It is understood that they are not going to get a citation, walk in, get their assessment, and have a clean urinalysis (UA) on day one and make it 90 days. We have one [individual] currently that has been in treatment for five or six weeks, I believe. He hasn't had a clean UA yet, but he shows up every week and to every appointment. So, for me, and I've talked to the DA, that is success. (Deflection coordinator)*

Most programs in Oregon define a "successful" deflection as a participant meaningfully engaging with the recommended treatment plan as determined by program staff. Some require additional criteria such as completing an SUD assessment and substance abstinence based on drug testing for a specified amount of time. As of March 3, 2025, all individuals who completed deflection met multiple criteria for program completion. **Figure 4** below displays the combinations of completion criteria Oregon BHD participants met. For example, 14 participants met the following criteria: completed an SUD assessment, completed treatment recommendations/goals, and accessed recommended services.

**Figure 4. Completion criteria used in Oregon BHD programs**

*Data from September 1, 2024, through March 3, 2025*

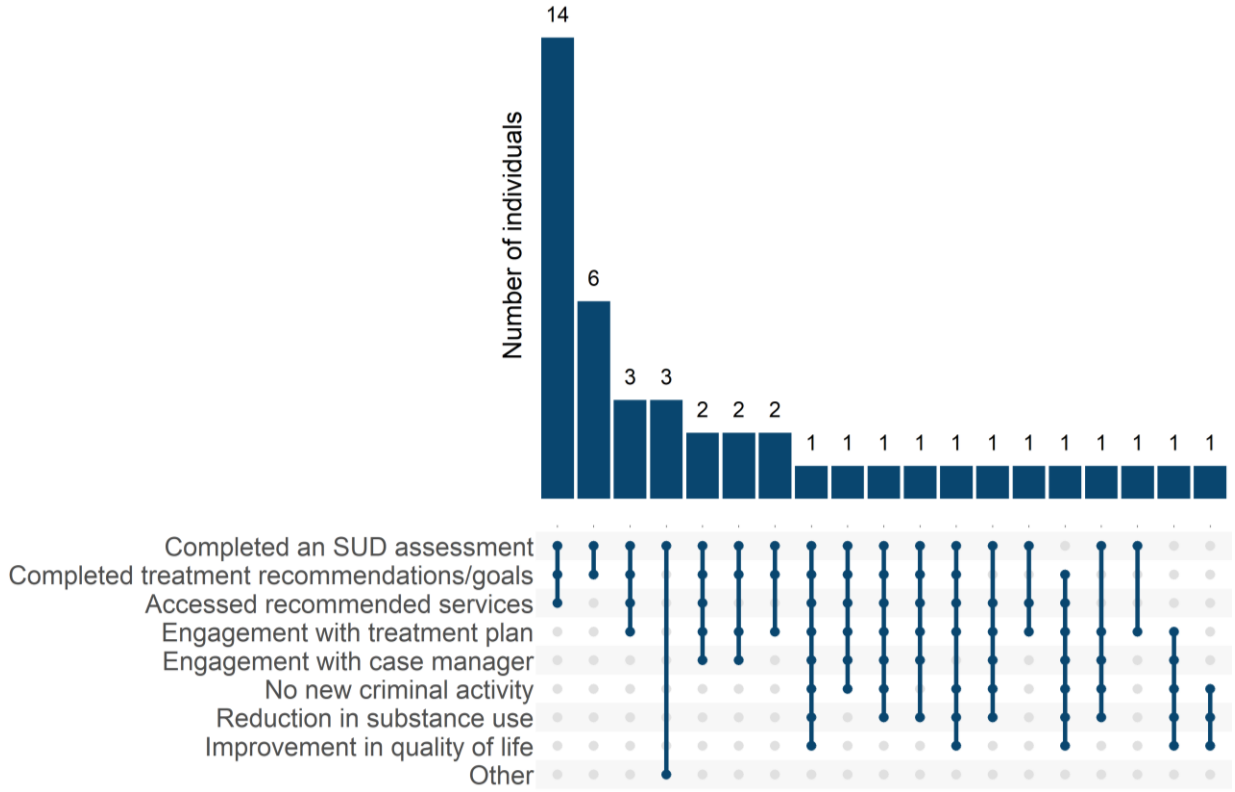
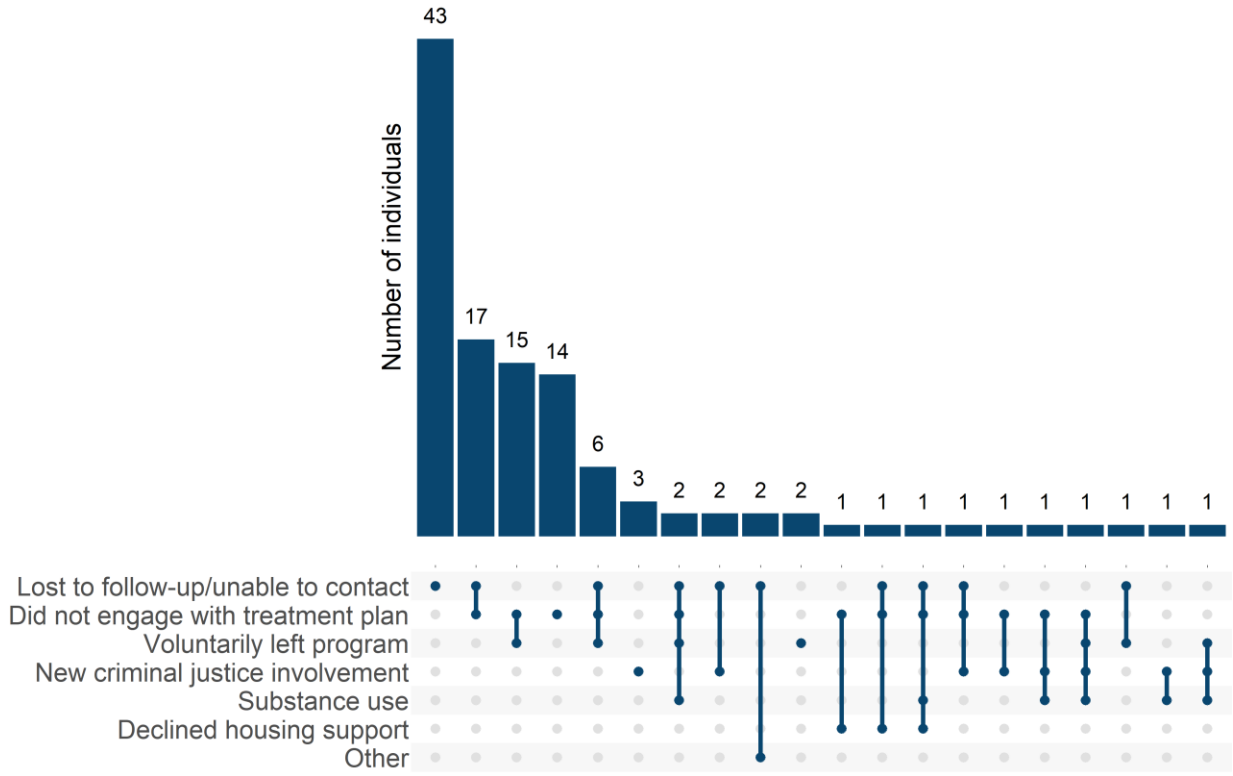


**Figure 5** below shows the reasons why participants did not complete deflection. Some individuals had multiple reasons for not completing the program. The figure displays the combinations of reasons reported by Oregon BHD programs. For example, 43 individuals were unable to be contacted, a deflection team member attempted to follow up with a participant but were unable to reengage, and 17 individuals were to be contacted and did not engage with their treatment plan.

**Figure 5. Reasons deflection was incomplete in Oregon BHD programs**

*Data from September 1, 2024, through March 3, 2025*



# Program planning

This section contains key findings and a brief introduction to some of the factors that should be considered when planning a deflection program: building partnerships, information exchange, and other considerations. More detailed information about program planning, including context specific to Oregon, is included in Appendix E.

## Building partnerships

Deflection program partnerships are multidisciplinary across public health, behavioral health, and public safety sectors, and typically include law enforcement and community treatment providers.[38] Effective collaboration between deflection partners are essential for successful implementation of deflection programs.[9]

### Key Findings

Programs can:

- Establish wide networks of partners across sectors with active involvement and cooperation to facilitate successful deflection programming.
- Leverage pre-existing community partnerships, networks, and resources to provide access to critical services and create efficient deflection implementation.
- Include people with lived experience as partners in planning and implementation to improve program operations and help reduce stigma.
- Create a sense of program ownership by allowing all partners to have an equal voice.

## Information exchange

With multiple agencies and departments involved in a deflection program, it is important to have a concrete plan for securely tracking and exchanging information. Effective information exchange can improve the provision of services across agency and provider types and may identify opportunities to improve referral processes.

Participant privacy and protection of confidential information are key considerations when developing processes for information exchange. A voluntary Release of Information (ROI) can facilitate multiple agencies tracking a participant's progress.[15] There are complex state and federal regulations regarding protected information which will guide the extent and manner in which law enforcement and service providers send and receive information, both electronically and on paper. Data collection, sharing and storage protocols should undergo careful legal review.

### Key Findings

- A ***common practice*** for facilitating information sharing is to create a single platform and workflow that safely sends information between departments and agencies.
- Leveraging existing data collection and documentation processes can facilitate ease of implementation but comes with its own set of challenges.
- Participant privacy and sharing protected information are key considerations when developing processes for information exchange.

**Resources:**

Code of Regulations, 42 CFR Part 2 🔗 Federal guidance for confidentiality of SUD patient records

Summary of the HIPPA Security Rule 🔗 Federal guidance on the Health Insurance Portability and Accountability Act (HIPAA) security rule

## Other planning considerations

During the planning phase, community factors may affect decision-making related to how programs are designed and implemented, such as the capacity of behavioral health services, law enforcement, and local recovery networks. Identifying potential barriers and challenges early in the process can facilitate smooth program implementation and operation.

### Key Findings

Successful programs may:

- Start small, ensuring resources are in place to provide the needed services.
- Identify and plan for potential obstacles to accessing treatment.
- Foster trust with the community, especially around any negative perceptions of law enforcement.

**Resource:**

A Decision-Making Tool for Police Leaders 🔗 Methods for deflecting people away from arrest and into services in the community

# Program implementation

This section contains key findings and a brief introduction to some of the factors that should be considered when implementing a deflection program: training and buy-in, use of navigators and peer support specialists, and program sustainability. More detailed information about program implementation, including context specific to Oregon, is included in Appendix F.

## Law enforcement training and buy-in

As law enforcement participation is a key component in most deflection pathways, it is critical to gain officer buy-in. This can be achieved in part by providing training, which is especially important during early program implementation and for carrying out program operations.

### Key Findings

- In addition to program-specific operations, trainings should include additional subjects that increase officer understanding of substance use and behavioral health treatment.
- Addressing misinformation, stereotypes, and stigma was commonly cited as a way to increase officer referrals to deflection.
- Reporting success back to officers has been shown to support buy-in and program awareness.

**Resources:**

Police-Mental Health Collaborations Framework Help for law enforcement agencies to better respond to calls for mental health service needs

Checklist for Obtaining Officer Support for Deflection or Pre-Arrest Diversion Programs This checklist offers evidence-based strategies to enhance officer buy-in for deflection programs

Crisis Intervention Team (CIT) Programs National Alliance on Mental Illness (NAMI) resources describing CIT Programs

## Program navigators and peer support specialists

Deflection programs often involve program navigators and peer support specialists who have lived experience with substance use and criminal legal involvement. Their role is critical to supporting participants on their deflection journey. Staffing structures and operations vary, even among programs utilizing the same deflection model.

### Key Findings

- Providing intensive case management supported by peers is described as extremely valuable to participants.
- Limited staff capacity was cited as a major barrier to many deflection programs.
- Partnerships with local treatment organizations or other service providers and nonprofits can facilitate access to navigators and peer support specialists.

**Resources:**

TIP 64: Incorporating Peer Support into Substance Use Disorder Treatment Services SAMHSA publication that supports learning about the key aspects, functions, and uses of Peer Support Services (PSS)

Peer Support Workers for Those in Recovery Resources to learn more about the role that peers play in recovery

Five Steps to Effective Integration of Peer Recovery Support Services in the Criminal Justice System Toolkit offers suggestions for organizations looking to understand the steps to implement peer support in CJ

Opening Career Pathways for Peers with Criminal Justice Backgrounds Guide for employers that provide behavioral health services, including peer support programs, to hire peers/persons with lived experience

## Program sustainability

Limited duration funding creates uncertainty and additional stress for staff and participants who rely on program services. Ensuring a program can continue operating after initial implementation can be challenging and requires both innovative approaches to funding and continuous assessment of program effectiveness.

**Key Findings**

- When possible, braided funding mechanisms can help support long-term programming.
- Disseminating data to policy makers and the community can demonstrate program impact and the need for continued support.
- Uncertainty of funding creates challenges for jurisdictions in planning their programs, especially as it relates to community buy-in, hiring, and service development.

# Program evaluation

This section contains key findings and a brief introduction to the different components to consider when evaluating deflection programs. A full discussion of program evaluation is out of scope for this report; however, more detailed information, including context specific to Oregon and evaluation resources, is provided in Appendix G.

## Data collection

Ongoing data collection is a critical component to deflection programs and should be approached intentionally. It is key to understanding if a program is serving its intended purpose. For programs looking to undertake their own data collection outside of what is required by the state, resources are provided below. Appendix H provides details on statewide data that are currently being collected and quantitative analysis methods.

### Key Findings

- Standardized and accurate data collection is necessary for program evaluation and requires continued training.
- Results should be communicated to leadership and staff to share program accomplishments and support program improvements.

**Resource:**

Northwest Center for Public Health Practice: Data collection for program evaluation This toolkit offers some additional information, templates, and resources to assist you in planning your own data collection for program evaluation

## Measures and outcomes

Published lists of measures to evaluate deflection programs range in length and scope. Selection of appropriate measures depends on program type and capacity for evaluation. Examples of published measures include the Police, Treatment, and Community Collaborative (PTACC) core measures and the more comprehensive Wisconsin Deflection Measures.[37,39] Proposed measures for the Oregon BHD statewide analysis can be found in Appendix I.

### Key Findings

- Common measures and outcomes for deflection programs are available, but application of these measures varies significantly by program.
- Selection of measures should be intentional to capture program goals and impact both locally and within broad jurisdictions, as appropriate.

**Resources:**

Wisconsin Statewide Deflection Performance Measures Guide 🔗 A set of suggested outcome and performance measures for Wisconsin deflection programs

PTAC Recommended Core Measures 🔗 Suggested outcome and performance measures for pre-arrest diversion programs, by framework

## Gaps in knowledge

Deflection is still in its infancy as an intervention, and it will take time to determine which specific program elements are the most effective. Developing standardized outcomes, fostering dissemination of information and evaluation results, and utilizing natural experimental designs can support collective understanding of deflection processes and how to define success.

### Key Findings

- Evidence is lacking for what specific programmatic elements are most effective.
- Future studies should include detailed demographic, quality of life and clinical information, and capture data over an extended period of time.
- Incorporate qualitative data into evaluations to provide better insight into program successes and challenges.

# Recommendations for deflection in Oregon

Deflection is a complex and nuanced intervention with many moving pieces. Intensive coordination is required by multiple partners in varying sectors to effectively operate programs and ensure connections to appropriate services for all participants. Programs in Oregon are continually evolving and will take time to fully develop. To facilitate program support and growth, this report presents the following recommendations to the Oregon Legislature.

## Recommendations

- Adopt a clear framework for program requirements while allowing flexibility to tailor programs by locality. The Sequential Intercept Model maps standard points of contact with the criminal legal system and could be used to clarify legislative expectations around deflection programming.
- To properly support deflection success, including staffing and access to services, local programs should have access to funding that is adequate for their purposes, consistently available, and at a predictable cadence. Local programs report that the initial minimum grant award of $150,000 for a 12- to 15-month project period is not sufficient.
- Support a baseline training curriculum for use across the state to ensure consistent understanding of deflection principles to facilitate buy-in by all involved partners as well as local communities.
- Given the concerns about financial sustainability by Oregon counties: build an intentional connection between Coordinated Care Organizations/Medicaid and deflection teams. Providing technical assistance to grantees can help ensure that deflection activities are reimbursed wherever possible. Consider adjusting Medicaid rules if they do not fit deflection case management activities.
- Continue legislative efforts to increase capacity of Oregon's behavioral health system, including services for co-occurring substance use and mental health and wrap-around services to meet social needs.

# Appendix A. Needs of the BHD population

Among the first 800 adults referred to Oregon Behavioral Health Deflection (BHD), 72% had an arrest prior to September 1, 2024. Due to this high rate of prior arrests, it is essential to consider the unique service needs of adults with history of criminal legal involvement (CLI) when planning service referrals for deflection participants. A high proportion of adults with CLI have a history of unstable housing, mental health, and substance use disorders, requiring urgent referral to multiple services.[40] More detailed descriptions of the behavioral and physical health needs of US adults with CLI are included below, as well as strategies to support program referrals.

## Profile of adults with criminal legal involvement

### Behavioral health

Over half of adults with past-year CLI have a substance use disorder, mental illness, or both.[41] Treatment agencies report that slightly over 35% of their referrals for substance use services come from the criminal legal system and that individuals in the system are more likely to complete treatment than those who are not.[42] However, repeated cycles of treatment discontinuation experienced through multiple incarcerations and other CLI disrupt and discontinue evidence-based treatment.

People with co-occurring substance use and mental health disorders are 12 times more likely to be arrested annually than adults without a mental health or substance use disorder, and 6 times more likely to be arrested annually than those with a mental illness alone.[43] Flores et al (2023)[44] and Timmer & Nowotny (2021)[45] have documented increased rates of CLI for adults with serious psychological distress compared to those without, and call for increased efforts needed to equitably triage individuals with acute mental health needs to psychiatric care instead of carceral settings.[44] They specifically recommend collaborative models of care that share resources across mental health and law enforcement organizations to prevent unnecessary incarceration.[44]

### Physical health

Recent research clearly indicates increased risk of poor health outcomes among adults with lifetime CLI, including increased risk of acute care utilization, i.e., emergency department visits and nights in hospital.[46] Among those with past year CLI, medical and mental health needs contribute equally to emergency department visits and nights in hospital.[47] Further, functional disability among those with CLI is

observed among younger adults at a higher rate compared to the general population.[48] Adults with CLI are also at higher risk for infectious disease and injury. The Center for Disease Control and Prevention reports that adults with CLI are more likely to experience risk factors for HIV, viral hepatitis, sexually transmitted infections, tuberculosis, latent tuberculosis (TB) infection, and traumatic brain injuries and concussions.[40]

### Housing and employment

Within the population of individuals enrolled in BHD (**Table 7** below), the need for multiple socials services and supports is clear. Less than 20% of enrolled BHD participants were housed in a personal residence at the time of deflection. Moreover, about 65% of participants were in an unstable housing situation, and at least half were in an unsafe housing situation. About 10% of participants were employed. Deflection programs historically prioritize referrals to behavioral health services, yet as programs expand the response to other immediate needs also expands. Deflection coordinators nationwide are well connected to stakeholder partners including cases managers, mental health and substance use disorder (SUD) providers, and a wide range of other services providers.[17]

**Table 7. Housing situation at time of deflection**

*Data from September 1, 2024, through March 3, 2025*

| Type of housing | Count |
|---|---|
| Unsheltered (or other place not fit for human habitation) | 210 |
| Personal residence (house/apartment/dorm) | 105 |
| Living in a vehicle | 63 |
| Staying with friends or family (couch surfing) | 49 |
| Living in a tent | 40 |
| Missing | 26 |
| Homeless shelter | 22 |
| Don't know | 18 |
| Transitional housing | 8 |
| Jail/correctional facility | 8 |
| Missing | 26 |
| Don't know | 18 |
| Total | 560 |

The 2020 national deflection survey found the most programs offering outreach do this in person in the community. This builds trust and has potential to identify participants' comprehensive needs and greater service engagement.[17] Among deflection programs nationally, nearly all report at least two service partners, and have had at least three. A quarter had four to six partners. In addition to behavioral health treatment and recovery supports, partners include civic groups, housing support, Emergency Medical Services (EMS), and vocational/educational services. Deflection program partnerships bring together public safety, public health, and a broad range of community services.[17] The strength of these collaborations can enhance the quality of wrap-around services offered to deflection participants to achieve stability.

## Strategies to support appropriate referrals

The strategies highlighted below are intended to support grantees and collaborating agencies with referrals and engagement for treatment and services. Culturally responsive services, peer supports, harm reduction, and medications for substance use disorders are briefly discussed, with links to resources.

### Culturally responsive services

House Bill (HB) 4002 specifically requires BHD grantees to provide services that are "culturally and linguistically responsive," "trauma-informed," and "evidence-based." Further grantees are required to provide a plan to "address language access barriers when communicating program referral options and program procedures to non-English speaking individuals." The Substance Abuse and Mental Health Services Administration (SAMHSA) developed at Treatment Improvement Protocol to "assist readers in understanding the role of culture in the delivery of behavioral health services (both generally and with reference to specific cultural groups)."[49] A Quick Guide for Clinicians is also available.

**Resources:**

Improving Cultural Competence: Quick Guide for Clinicians
Information for behavioral health clinicians about culturally competent counseling skills

**Peer support**

Peer Support Specialists (PSS) have lived experience with mental health conditions or SUD and draw from this knowledge to support individuals in behavioral health and other service delivery systems. A narrative research review found that people who use drugs preferred to interact with peer workers in street outreach, harm reduction, and hepatitis C treatment contexts.[50] Engagement with peer workers also improved follow-up after SUD-related emergency department visits and increased the likelihood of follow-up care post-overdose.[50]

The Law Enforcement Assisted Diversion (LEAD®) Community Toolkit states that both "lived experience and superb clinical skill are essential" on the deflection team. LEAD® recommends that deflection case management team composition be diverse and include people with lived experiences of houselessness and criminal-legal involvement.[51]

The National Council for Mental Wellbeing advocates for the role of peer-*case managers* in deflection programs.[51,52] This role expands to new skillsets and responsibilities beyond baseline peer support certification and training. Specifically, peer-case managers are informed by lived experience and the values of peer support work, but obtain broader case management training to coordinate with law enforcement.

**Harm Reduction**

Harm reduction can refer to both a philosophical approach to care and a specific set of services aimed at reducing negative consequences associated with drug use.[53,54] According to SAMHSA, "harm reduction strategies are shown to substantially reduce HIV and hepatitis C infection among people who inject drugs, reduce overdose risk, enhance health and safety, and increase by five-fold the likelihood of a person who injects drugs to initiate substance use disorder treatment."[55] Common harm reduction strategies include syringe service programs and naloxone education and distribution models. In Oregon, *Save Lives Oregon/Salvando Vidas Oregon* distributes naloxone and other supplies at no cost to service providers.[56]

In 2024, the American Society of Addiction Medicine (ASAM) published a resource guiding care for non-abstinent patients.[57]

**Resources:**

Expanding Harm Reduction and Syringe Service Programs 🔗
Harm reduction and syringe service program resources and materials from the Oregon Health Authority

Harm Reduction at SAMHSA 🔗 Harm reduction information, resources, a framework, and more from SAMHSA

### Medications for Substance Use Disorder

Referrals to treatment for a substance use disorder can be especially complex, when a clinical prescriber must be included on the treatment team. Program coordinators and other staff assessing treatment needs should be familiar with local resources offering medications for opioid use disorder (MOUD) and alcohol use disorder (MAUD) as treatment options, in addition to outpatient and residential treatment, mutual support groups, and other recovery supports.

***FDA approved Medication for Opioid Use Disorder (MOUD)*** include buprenorphine, extended-release naltrexone, and methadone. MOUD can prevent or lessen withdrawal symptoms and reduce cravings. Buprenorphine (a partial opioid agonist) and extended-release naltrexone (an opioid antagonist) can be prescribed by a licensed clinician in any treatment setting. Methadone (an opioid agonist) can only be dispensed through a SAMHSA certified Opioid Treatment Provider (OTP).

***FDA approved Medication for Alcohol Use Disorder (MAUD)*** is used for individuals who use a large quantity of alcohol or are diagnosed with an alcohol use disorder. Clinicians prescribe a variety of medications to treat alcohol withdrawal in different settings and clinical situations.[58,59] There are three FDA-approved medications indicated for the treatment of chronic alcohol use disorder: disulfiram, acamprosate, and naltrexone.[60] All of these medications can be prescribed by a licensed clinician in any treatment setting.

**Resource:**

Medications for substance use disorders 🔗
Information from SAMHSA on medications for opioid use disorder and alcohol use disorder

# Appendix B. Program model examples

There are several examples of how various communities use these pathways as a framework for their programs. **Table 8** below provides descriptions of selected programs and which pathways are utilized in the program.

**Table 8. Selected program models**

| Model name | Pathway(s) | Program description |
|---|---|---|
| Police Assisted Addiction and Recovery Initiative (PAARI) | Self-Referral, Active Outreach, First Responder and Officer Referral, Officer Intervention | The mission of the Police Assisted Addiction and Recovery Initiative (PAARI) is to provide police with the tools they need to help prevent overdose deaths and to get those dealing with addiction into treatment. PAARI helps police departments design and launch programs, change police culture, and shift the perception of addiction as a crime to addiction as a disease. Link for more about PAARI. |
| Drug Addiction Recovery Team (DART) | Naloxone Plus | DART's goal is to prevent opioid overdose deaths by bridging the gap in services that impacted people's ability to use safer or seek recovery. DART uses the principles of harm reduction to keep people who use drugs as safe as they can be, while also providing advocacy and support for all pathways to recovery. Link for more about DART. |
| Quick Response Team (QRT) | Naloxone Plus | A QRT often includes first responders (law enforcement, fire and EMS), clinicians and peer mentors (living examples that recovery is possible). Members of the QRT visit the home of a person who recently overdosed and offer support services to the individual and their family. QRT members then follow up to encourage the person to seek treatment and help navigate obstacles to treatment. Link for more about QRT. |

| Model name | Pathway(s) | Program description |
|---|---|---|
| Law Enforcement Assisted Diversion (LEAD®) | First Responder and Officer Referral, Officer intervention | LEAD is a collaborative, prebooking diversion program that provides individuals suspected of low-level drug and prostitution offenses with legal assistance and harm reduction–oriented case management instead of prosecution and incarceration. It is an adaptable model that has been deployed across the country. LEAD® maintains the LEAD® Support Bureau for communities looking to start their own program. Link for more about LEAD®. |
| Civil Citation Diversion & Deflection Network (CCDN) | First Responder and Officer Referral, Officer Intervention | CCDN is a nonprofit entity with the goal of promoting the expansion of both juvenile and adult pre-arrest diversion programs. CCDN provides toolkits and model guidelines for adult and juvenile pre-arrest diversion programs. Link for more about CCDN. |

# Appendix C. Qualitative methods and analysis

To better understand BHD planning and implementation processes across Oregon, the OHSU-PSU School of public Health analysis team completed 17 interviews with grantees between July and November 2024. A total of 19 counties were represented. Participants included deflection program coordinators, law enforcement officers, behavioral health agency team members, corrections staff, members of district attorneys' offices, and other county-level staff. The number of participants in each interview ranged from one to six. Two members of the analysis team coded each transcript. All themes were developed and refined by the full team.

During the interviews, participants reflected on their previous experience with deflection-related activities and their motivations for starting a deflection program. They also described unique characteristics of their counties, and how community priorities, geography, and resources shaped their BHD programs. Their experiences shed light on the wide variation in Oregon counties.

## Qualitative interview findings

**Motivation to start a deflection program**

BHD partners from multiple law enforcement and service sectors agreed on the urgency of addressing substance use disorder-related problems facing their localities. Participants described deflection as "another tool in our toolbox" for addressing the needs of individuals involved with the criminal legal system. For example, teams hoped to use deflection to:

- Avoid overloading the criminal legal system with repeat individuals involved in low-level crime related to untreated behavioral health conditions.
- Address community livability and safety issues, including increased drug overdose, drug-related crime, and unmet basic needs among some residents with SUD.

> *This is just the height of stupidity that we are spending inordinate amounts of money on a population that largely commits low-level misdemeanor crimes, that have really high needs, but we continue to use the most expensive intervention, which is our jail, for a very short period of time, to minimal effect. (County deflection staff)*

- Strengthen law enforcement and service sector connections to provide more sustainable, person-centered support for people with SUD or other behavioral health conditions.

**Previous deflection experience**

While only two counties interviewed (Marion and Multnomah) had formally utilized officer intervention before, most had previous experience bringing together criminal-legal personnel with treatment and social service providers through alternative models:

- More than half of counties reported experience with diversion programs prior to HB 4002, whether for SUD-related offenses or for Driving Under the Influence (DUI) offenses.
- Counties had collaborated with BHD partners on drug court models, mobile crisis efforts, jail-based medication-assisted treatment programs, conditional discharge, and supervision programs.
- About a third of counties had law enforcement-associated street outreach or harm-reduction efforts offering SUD treatment and other services to residents, often in collaboration with behavioral health partners and community organizations.

> *One of the things that I've learned in all this is we've been running a piecemeal deflection program for years. We just didn't know it was called deflection… So now we're just formalizing it, hopefully making it better… (Deflection coordinator)*

**County characteristics**

Local resources, services, geography, and county leadership culture shaped BHD program designs and expectations. For example,

- Access to deflection-related services varied across counties. Some counties had stabilization and withdrawal management ("detox") facilities already in place to serve as deflection drop-off points, but quick access to these services were more limited in other areas.

- Long distances to service locations in rural and frontier counties posed potential barriers. Ensuring all participants had the ability to attend treatment or access services was a concern.
- While a few county teams felt confident about SUD treatment capacity for deflection participants, most experienced long wait times for services, especially for residential services.
- The need for culturally specific deflection services and attention to equity in deflection outcomes were raised as priorities in two counties with urban populations.
- In rural counties, travel distances were a dominant factor teams had to consider while planning how partners would coordinate deflection hand-offs and services.
- Interests of local leaders, local partnership histories, and administrative resources such as grant writers or evaluation support, facilitated participants' motivation to try new models and collaborations.
- Rural counties in particular appreciated the flexibility to customize their BHD models to local needs.

> *[The county's SUD treatment center] is at least an hour in every direction to every corner of our county. And for someone that might not have a car or reliable ride, that could be a challenge. (Deflection coordinator)*

> *There's sometimes a six-week wait from when somebody, once they are referred to treatment, to actually getting that first appointment. (Sheriff)*

**Concerns about community capacity**

Known shortages in behavioral health, social services, and law enforcement personnel led to concerns about whether their programs could successfully enroll and meet the needs of deflection participants:

- Adequate access to treatment for mental health and co-occurring disorders was a big concern even in counties with more readily available outpatient SUD access. This concern cut across state regions and urban/rural distinctions.

> *I can get them the substance use treatment, outpatient treatment. What I can't get is the co-occurring [mental health and SUD treatment]. And then on top of that I can't get any inpatient co-occurring [treatment]. (Deflection coordinator)*

- County teams reported concerns about access to emergency and recovery housing. Two counties had no emergency shelters to support deflection work. More counties described lack of sustainable housing as a risk factor for program success.
- In several counties, retirement and turnover in front-line law enforcement personnel since 2020 meant that a substantial proportion of officers had never made a drug arrest=, leading to intensive training needs for law enforcement agencies.
- Several counties worried that deflection programs may fall short of some community and partner expectations and wouldn't deliver fast change to community addiction or crime issues.

> *I worry that there's this expectation that we're gonna see a big change in things early and I guess I'm optimistic we're gonna see a change, but I'm… It's not gonna be for a while. I think you gotta give them six months to a year. (Sheriff)*

Interview participants' reflections emphasized the need for localities to continue to customize their BHD programs based on their local needs, resources and priorities. They described the importance of leveraging and strengthening cross-sector collaborations to optimize referrals and retention in deflection programs. While barriers to successful implementation of programs do exist, interview participants expressed a commitment to overcoming these challenges.

# Appendix D. Oregon BHD implementation technical assistance

Oregon BHD Implementation Technical Assistance (TA) functioned as a partnership between OHSU's Department of General Internal Medicine Section of Addiction Medicine and OHSU's Oregon Rural Practice Based Research Network. Between July 2024 and February 2005, the TA team organized in person training events, one on one TA with BHD grantees, and multiple remote learning opportunities.

## Regional deflection training workshops

BHD kickoff workshops in July 2024 introduced deflection pathways and models in effect across the United States. Workshop sessions were facilitated by TASC, Inc. (Treatment Alternatives for Safe Communities). Full day in-person sessions were held in Baker City, Portland, and Bend.

## Regional law enforcement trainings

Law enforcement trainings engaged patrol officers, Sheriff's offices, and state police and focused on understanding substance use disorders, learning addiction care systems, and practicing officer conversations for deflection referrals. Trainings took place in John Day, Albany, Boardman, Pendelton, Hillsboro and Medford. **Register here.**

## ECHO

ECHO is an interactive learning environment offered through the convenience of real-time video connection. The TA team conducted two ECHO series in Spring and Fall of 2024: *Deflection Implementation and Leadership (Spring/Summer 2024)* and *Deflection Engagement and Coordination (Fall 2024/Winter 2025).* **Recordings and registration info are here.**

## Deflection technical assistance webinars

Webinars on deflection related topics featuring subject matter experts from law enforcement, criminal justice, addiction medicine and behavioral health are **available here, along with registration information.**

# Appendix E. Program planning

## Building partnerships

### Key findings

- Establishing wide networks of partners across sectors with active involvement and cooperation are the most cited facilitators of successful deflection programming.
- Leverage pre-existing community partnerships, networks, and resources to provide access to critical services and create efficient deflection implementation.
- Include people with lived experience as partners in planning and implementation to improve program operations and help reduce stigma.
- Create a sense of program ownership by allowing all partners to have an equal voice.

Deflection program partnerships are multidisciplinary across public health, behavioral health, and public safety sectors, and typically include law enforcement and community treatment providers.[38] Effective collaboration between deflection partners are essential for successful implementation of deflection programs.[9]

### National landscape

A 2020 scoping review of joint deflection programs operating between "criminal justice first responders" and health care providers identified three recommendations for improved collaboration across these agencies: 1) improve police/community relations, 2) conduct direct referrals as opposed to passive data sharing; and 3) data sharing and collaboration across disciplines requires first responder education and training.[38] LEAD® research further supports development of clear guidelines for communication across partners and collaborators. [61]

***Common practices*** seen in the literature for cultivating and sustaining deflection partnerships are described below.

- **Establishing wide networks.** Engaging a breadth of criminal legal system partners, including prosecutors, judges, defenders, and community corrections may reduce barriers for those seeking services.[17] Active involvement and cooperation between key partners are the most cited facilitators of successful deflection programming.[13,18,22]

- **Leveraging existing community partnerships.** For example, communities with functioning partnerships, such as Quick Response Teams, have the infrastructure and resources needed for efficient deflection implementation.[12]
- **Cultivating a sense ownership among all deflection partners.** When partners, particularly law enforcement and case managers, have an equal voice in program implementation, there is a shared sense of ownership of the program and its success.[13,62]
- **Involving people with lived experience.** Partnering with people who are in recovery and others with lived experience in the criminal legal system can improve program operations and may build program support and credibility with recovery communities.[9,15,17]
- **Engaging high-profile champions to generate program support.** Raising awareness of program intent, goals, and successes in a community by "getting the word out" through local media can build understanding of deflection and secure partner buy-in.[13,23]
- **Formalizing processes to identify and connect with high-risk individuals.**[17] Standardized deflection processes support better outcomes for participants. Programs with unclear policies have experienced loss of buy-in from partners and participants.[13,15,23]

### Oregon programs

Partnerships are a foundational component of Oregon Behavioral Health Deflection (BHD) programs. Oregon's BHD programs involve partnerships with their district attorney (DA), law enforcement agency/agencies, community mental health programs, and a provider from a Behavioral Health Resource Network, at minimum.[1,63] During interviews, BHD grantees reflected on the value of partnerships within their jurisdiction and across jurisdictions.

- **Counties valued networking** to understand other BHD programs, clarify their models and explore new ideas. They were doing this informally (coffee meetings) and through more structured forums such as ECHO and law enforcement associations and meetings.
- Most counties had some sort of **pre-existing collaborative relationships** with deflection partners, while others were still actively building trust and familiarity.
- **Building partnerships is challenging, but essential.** Counties found it critical to have buy-in and continuous communication among all partners for effective deflection programs.

- **Some rural counties with small populations collaborated with neighbors,** especially if they shared resources such as behavioral health partners. A common partner promoted efficient resource use and alignment.
- Health department leadership, DAs, Sheriffs, and county commissioners were mentioned as **champions who have been particularly supportive** of or involved in deflection efforts.
- Some counties needed more time to plan. **Program rollout in some counties was delayed** by challenges in getting policies, procedures, and messaging to and from the individual partner agencies.
- To be responsive to the House Bill (HB) 4002 law change on September 1, 2024, interdisciplinary deflection teams were stood up quickly, sometimes with a high level of public scrutiny. Some grantees reflected that **additional time for relationship building would have been helpful.**

## Information exchange

### Key findings

- A ***common practice*** for facilitating information sharing is to create a single platform and workflow that safely sends information between departments and agencies.
- Leveraging existing data collection and documentation processes can facilitate ease of implementation but was noted to come with its own set of challenges.
- Participant privacy and sharing protected information are key considerations when developing processes for information exchange.

With multiple agencies and departments involved in a deflection program, it is important to have a concrete plan for securely tracking and exchanging information. Effective information exchange can improve the provision of services across agency and provider types and may identify opportunities to improve referral processes.

### National landscape

While "no predominant approach appears to exist," there are commonly cited methods used by programs to share information across partners.[9] One of the most common approaches is sharing a single database and workflow across agencies and departments to track participants.[12,21,22,64] Recommendations include:

- Use data tracking tools accessible to multiple organizations and agency types, to safely send participant information between different agencies and departments, preferably useable in the field.[18,65]

- Use electronic forms whenever possible.[65]

Another strategy is adding deflection-specific data collection forms to existing documentation processes, such as arrest cover sheets or officer referral forms.[15,23] While this may be more easily implemented than standing up a new data system, potential barriers were identified in the Report to the California State Legislature (2020) on the evaluation of Law Enforcement Assisted Diversion (LEAD®) programs in San Francisco and Los Angeles: 1) Using paper forms or having to enter the data into multiple data systems contributed to administrative burden; 2) Without a single electronic data system, it was difficult to track participants and share information between agencies; and 3) it was difficult to communicate new protocols to line officers and contributed to a lack of investment from law enforcement.[13]

Participant privacy and protection of confidential information are key considerations when developing processes for information exchange. A voluntary Release of Information (ROI) can facilitate multiple agencies tracking a participant's progress.[15] There are complex state and federal regulations regarding protected information which will guide the extent and manner in which law enforcement and service providers send and receive information, both electronically and on paper. Data collection, sharing and storage protocols should undergo careful legal review.

**Oregon programs**

Over half of the counties interviewed planned to have all information and communications about data flow through their program coordinator. This included communicating back to law enforcement when a participant failed to complete deflection and needed follow-up law enforcement action. During qualitative interviews, interviewees described the work involved in setting up new program processes around sharing information across organizations. They described how establishing new workflows has been time-consuming, especially setting up data and information sharing procedures between partners.

**Resources:**

Code of Regulations, 42 CFR Part 2 🔗 Federal guidance for confidentiality of SUD patient records

Summary of the HIPPA Security Rule 🔗 Federal guidance on the Health Insurance Portability and Accountability Act (HIPAA) security rule

# Other planning considerations

### Key findings

- Start small, ensuring resources are in place to provide the needed services.
- Identify and plan for potential obstacles to accessing treatment.
- Foster trust with the community, especially around any negative perceptions of law enforcement.

During the planning phase, community factors may affect decision-making related to how programs are designed and implemented, such as the capacity of behavioral health services, law enforcement, and local recovery networks. Identifying potential barriers and challenges early in the process can facilitate smooth program implementation and operation.

### National landscape

Planning considerations that are common practices from the national literature are described below.

- **Start small and scale up.** A trend emerging in the deflection field is gradual incorporation of additional pathways.[9] Take the time to identify and establish collaborating providers, and continuously engage with community members and organizations to expand the network of programs.[32] This should include services such as employment, education, and food support that lead to better participation in treatment and long-term program success.[9,17]
- **Identify and plan for challenges accessing services.** Deflection programs have experienced inadequate treatment capacity to meet the demand of participants.[9,13,27,28,66] Moreover, programs have lacked access to supportive services including housing, transportation, cost of treatment, and lack of insurance coverage.[5,9,13,18,32] Rural settings in particular should consider and plan for distances between police departments and service providers.[32]
- **Build trust with the community; and address negative perceptions of law enforcement.** For deflection program participants, mistrust of law enforcement can be a barrier to participation in deflection programs, especially when law enforcement is the first point of contact.[9] Deflection participants have described feeling stigmatized by law enforcement, and were concerned when program staff were working for law enforcement, or would report them to law enforcement.[9,30,67] This to participation in deflection has extended to programs

with services were co-located within the criminal legal system, such as in courts.[13]

### Oregon programs

Most of the grantee interviews were conducted prior to BHD implementation, allowing grantees to reflect on current planning process, anticipated challenges, and emerging strategies to expand program reach as resources allowed.

- **Starting small.** A few counties planned to implement deflection first in a subgroup of municipal police departments or have other "pilot" sites within the county. Across multiple sites, strategies for starting included limiting geographic area, limiting eligibility criteria to Possession of a Controlled Substance (PCS) only, limiting pathways to law enforcement intervention, limiting operational hours, and limiting to certain law enforcement jurisdictions.
- **Addressing administrative challenges.** In some counties, slow payment and sub-contracting processes delayed partner engagement and hiring of coordinators. In some cases, this may have delayed protocol development work as well scheduling as some go-live date and trainings.
- **Considering reach of programs.** Some counties struggled with building a county-wide program that was responsive and effective in areas that are not population centers of the county. Geographic and transportation barriers limited program reach as behavioral health treatment and services are less accessible for some county residents.

**Resource:**

A Decision-Making Tool for Police Leaders Methods for deflecting people away from arrest and into services in the community

# Appendix F. Program implementation

## Law enforcement training and buy-in

**Key findings:**

- In addition to program-specific operations, trainings should include additional subjects that increase officer understanding of substance use and behavioral health treatment.
- Addressing misinformation, stereotypes, and stigma was commonly cited as a way to increase officer referrals to deflection.
- Reporting success back to officers has been shown to support buy-in and program awareness.

As law enforcement is a key component in most deflection pathways, it is critical to gain officer buy-in. This can be achieved in part by providing training, which is especially important during early program implementation and for carrying out program operations.

### National landscape

Nationally, most law enforcement agencies train their officers in either Crisis Intervention Teams (CIT), which provides 40 hours of training on mental health, or Mental Health First, which provides eight hours of training.[68,69] The examples below describe suggestions for training content from national deflection literature.

- **Provide training on how deflection programs operate, communication techniques, and effective collaboration between service providers and law enforcement.**[13,38] Where possible, provide local examples of positive change and success stories to show potential for change under the most challenging circumstances.[13] Reporting successful program completions, and incremental progress of individuals, can reinforce that the law enforcement buy-in and the program is serving its intended purpose.[13,15]
- **Provide training on the science of addiction and naloxone, and how to refer to behavioral health.**[17,20,35,38,65,70] Conduct onboarding and periodic refresher trainings to ensure law enforcement and other first responders understand the nature of substance use disorders as a chronic condition and the continuum of care for those with substance use disorders.[28,32,65] Beneficial topic areas for all partners include harm reduction, motivational interviewing, mental health and

trauma, local behavioral health systems and local criminal legal systems (e.g., laws and processes), and equity issues.[13,17,32,71]

- **Address misinformation, stereotypes, and stigma toward people who use drugs and people using medications for opioid and stimulant use disorders through training.**[70] If law enforcement personnel have negative perceptions of people who use drugs, it is likely to impact initiation of or acceptance of deflection referrals.[70] Addressing stigma and reframing substance use disorders as a public health issue increases the likelihood of law enforcement referrals to treatment [20,71] Officer training and education should emphasize the potential for a person's recovery, including hearing directly from (or about) the experiences of people who use drugs and have been in recovery, as this approach has been shown to reduce stigma.[20,71]
- **Focus trainings on specific skill sets.** When planning trainings, be sensitive to time commitments that impact deflection service delivery. Ensure time well spent through real-life applications of the training content.[13,36]

**Oregon programs**

A full description of BHD trainings is provided to Oregon grantees is included in Appendix D. Grantees who participated in qualitative interviews reflected on engaging law enforcement officers with the deflection program and other training plans and needs:

- ***Buy-in from law enforcement officers*** was challenging for some counties. In some settings, it has been difficult to change officer's opinions about deflection with just a few hours of introductory training. Most grantees felt that early successes communicated back to law enforcement would boost officer support.
- ***Training occurred at different levels of intensity*** among county deflection teams engaged. Some county teams visited local law-enforcement teams for 1-2-hour interactive trainings. Others recorded videos or made slide decks for local leaders to share with officers or had left decisions on training front-line staff entirely up to local chiefs. Only one county described including peer navigators at initial law enforcement trainings.
- Due to high turnover in their ranks between 2020 and 2024, training and ***re-training was needed on Possession of a Controlled Substance (PCS)*** procedures that had not been used for four years.

- Several counties saw a need for differential training approaches between more urban & more rural areas within their boundaries, with coordinators working to implement different strategies.

**Resources:**

Police-Mental Health Collaborations Framework 🔗
A framework to help law enforcement agencies better respond to the growing number of calls for mental health service needs

Checklist for Obtaining Officer Support for Deflection or Pre-Arrest Diversion Programs 🔗 This checklist offers evidence-based strategies to enhance officer buy-in for deflection programs

Crisis Intervention Team (CIT) Programs 🔗 National Alliance on Mental Illness (NAMI) resources describing CIT Programs

## Program navigators and peer support specialists

**Key findings**

- Emerging evidence supports utilizing peer support specialists to support program navigation and intensive case management.
- Limited staff capacity was cited as a major barrier to many deflection programs.
- Partnerships with local treatment organizations or other service providers and nonprofits can facilitate access to navigators and peer support specialists.

Deflection programs often involve program navigators and peer support specialists with lived experience with substance use and criminal legal involvement. Their role is critical to supporting participants on their deflection journey. However, staffing structures and operations can vary, even among programs utilizing the same deflection model.

**National landscape**

Staffing is not standardized across national deflection programs. Even programs following the same framework "vary substantially in their organization and

operations."[12] Often, the variation in staffing is due to budget constraints or other local context.[15] Limited staff capacity (including staff turnover and overburdened staff) was cited as a major barrier to many deflection programs effectively limiting the reach of the program and speed of referral follow-ups.[13,15,22,23]

Many programs partner with local treatment organizations or other service providers and nonprofits to provide case management and service coordination to participants.[11,23] Programs credit their success to intensive case management, calling it "deeply transformative and valued by clients."[23] Specifically, programs have described hiring peers with lived experience or other relevant experiential knowledge as helpful.[11,72] Participants and their program navigator can build relationships quickly and successfully. [21,73] Peers across programs can provide support services, resource connection, recovery coaching, and links to support groups.[21,73] Emerging evidence from the literature highlights the importance of utilizing program navigators and peer support specialist in deflection programs.

Identifying appropriate caseloads for case managers and peers is challenging and depends on the extent of daily contact that is expected with participants. Law Enforcement Assisted Diversion (LEAD®) has developed specific strategies for handling case management capacity that includes 20-25 participants per case manager. This is somewhat higher than national case management models that may be limited to 12-15 participants per case manager. The higher caseload in LEAD® accounts for individuals who may not be consistently engaged or "in the wind."[51] For peer support specialists in particular, standards for caseloads vary tremendously, and may range anywhere from 8-12 to 35-55.[74] Careful attention must be paid to the stress caused by high caseload and the chronically traumatic work environment experienced by many behavioral health workers, especially in the public behavioral health system. Providing the appropriate and sufficient organizational and supervisory supports can help prevent burnout and subsequent attrition.[75]

**Oregon programs**

In interviews, grantees discussed their program structures and staffing plans, which varied considerably by site, but most described challenges of balancing resources to support staff time and provision of comprehensive services. For example,

- **Counties wanted more positions and staff time** dedicated to their BHD programs, while general staffing shortages remained an issue across deflection partner organizations.

- **Leveraging peer support workers** to connect with potential participants, enroll them into the program, and move people through the process was a key to success for some grantees, but there was not consistency across programs in expectations for utilizing peers.

**Resources:**

TIP 64: Incorporating Peer Support into Substance Use Disorder Treatment Services ⛓ SAMHSA publication that supports learning about the key aspects, functions, and uses of Peer Support Services (PSS)

Peer Support Workers for Those in Recovery ⛓ Resources to learn more about the role that peers play in recovery

Five Steps to Effective Integration of Peer Recovery Support Services in the Criminal Justice System ⛓ Toolkit offers suggestions for organizations looking to understand the steps they can take to implement peer support in criminal justice settings

Bringing Recovery Supports to Scale Technical Assistance Center Strategy ⛓ Resources to learn more about the role that peers play in recovery

Oregon Health Authority Peer Support Specialist (PSS) ⛓ Describes role and qualifications of PSS in Oregon, including certification requirements, tests, and application

Mental Health and Addiction Certification Board of Oregon ⛓Behavioral health course offerings and certification information for Oregon's behavioral health workforce.

Opening Career Pathways for Peers with Criminal Justice Backgrounds ⛓ Guide for employers that provide behavioral health services, including peer support programs, to hire peers/persons with lived experience6 of SMI/SUD and criminal justice involvement

## Program sustainability

### Key findings

- When possible, braided funding mechanisms can help support long-term programming.
- Disseminating data to the policy makers and the community can demonstrate program impact and the need for continued support.
- Uncertainty of funding creates challenges for jurisdictions in planning their programs, especially as it relates to community buy-in, hiring, and service development.

Limited duration funding creates uncertainty and additional stress for staff and participants who rely on program services. Ensuring a program can continue operating after its demonstration period can be challenging and requires both innovative approaches to funding and continuous assessment of program effectiveness.

### National landscape

Often demonstration projects are difficult to maintain due to limited funding, change in priorities, or lack of commitment to continuing the program. Nationally, deflection programs have described multiple strategies to advance sustainability.

- **Deflection programs may require multiple sources of funding.** Braiding funding mechanisms can help support long-term programming.[76] Programs with limited duration or uncertain funding create additional stress for staff and participants.[13,15] Programs noted that having flexible funds to meet immediate individual needs such as food or clothing were necessary.[13,15]
- **Data-driven decision-making** supports the sustainability of deflection programs. Process evaluation data can identify problems, tell stories of how programs operate and document successful deflections to treatment. Data should be shared with policymakers and the broader community to demonstrate impact.[12,77]
- **Program buy-in and awareness supports sustainability.** Active promotion of the benefits of deflection in communities helps to build program buy-in and support, creating a culture of acceptance.[32,76] Law enforcement leadership is vital in the early stages and remains critical to the sustainability of deflection programs.[32,76] Gaining the buy-in of law enforcement is a commonly cited barrier to program success.[13,15,67] Law enforcement may view deflection as

outside of their scope or not see its value. Training for law enforcement on Substance Use Disorder (SUD) and harm reduction can garner additional support.[13,15]

**Oregon programs**

Interviewees expressed uncertainty about the future of their programs and discussed challenges securing buy-in and hiring staff, given funding amounts and uncertainty of future funding.

- A few counties mentioned that grant funds awarded for the deflection demonstration were not sufficient to stand up a new program.
- Uncertainty about future funding produced cynicism and concerns about program sustainability in several counties.
- Continued buy-in could be facilitated by assurances of financial security for deflection programs.
- More robust population engagement efforts from behavioral health partners would be helpful for deflection programs but are not always billable.

# Appendix G. Program evaluation

## Data collection

### Key findings

- Standardized and accurate data collection is necessary for program evaluation and requires continuing training.
- Results should be communicated to leadership and staff to share program accomplishments and support program improvements.

Ongoing data collection is a critical component to deflection programs and should be approached intentionally. It is key to understanding if a program is serving its intended purpose. For programs looking to undertake their own data collection outside of what is required by the state, resources are provided below. Appendix H provides details on statewide data that are currently being collected and quantitative analysis methods.

### National landscape

Data collection can often cause undue administrative burden on staff with limited resources. However, creating a systematic way to understand if a program is serving its intended purpose can help with program improvements. It is important to instill the importance of standardized and accurate data collection by program staff through providing clear instructions, incorporating regular data collection training, and emphasizing that data collection is a way to provide an even more comprehensive picture of participants and the work that is being done.[23,65]

A full discussion of data collection methods for program evaluation is out of scope for this report, but we provide resources below with toolkits and examples of deflection evaluations for programs looking to undertake their own data collection outside of what is required by the state.

### Oregon programs

While program interviews generally took place prior to implementation and live data collection, counties were able to reflect on both the value of collecting standardized data as well as their concerns.

- About a third of counties interviewed explicitly mentioned that collecting data to inform program improvements and share successes was extremely important to program operations.
- Interviewees reflected that since data collection involves a lot of moving pieces it is critical to work with partners to determine how information is recorded and shared.

Oregon statewide data collection is led by the OHSU-PSU School of Public Health (SPH). The SPH data team was contracted to design, build, and manage the statewide tracking system on behalf of the Oregon Criminal Justice Commission using OHSU's Research Electronic Data Capture (REDCap®) platform.[78,79] Legislation requires tracking individual-level program outcomes and deflection-related measures for the statewide evaluation and individual use by grantees. To ensure appropriateness of the database across diverse counties and program designs, we identified essential local context and program goals as well as nationally established deflection principles to inform the selection of data elements included in the system. Some grantees have opted to collect additional data that is relevant to their site. The statewide REDCap® database was organized to capture outcomes and what happens to participants at each stage in the deflection process, allowing programs to assess where there might be points within their program that are not functioning as intended.

These stages include:

- First point of contact
- Deflection pathway
- Type of handoff
- Program eligibility
- Assessments and referrals to services
- Deflection completion

The REDCap® database stores participant identifiers in restricted access fields, for linkage by the Criminal Justice Commission (CJC) to state administrative data from the Law Enforcement Data System (LEDS) (for arrest data), Odyssey (for case data),

and the Department of Corrections (DOC) (for supervision and sentencing data). This will allow assessment of trends in drug possession arrests and convictions, as well as recidivism and other criminal legal outcomes among deflection participants.

Grantees enter data on an ongoing basis and receive monthly reports on data collected up to that point. As data are coming from many different sources, often from different organizations, the ability for multiple people to have access to data entry is crucial. Many sites have someone from each agency partner responsible for entering data that is housed in their organization.

See Appendix H for a full description of database design, data elements, and analysis methods used for the statewide evaluation.

**Resource:**

Northwest Center for Public Health Practice: Data collection for program evaluation This toolkit offers some additional information, templates, and resources to assist you in planning your own data collection for program evaluation

## Measures and outcomes

**Key findings**

- Common measures and outcomes for deflection programs are available, but application of these measures varies significantly by program.
- Selection of measures should be intentional to capture program goals and impact both locally and within broader jurisdictions as appropriate.

Published lists of measures range in length and scope. Selection of appropriate measures depends on program type and capacity for evaluation. Examples of published measures include the Police, Treatment, and Community Collaborative (PTACC) core measures and the more comprehensive Wisconsin Deflection Measures.[37,39] Proposed measures for the Oregon BHD statewide analysis can be found in Appendix I.

### National landscape

While a standardized list of measures and outcomes to evaluate the wide range of deflection programs has not been developed, the national literature includes common elements for measures and outcomes used by existing deflection programs. The most common measures and outcomes fall into three general categories as outlined below.

Program referral and engagement

- Number and source of referrals[11,15,19,21,22,25,26,28,37,38,66,80-82]
- Screenings and assessments[11,37,66,81]
- Treatment and service utilization[9,11,14,15,18,19,21,23,25,27,37,38,66,80,81,83,84]
- Completion rates[19,23,25,26,37]

Program impact

- Reduction in substance use/abstinence/sobriety[38,83,85]
- Emergency Department (ED) visits, overdose rates[9,86,87]
- Recidivism[9,11,13,14,18,23-26,37,73,83-89]
- Cost effectiveness[23,82,83,88,90,91]

Demographics and Social Determinants of Health (SDOH)

- Basic demographics (age, gender, race)[19,21,22,28,66,80,87]
- Behavioral Health (BH) diagnoses (Substance Use Disorder (SUD) and mental health)[21,37,73,80,89,90]
- Psychosocial functioning, trauma, quality of life[23,73,83-85]
- SDOH (housing, employment, income, insurance, education level)[18,37,64,73,80,85,87]

Careful consideration should be used when selecting measures. Measures should be relevant to stated program goals and serve to demonstrate overall program reach and effectiveness.

### Oregon programs

For the statewide evaluation, legislation established the requirement for "a statewide system for tracking simple, clear and meaningful data concerning deflection program outcomes, including connections to social services and criminal justice system avoidance, and other data deemed relevant" in addition to racial and other demographic data to assess disparities.

Oregon Behavioral Health Deflection (BHD) programs defined participant success in a variety of ways. The deflection process itself is also very complex with a wide range in program diversity in Oregon. This presented challenges around how to define success with respect to the statewide evaluation. Within complex systems and behavioral health disorders, success cannot be judged as simply as yes or no, it is often subjective, and change is incremental.

To accurately track outcomes for individuals as well as programs, the SPH data team chose measures that capture the nuanced story of deflection in Oregon. These include measures for program uptake, deflection process, referrals to treatment and social services, changes in quality of life and social determinants of health, and criminal-legal status. See Appendix I for a list of measures tracked in the REDCap® database.

**Resources:**

Wisconsin Statewide Deflection Performance Measures Guide 🔗 A set of suggested outcome and performance measures for Wisconsin deflection programs

PTAC Recommended Core Measures 🔗 Suggested outcome and performance measures for pre-arrest diversion programs, by framework

## Gaps in knowledge

**Key findings**

- Evidence is lacking for what specific programmatic elements are most effective
- Future studies should include detailed demographic, quality of life and clinical information, and capture data over an extended period of time.
- Incorporate qualitative data into evaluations to provide better insight into program successes and challenges.

Deflection is still in its infancy as an intervention, and it will take time to determine which specific program elements are the most effective. Developing standardized outcomes, fostering dissemination, and utilizing natural experimental designs can support our growing understanding of deflection processes and how success is defined.

**National landscape**

A review of national literature revealed key knowledge gaps for establishment of evidence-based best practices for deflection programs. These are outlined below.

Areas where more study is needed:

- Determining what is generalizable across communities and programs [64,88]
- Understanding how programs can effectively scale up programs to include multiple pathways[22]
- The use of training to reduce law enforcement stigma towards people with SUD and understanding what tools are most effective in reducing stigma[20,92]
- Determining what specific programmatic elements are associated with program effectiveness[9,64,90]
- Examining the cost-effectiveness of programs and specific program elements[14,86,88]

Future studies should include:

- Detailed demographic information and outcomes related to quality of life measures, such as reduction in substance use and housing situation[64,83,86]
- A mixed methods approach that incorporates both qualitative and quantitative data to assess successful implementation, program impact, and partner perspectives[22,30,83]
- Collection of participant data over extended periods of time and ensuring sufficient sample sizes to adequately determine long term impact.[83,84,86]
- Inclusion of clinical information in the data collection to assess linkages between arrests/recidivism and behavioral health outcomes[83,86]

Barriers to bridging these knowledge gaps do exist. There is a need to develop standardized outcomes that can be used across all deflection and diversion-related programs so that results can be compared.[14,38,83] The lack of control groups in most programs can also make causal analysis problematic, however programs can utilize evaluation methods that incorporate natural experiments or other quasi-experimental designs where appropriate.[83] As deflection moves forward it will be important for programs to systematically share research and evaluation results, especially those that highlight successful models and outcomes.[38]

### Oregon programs

The Oregon BHD Program provides a unique opportunity to examine the effectiveness of various program elements. Oregon has created a natural experiment by simultaneously implementing programs with differing models and program elements, but with standard data collection metrics so programs can be compared.

# Appendix H. Quantitative methods

Development of a statewide system to broadly track deflection requires understanding of local complexities and challenges for design, implementation, and definitions of successful completion. Our iterative process included direct input from all counties and enabled development of a system that provides meaningful and useful statewide data to contribute to program evaluation.

## REDCap database

Individual-level identified participant data is collected and managed using REDCap® (Research Electronic Data Capture) tools hosted at OHSU.[78,79] REDCap® is a secure, web-based software platform designed to support data capture for research studies. Database design and construction occurred July through August, 2024 followed by two weeks of beta testing by grantees and Criminal Justice Commission (CJC) program staff. The database was streamlined and edited based on their feedback and was opened for data entry on October 4, 2025. A full list of data elements included in the database can be found below. Procedures for data collection and analysis conducted using these data were reviewed by the OHUS Institutional Review Board (STUDY00027501).

## Quantitative analysis

The REDCap® analytic database is set up so that personal identifiers of BHD clients will be masked to all but one analyst and Principal Investigator. Identifiers are used by the SPH data team to check for duplicate entries. The primary analytic database will include a study ID only. CJC staff will have access to view identifiers, as required for data linkage.

Data are conducted in SPSS and R statistical packages. These include descriptive reports (frequency and multiple response tables) statewide and by grantee. To assess differences in program characteristics and outcomes, the SPH data team, in collaboration with CJC, will conduct chi square, t-test, and multivariable regression analyses. As required, analyses will adjust for clustering effects by region. All statistical analyses are conducted in consultation with the OHSU Biostatistics and Design Program.

## List of REDCap data elements

**Identifiers**
Name
Date of birth
State Identification Number (SID)
**Demographics**
Race/ethnicity
Gender identity
Disability
Preferred language for services
**Deflection referral**
Date of first point of contact
Age at first point of contact
Who was the first point of contact with the participant?
Location of contact
Referral pathway
Type of handoff
**Eligibility and program entry**
Date of eligibility determination
Who determined eligibility
Charges associated with event
Were deflection-related charges held in abeyance?
Did they qualify for the deflection program?
Did they agree to enter the deflection program?
**Social Determinants of Health (SDOH) measures pre-deflection**
Housing situation at time of deflection
Is their housing situation stable?
Is their housing situation safe?
Employment status at time of deflection
Medical needs at time of deflection
Food insecurity at time of deflection
Insurance status at time of deflection
**Behavioral health information**
Screenings and assessments
Type of substance use
Mental health diagnosis
**Referrals to services**
Referrals to treatment and social services
Reason for not receiving treatment and social services
**Program exit**
Deflection completion
Reason for not completing
What qualified them for completion
Disposition of deflection charges
Criminal justice status
**SDOH measures post-deflection**
Housing situation at program completion
Is their housing situation stable?
Is their housing situation safe?
Employment status at program completion
Medical needs at program completion
Food insecurity at program completion
Insurance status at program completion

# Appendix I. Outcomes and measures

As required by House Bill (HB) 4002, grantees submit participant-level data for the statewide evaluation. Measures will assess program participation and completion across sites and identify patterns of engagement that may vary across models, communities, or sociodemographic characteristics. See **Table 9** below for details.

**Table 9. Proposed measures for the Oregon BHD Program**

| Outcome | Measures |
|---|---|
| Program engagement | Deflection referral rate |
| | Referrals by agency/role |
| | Location of initial referral |
| | Deflection pathway |
| | Citations issued |
| Program uptake | Type of handoff |
| | Eligibility rate |
| | Program admission rate |
| | Reasons for ineligibility |
| Racial and other demographic disparities | Number of participants by race/ethnicity |
| | Number of participants by gender |
| | Number of participants by age |
| | Number of participants w/ a disability |
| | Number of participants w/ mental health disorder |
| | Number of participants w/ substance use disorder |
| | Number of participants w/ co-occurring disorders |
| Connections to treatment and social services | Assessment rate |
| | Type of assessments received |
| | Referrals to treatment and services |
| | Engagement with treatment and services |
| | Array of services received |
| | Access to services |
| Successful program completion | Successful deflection rate |
| | Successful completion criteria |
| | Reasons for failed deflection |
| | Average number of deflections per participant |
| | Average length of time in program |
| | Change in quality-of-life measures post deflection |
| | Recidivism |

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