Words to Deeds

From Silos to Solutions

Cross-System Implementation in California's Behavioral Health and Criminal Justice Reform Initiatives

Co-Hosted by Third Sector &
California Commission for Behavioral Health

September 25 and 26, 2025
Los Angeles, CA

Words to Deeds

Commission for Behavioral Health

Table of Contents

This document begins with an executive summary including key findings, followed by a detailed review of each session and discussion. Comparison tables to easily review recommended outcome metrics to measure and assess are located in the Appendix.

Executive Summary

At Words to Deeds (W2D) 2025, leaders from across California's behavioral health and public safety systems explored how cross-system collaboration can successfully implement meaningful reform. The theme, "From Silos to Solutions," reflects a growing commitment to breaking down institutional barriers and building integrated approaches to care, accountability, and public safety.

Attended by 100 professionals from corrections, behavioral health, the judiciary, law enforcement, and advocacy organizations, the convening examined how trust, empathy, and shared purpose enable lasting change across systems. As it has for the past 20 years, Words to Deeds elevated successful examples of cross-agency partnerships that can serve as models for replication throughout California and potentially in other states.

W2D 2025 emphasized the importance of relationship building, especially when integrating lived experiences in behavioral health and public safety systems. Each of the nine sessions reminded us that reform is not just a policy challenge, but a human one as well. When systems work together with respect and solidarity, transformation is possible.

Session Insights and Recommendations

Build the workforce pipeline for peers and cross-trained frontline staff.

Counties described persistent staffing shortages, uneven training, burnout, and gaps in culturally responsive engagement. Participants also elevated the unique value of peers and lived experience leadership to build trust, improve follow-through, and prevent avoidable escalation.

Recommendation: Treat the workforce as the central strategy for successful implementation of programming. Expand and formalize peer roles across justice and behavioral health settings, invest in cross-training for shared practices (de-escalation, motivational engagement, harm reduction, trauma-informed care), and create clear supervision, career ladders, and sustainable funding for these positions.

> *"We have a chance to discuss the intersectionality of these policy areas and identify where there are opportunities to align data with policy to ensure that strategic actions really can be realized…strategic, thoughtful, data-driven actions versus us feeling the instability that the Federal government has created and simply react."*
>
> *— Supervisor Holly J. Mitchell*
> *Los Angeles County*
> *Board of Supervisors*

Make cross-system collaboration operational through shared workflows, not just goodwill.

W2D 2025 highlighted that strong relationships matter most when they translate into repeatable practice. Teams move faster and reduce churn when they align on referral pathways, eligibility criteria, handoffs, and decisionmaking roles across agencies and community partners.

Recommendation: Establish a shared "front door" for referral and triage, along with agreed-upon protocols for warm handoffs, multidisciplinary case conferencing, and escalation pathways. Assign clear ownership for coordination and maintain a consistent cadence for cross-system problem-solving.

Define success together and use data for learning, not only reporting.
Participants emphasized that fragmented metrics and lagging data prevent systems from seeing what works, where people get stuck, and what needs to change. The convening repeatedly returned to a shared truth: meaningful reform requires shared outcomes that reflect stability, recovery, and safety, supported by a manageable measurement approach that frontline teams can use.

Recommendation: Align on a small set of shared outcomes and a monthly learning routine. Start with simple, feasible measures and improve over time, focusing on the decisions the data should enable (service matching, case planning, resource allocation, and continuous improvement).

Calls To Action

 **For Leaders in Government or Community-Based Organizations**	• ***Build Trust Across Systems:*** Success requires empathy and strong bonds between behavioral health, reentry, housing, and public safety systems. • ***Bridge Policy to Implementation:*** Counties need tools, data, and capacity to turn policy wins into sustained impact across county systems. • ***Invest in Workforce and Peers With Lived Experience:*** Sustainable reform depends on building a behavioral health workforce and integrating peers with lived experience.

Speakers discussed various funding streams detailed in each of the sessions. Agency leaders should prioritize pursuing the California Commission for Behavioral Health's Innovation Partnership Fund (IPF) to improve or expand services that address behavioral health and public safety needs. The RFP for $100 million will be released after the January 2026 Full Commission Meeting.

 **For Philanthropic Partners**	Fund the "glue capacity" that counties cannot easily procure, namely implementation support, data infrastructure, change management, and training. These investments can result in multi-county learning and evidence-building that compares models and documents operational playbooks.
 **For Researchers and Evaluators**	Right-size evaluation to implementation maturity with rapid-cycle learning questions, then scale to rigorous designs. Building common measures across sites will enable credible cross-county comparisons and transferable lessons.

About Us

Words to Deeds is a statewide collaborative and California's premier forum for cross-sector leaders working at the intersection of criminal justice and behavioral health. Launched in 2003, Words to Deeds has supported state and county leaders to implement policies that decriminalize mental illness and disrupt the cycle of hospitalization, criminal justice involvement, and homelessness for people with behavioral health needs. From crisis response to reducing recidivism to addressing complex needs through whole-person care, Words to Deeds shares learnings and elevates solutions to address the most pressing issues in criminal justice and behavioral health.

Contact: Kit Wall, Project Director - kitwall@sprintmail.com

Third Sector is a national technical assistance provider that advises state and county governments on systems change initiatives that reshape their policies, systems, and services toward better outcomes for all people, no matter their race, background, or circumstances. The tools and practices designed and implemented with public systems enable human services agencies to unlock possibility, confront inequity, and catalyze change to the benefit of the people and places our government, community-based, and philanthropic partners serve. Working across its five practice areas of Behavioral Health, Diversion and Reentry, Early Childhood Development, Workforce Pathways, and Post Secondary Opportunities, Third Sector's teams recognize that responsive services best meet the needs of the community, rebuild trust in our systems and structures, and achieve optimal outcomes for all. Founded in 2011, Third Sector is a 501(c)3 organization that has worked with more than 35 states to deploy more than $2 billion of government resources toward improved outcome initiatives.

Contact: Oscar Benitez, Managing Director of Diversion & Reentry- obenitez@thirdsectorcap.org

Acknowledgements: Words to Deeds is grateful to the *California Endowment* for hosting the 2025 convening and the *California State Association of Counties* for providing print materials this year, in addition to its advocacy and representation throughout the years. We also recognize the *Commission for Behavioral Health* (CBH), the *Council on Criminal Justice and Behavioral Health*, the *California State Sheriffs' Association*, the *County Behavioral Health Directors Association of California*, the *California Board of State and Community Corrections*, the *California Commission on Peace Officers Standards and Training*, and the *Words to Deeds Leadership Group*, comprised of leaders representing partnering organizations throughout California, for their support to guide content, refer presenters, and publicize the event. These partners' commitment to improving outcomes at the intersection of criminal justice and behavioral health is invaluable to the state and the communities they serve.

Convening Goals & Approach

The goal of Words to Deeds (W2D) is to convene thought leaders from California's state and county behavioral health and public safety discplines to discuss implementation challenges and highlight solutions that prevent people with behavioral health (i.e., mental health and/or substance use disorder) needs from becoming involved with the criminal justice system.

Through peer-to-peer dialogue, W2D establishes a platform for increased relationship-building, learning, and continuous improvement across systems and jurisdictions, which can help staff from government and community-based organizations deliver more outcomes-focused and responsive services.

"If we're serious about our humanity, if we're serious about reform, we have to look at it as an ecosystem in its entirety. I hope we remain steadfast in our goal to again, use data, to make sound program and fiscal policy decisions, and hope that we can do so with courage and empathy."

— Supervisor Holly J. Mitchell, Los Angeles County Board of Supervisors

Each session addressed the following questions, among others:

- What data/measurements from your program(s) have been most impactful?
- What are key takeaways/decisions made as a result of that information?
- What would you/your organization like to change, or want to have done or do differently?
- What does future success look like?
- What resources do you need from your peers or state to be successful?
- What is the call to action for your peers?

"In my 25-plus years, I've never seen this much money in behavioral health and for [the justice-involved] population. But the real magic happens as we bring people together. The talent in this room is being asked to work across sectors, one of my favorite things to do. Disparate worlds can be brought together. It just takes some time, patience, understanding, and grace."

— Brenda Grealish, Executive Director, California Commission for Behavioral Health

Agenda Overview

- Examine cross-system strategies for integrating behavioral health and criminal justice systems, with a focus on forensic care, reentry, diversion, and supportive housing.
- Learn from county and state leaders implementing new policies, including Care Court, Prop 36, Incompetent to Stand Trial improvements, and CalAIM's Justice-Involved Initiative.
- Identify actionable solutions for counties to implement through data, lived experience, and early implementation lessons that strengthen coordination across behavioral health, justice, and housing systems.

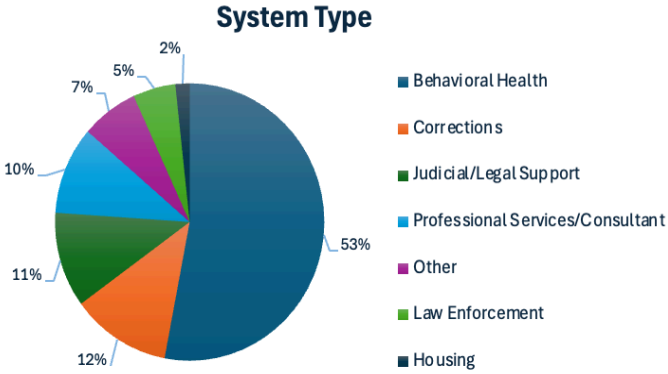
"The conversations about how to build cross-department collaboration, break silos, define outcomes, and get real about the data we need to make anything happen, is what gets us up in the morning to plan Words to Deeds."

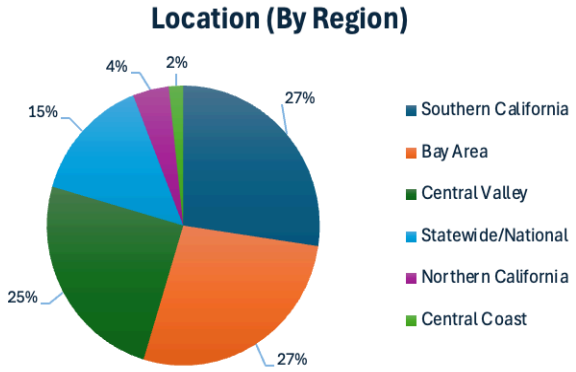
— Caroline Whistler, CEO & Co-Founder, Third Sector

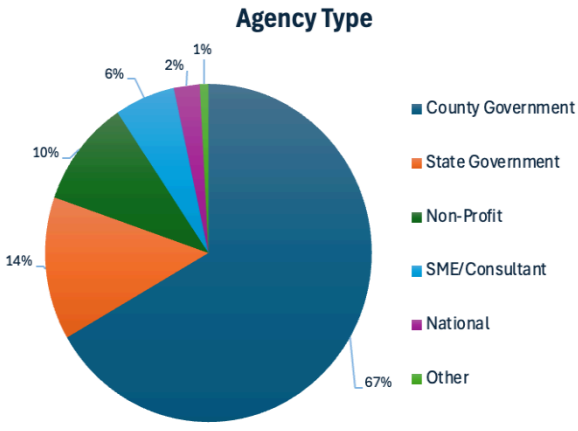
Attendee Profile

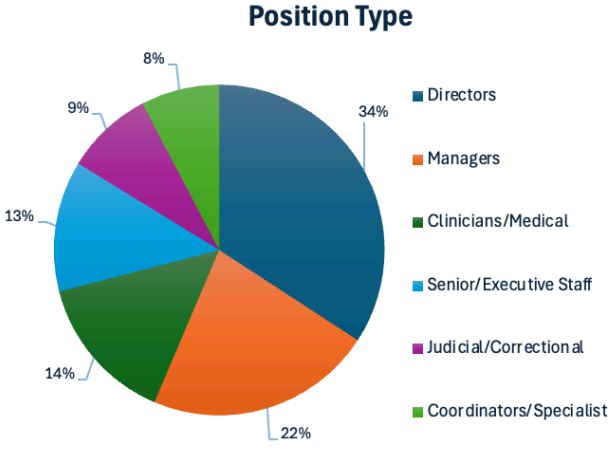
For the 2025 convening, 110 attendees registered for the event at no cost, including speakers and facilitators. More than 100 individuals attended W2D 2025 in person, 36 of them facilitators or presenters. The majority of facilitators and presenters remained in attendance for at least a day. On the first and last day of the convening, 102 and 104 individuals attended, respectively, alongside five experts who presented virtually. Ninety-five attendees participated in W2D both days.

Demographic information for attendees is below.









The 2025 attendee list is available on the dedicated 2025 convening website.

SESSION INSIGHTS & LESSONS LEARNED

The following sections provide a summary of these presentations and conversations, including supplementary materials for community and government leaders.

Session 1: A Glance at the Numbers Statewide - Full-Service Partnerships

This session grounded attendees in California's statewide data on Full Service Partnership (FSP) clients with justice-involvement and highlighted the foundational role of cross-system alignment in achieving better outcomes. The session introduced data tools and conceptual frameworks to help local leaders move from reactive system silos to coordinated responses that prioritize the right care, at the right time, with the right partners.

Facilitator: Oscar Benitez — Managing Director of Diversion & Reentry, Third Sector

Presenters:

- Hallie Fader-Towe — Director of Justice & Health Initiatives, Behavioral Health, Council on State Governments Justice Center
- Marcus Galeste — Policy & Evaluation Research Scientist, Commission for Behavioral Health

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Quantify the size and needs of the justice-involved population served by FSPs
- Identify data limitations and needed reforms in performance measurement
- Introduce frameworks (e.g., SIM, Justice & Behavioral Health Framework) to guide future program design

Presentation Materials and Resources:

- Meeting materials posted on 2025 convening website
- For a centralized source of state initiatives that improve outcomes for people with behavioral health needs and justice system involvement, consult the Aligning Health and Safety webpage.
- "Transforming Behavioral Health for Justice Populations: A California Snapshot" identifies various community needs and initiatives occurring at different "intercept points" for behavioral health or criminal justice support.

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

FSPs are a core tool for justice-involved populations when aligned to need. Between 2007 and 2016, more than 64,000 individuals participated in an FSP. Nearly 30% of those FSP participants had prior arrests, and within that subset Black residents and men experienced higher rates of co-occurring disorders. Individuals with

justice involvement show meaningful declines in arrest rates, reinforcing that FSPs can function as a public safety strategy, not just a treatment resource.

State initiatives provide a framework to align health and safety. The Aligning Health and Safety Initiative centralizes resources and updates for various statewide initiatives. CBH recommends that counties apply the Sequential Intercept Model (SIM) to synchronize the "blizzard" of recent policy changes by mapping needs and interventions across intercept points. Used well, the SIM framework allows counties to identify system gaps, align programs to recidivism risk and behavioral health needs, and integrate FSPs with other housing and treatment resources rather than operating them in isolation.

Data integration is necessary for accountability across housing, treatment, and safety. CBH currently relies on multiple disconnected datasets, which fragment how success is measured statewide. CBH is laying a foundation for data integration through its Transparency Suite dashboards, promoting cross-departmental integration (e.g., Department of Justice and the Department of Health Care Services) and FSP metrics standardization. Counties and the state now need to close remaining gaps in real-time, cross-system data to understand who connects to treatment and housing after justice involvement and to hold systems accountable for outcomes achievement.

> *"Data is not just a reporting requirement—it's a reflection of who we're accountable to. The more fragmented the data, the more fragmented the care."*
>
> — Marcus Galeste, Research & Evaluation Scientist, Commission for Behavioral Health

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Strong public safety results for initiatives that coordinate behavioral health resources. The Transforming Behavioral Health for Justice Populations: A California Snapshot report illustrates how sustained initiatives at key intercept points translate into measurable gains.

- **2007-2016:** Arrests among adults ages 26 to 59 decreased by 34% percent over the 9 years FSP programs have been active
- **2021-2022:** Among people eligible for Medi-Cal who left the California Department of Corrections and Rehabilitation (CDCR), more than 50% of people with mental health-only designations and co-occurring disorders received at least one Medi-Cal behavioral health service within one year of leaving prison. Improvements are needed for people with substance use disorders.
- **2021-2023:** State and local partners have worked to decrease the felony Incompetent to Stand Trial waitlist by 70% from 2021 to 2023
- **2023:** Engagement with Enhanced Care Management for people leaving prison increased to 61% (vs. 39% in 2022)

Close utilization gaps by integrating peer support and community health workers. Peer support specialists and community health workers, when embedded in reentry pathways and FSP teams, are uniquely positioned to increase treatment uptake through trusted outreach, navigation support, and culturally responsive

engagement. Trained individuals with lived experience effectively address the following system barriers surfaced by research from the Medi-Cal Utilization Project: lack of awareness of Medi-Cal enrollment, limited understanding of available services or how to transfer coverage across counties, uncertainty about how to access care, and cultural or behavioral norms such as shame, stigma, or fear of disclosing justice involvement.

Deeds – Calls To Action & Requests

Practices & Behavior Change for Public Safety and Behavioral Health Staff

- Embed justice-informed FSP enrollment pathways at jail discharge, arraignment, or probation referral for individuals eligible for FSP services
- Use the Sequential Intercept Model and risk/need tools to redesign and coordinate behavioral health, homelessness, and public safety programs
- Ensure forensic peer navigators/peer support specialists are part of every FSP justice-involved team

Data & Resources for County Leadership

- Improve access to Medi-Cal utilization data post-incarceration
- Track whether individuals referred from jail or prison receive treatment engagement within 30 days
- Expand the use of shared service dashboards for local and regional collaboration
- Prioritize helping community-based organizations providing Medi-Cal billable services become Medi-Cal providers (or bill Medi-Cal for their services)

> ***"We're seeing the same clients show up across systems, and still failing to coordinate or hold ourselves accountable to their long-term stability. Better integrated data is a starting point to know what is working and what is not."***
>
> — Oscar Benitez, Managing Director of Diversion & Reentry, Third Sector

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of FSPs. Please see ***Appendix Item 1*** for suggested outcomes and use cases.

Session 2: Proposition 36 - Early Lessons Learned on Drug Offenses

Session 2 examined early lessons from implementing California's Proposition 36: The Homelessness, Drug Addiction, and Theft Reduction Act (2024), which partially repealed Proposition 47 by allowing felony charges for repeat low-level drug and theft offenses. Prop. 36 also introduced a treatment-mandated felony option, aiming to reduce crime, homelessness, and drug addiction.

With the enhancements to theft, property damage, and drug-related crimes, what are the persistent county challenges with implementing the policy change specifically for residents arrested for drug-related offenses?

Facilitator: Magnus Lofstrom — Policy Director, Public Policy Institute of California

Presenters:

- Phebe Bell — Director, Behavioral Health Department, Nevada County
- Michael Rand — Commander, San Diego County Sheriff's Office
- Yvette Verastegui — Supervising Judge, Criminal Division, County of Los Angeles Superior Court of California

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Understand cross-sector challenges impacting Prop. 36 implementation
- Identify behavior changes and resource investments needed
- Collaboratively workshop solutions to align justice, behavioral health, and court systems

Presentation Materials and Resources:
Meeting materials posted on 2025 convening website

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Prop. 36 operates as an under-resourced mandate. The measure created new expectations for courts, jails, and treatment providers, but without dedicated operational funding to meet the increased demand for services. Core activities such as court reporting, hearings, and jail-based assessments are not Medi-Cal billable. Existing state programs and resources, such as the Behavioral Health Continuum Infrastructure, Drug Medi-Cal Organized Delivery System, and the CalAIM Justice Initiative, may alleviate bed and workforce constraints in the years to come, but they do not address near-term gaps. Counties risk relabeling existing work as Prop. 36 rather than expanding timely access to treatment.

Implementation is fragmented and roles are unclear across systems. Counties apply Prop. 36 differently, reflecting local legal interpretations, culture, and capacity. Ambiguity around core terms and responsibilities (e.g., "drug and alcohol professional," "completion of treatment") leaves probation, behavioral health, and court partners informally "volunteering" as leads for case management, court communication, and treatment access. This fragmentation undermines shared accountability and makes it difficult to compare outcomes or learn across counties.

> *"Better outcomes depend on stronger and more effective wraparound support services. Proposition 36, however, asks us to take on additional responsibilities without corresponding resources, specifically without adequate funding, staffing, or clearly defined roles."*
>
> — Judge Yvette Verastegui, Supervising Judge, Criminal Division, LA County Superior Court

Unclear incentives and success metrics may lead to more punitive outcomes. Law enforcement and judges lack clear guidance on what constitutes treatment success, how to structure sanctions and incentives to promote engagement, and when to utilize collaborative or problem-solving court models. Where treatment capacity is limited, people receive court mandates without timely access to care, heightening safety concerns for law enforcement, eroding trust among defendants, and pulling the system back toward punitive patterns that Prop. 36 was designed to disrupt.

Highlights

> *" [Prop. 36] individuals who are coming in[to the jail] are a sicker population — a lot of mental health and drug challenges and then just more significant overall health challenges."*
>
> — Michael Rand, Commander San Diego County Sheriff's Office

Courts and jails are absorbing a new workload without Prop. 36 court structures. Los Angeles and San Diego report more filings and higher daily jail populations as a result of Prop. 36. They have not created dedicated Prop. 36 courts because doing so would divert scarce staff and services from existing collaborative and specialized courts. In practice, most people receive similar jail assessments and reentry resources whether or not their charge is labeled as Prop. 36. Courts in Los Angeles, however, are beginning behavioral health assessments at arraignment to triage limited capacity earlier in the process.

Rural and smaller counties face significant challenges with limited infrastructure and unclear leads. Behavioral health leaders from small counties report increased Prop. 36 case volume that can significantly impact systems with limited residential treatment, detox, and substance use disorder workforce. Many services are not Medi-Cal billable, making it harder to expand capacity. Statutory ambiguity produces inconsistent definitions and expectations, and often forces either probation or behavioral health to step into de facto lead roles without clear authority, adequate staffing, or sustainable funding.

Early state investments and local innovations are promising, but they are also narrow and uneven. The state's $75 million for select counties to support Prop. 36-related activities offer a laboratory to test standardized workflows, staffing models, and data sharing. However, these funds reach only a subset of jurisdictions and are time-limited. Without a broader implementation and evaluation strategy, the state risks a

patchwork of pilots rather than a coherent, statewide approach to using Prop. 36 as a treatment-first diversion tool.

Deeds – Calls To Action & Requests

Prop. 36 will remain an important topic at Words to Deeds for the foreseeable future so that we can continue to identify effective cross-system approaches to mitigate some of the above-stated challenges and any unintended consequences that may persist. Two key topics for future discussion will be (i) strategies for cross-departmental capacity building for ongoing implementation and (ii) increasing data and evaluation capacity.

Practices & Behavior Change for Public Safety and Behavioral Health Staff

- Collaborate with other agencies or jurisdictions to identify strategies that encourage and incentivize individuals to enroll in treatment programs
- Seek structured solutions and community feedback to improve cross-departmental coordination and program design consistency
- Create multi-departmental Prop. 36 implementation teams, including private insurance health plans, at the county level
- Integrate Prop. 36 workflows with existing collaborative or diversion courts
- Develop a statewide Prop. 36 technical assistance hub for training and data support

> *"From a behavioral health perspective, we are layering this new initiative on top of what is a very underfunded substance use disorder treatment system. There is a lot of unbillable work and nuance to the funding in Prop 36. We absolutely support getting people linked to treatment wherever we can and want to make that happen. I think there's potential for pathways there, and we've got to make them clearer and fund them."*
>
> — Phebe Bell, Director, Behavioral Health Department, Nevada County

Data & Resources for County Leadership

- Expand Medi-Cal billing eligibility for court-mandated treatment
- Define clear, shared treatment success metrics across counties
- Link Medi-Cal billing data with justice data to assess cost-effectiveness and utilization
- Track time to treatment initiation after judicial order, and engagement rates at 30/60/90 days
- Monitor racial and geographic disparities in charging, sentencing, and treatment referrals

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of Prop. 36. Please see ***Appendix Item 2*** for suggested outcomes and use cases.

Session 3: Building on Incompetent to Stand Trial (IST) Solutions Workgroup Recommendations & Strengthening the Continuum of Care

California has been a national leader in addressing the crisis of individuals found Incompetent to Stand Trial (IST), focusing on people with serious behavioral health needs who become stuck between county jails and the state hospital system. Building on the recommendations of the statewide IST Solutions Workgroup, the Department of State Hospitals (DSH) described how counties and state partners can strengthen a full continuum of care that prevents IST declarations when possible, shortens time in custody, and supports long-term community stability.

Facilitator: Hallie Fader-Towe — Director of Justice & Health Initiatives, Behavioral Health, Council of State Governments Justice Center

Presenters:

- Chris Edens — Chief Deputy Director, California Department of State Hospitals
- Melanie Scott — Assistant Deputy Director, California Department of State Hospitals
- Ambar Faizi — Assistant Medical Director, California Department of State Hospitals

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals

- Summarize progress to date on reducing the felony IST waitlist and implementing IST Solutions Workgroup recommendations
- Identify remaining gaps across prevention, jail-based services, state hospital placements, and community-based restoration
- Surface concrete system-wide strategies counties can use to strengthen their IST continuum of care with courts and other human service agencies and align with state priorities.

Presentation Materials and Resources:

- Meeting materials posted on 2025 convening website
- IST Solutions Workgroup: Resources and Report of Recommended Solutions
- Involuntary Medication Order (IMO) Toolkit for Justice System Professionals and Treatment Providers
- Serious Mental Illness (SMI) Cal Advisor launched in August 2025 with the American Psychiatric Association to provide statewide technical assistance, consultation, and evidence-based training.

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

IST reforms show system change is possible but fragile. Between 2021 and 2023, DSH and county partners reduced the felony IST waitlist by approximately 70%, decreasing from nearly 2,000 people waiting more than

100 days in jail to an average time-to-treatment of around 6–7 days and a real-time waitlist of approximately 250. A combination of statutory changes, new funding, and intensive coordination, not a *single* program, facilitated these gains. Without sustained resources, clear governance, and continued statutory alignment, these improvements will erode and today's "success" will become tomorrow's baseline to recover all over again.

> *"Seeing the evolution of our department is unreal. A few years ago, we were overwhelmed by the wait list continuing to increase, but we hung in there. Sometimes it looks hopeless, but when we band together, we can accomplish some amazing things."*
>
> — Dr. Melanie Scott, Assistant Deputy Director, CA Department of State Hospitals

Early, clinically appropriate intervention is more effective than cycling people through competency. DSH's research with UC Davis shows that about 70% of IST patients have schizophrenia, schizoaffective disorder, or bipolar disorder, more than 60% were homeless at the time of arrest, nearly half had 15 or more prior arrests, and about 70% were re-arrested within three years after discharge. Almost half had no Medi-Cal mental health services in the six months prior to arrest. These data confirm that untreated serious mental illness, homelessness, and fragmented care drive repeated justice system contact. Strengthening crisis response, developing field-based relationship-centered programs, improving access to inpatient psychiatric care when needed, outpatient stabilization, and diversion at early intercept points is more effective and less costly than waiting for a felony IST declaration to initiate treatment.

Housing, step-down supports, and workforce capacity drive IST continuum success. More than 60% of IST admissions are homeless, and many people still leave jails or hospitals into unstable or unknown housing situations. Infrastructure investments, diversion housing, community facilities, and workforce training hubs are beginning to fill gaps, but workforce constraints will hinder service optimization or expansion. The workforce serving the IST population continues to face high turnover, burnout, recruitment challenges, and oftentimes lacks the specialized skills for (or discomfort with) forensic work. This is especially true in smaller counties. For workforce-specific solutions and pipeline strategies, see insights in *Session 5: The Power of Peers - Bridging Lived Experience into Forensic Behavioral Health* and *Session 9: Integrating Peers into the Continuum of Care Workforce Pipeline & Training*.

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

The IST Solutions Workgroup models effective cross-system collaboration. DSH oversees the largest mental health system in the country, serving more than 14,000 annually, almost all justice-involved. The IST Solutions Workgroup convened state, county, court, defense, prosecution, service provider, and advocacy partners to produce more than 40 recommendations and secured more than $500 million in annual funding. Short- and medium-term actions created treatment in jail within roughly three days of commitment (Early Access and Stabilization Services), expanded jail-based competency treatment, funded long-acting injectables, shifted conditional release presumptions toward outpatient and diversion when safe, allowed involuntary medication orders to follow the person between jail and hospital, and added community inpatient facilities as clinical step-downs. Longer-term work focuses on expanding community-based restoration and diversion, forensic ACT teams, and housing tied to the IST population.

Workforce, training, and discharge coordination are emerging levers for durable change. Resources like the IMO Toolkit and SMI Cal Advisor provide immediate support to rural and urban providers, allowing both to access similar expertise and support. DSH is piloting reentry and housing connections by notifying county behavioral health when an IST patient is returning to jail. This involves using CARE Court petitions and CalAIM's 90-day jail in-reach to identify individuals likely to be released. Additionally, DSH collaborates with housing partners to ensure more individuals exit restoration settings into community treatment and housing, rather than experiencing homelessness.

> *"We at the state hospitals are that intersection point between our patients that have severe mental illness and those that have legal involvement as well. [Like the counties] we understand it takes a highly skilled workforce to provide effective treatment to this patient population."*
>
> — Dr. Ambar Faizi, Assistant Medical Director, CA Department of State Hospitals

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Establish county-level multidisciplinary IST coordination teams that meet regularly and include representatives from courts, sheriffs, behavioral health, public defenders, and prosecutors.
- Implement standardized IST screening and referral processes at jail and court intake to identify significant behavioral health needs as early as possible.
- Expand diversion, stabilization, and treatment court options for individuals at risk of IST when charges and risk profiles allow alternatives to traditional prosecution.
- Integrate restoration planning with reentry planning from the outset to ensure that legal, clinical, housing, and supervision needs are addressed simultaneously.
- Use the IMO Toolkit, SMI Cal Advisor, and alienist trainings (referenced above in "Presentation Materials and Resources") to strengthen clinical practice, reduce variation in evaluations, and support forensic engagements.

Data and Resources for County Leadership

- Continue advocating for the DSH Growth Cap (Senate Bill 184) calculations to include an average of prior years (vs. prior year) to minimize county financial burdens due to outlier data.
- Develop IST dashboards that track flow across key stages (e.g., identification, IST findings, placement, restoration, discharge, and community follow-up).
- Standardize definitions and reporting for IST status, type of restoration setting, diversion participation, and post-restoration outcomes.
- Direct new state and federal funding streams toward workforce development, community-based restoration capacity, and housing aligned with the needs of the IST population.

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of IST Programs. Please see ***Appendix Item 3*** for suggested outcomes and use cases.

Session 4: Early Lessons Learned in CalAIM's Justice-Involved Reentry Initiative Implementation

> *"One of the reasons CalAIM is the most frequently cited topic at Words to Deeds is that the initiative itself requires intensive multi-disciplinary collaboration and care coordination across sectors, including behavioral health, managed care plans, and state and local correctional facilities."*
>
> — Jessica Headley Ternes
> Director of Behavioral Health, Third Sector

California has been a national leader in addressing the crisis of individuals found Incompetent to Stand Trial (IST), focusing on people with serious behavioral health needs who become stuck between county jails and the state hospital system. Building on the recommendations of the statewide IST Solutions Workgroup, the Department of State Hospitals described how counties and state partners can strengthen a full continuum of care that prevents IST declarations when possible, shortens time in custody, and supports long-term community stability. This session explored early lessons from implementing California's CalAIM Justice-Involved (JI) Initiative, which creates new pre-release Medi-Cal benefits, Enhanced Care Management (ECM), and Community Supports for people in jails and prisons. Speakers discussed the state policy and operations framework for prisons, and then grounded it in the experience of a rural bi-county behavioral health system that operates with limited health infrastructure but high cross-system collaboration. The conversation emphasized that CalAIM JI is both a funding reform and a relationship-oriented project. CalAIM JI's successful implementation of systems change depends on trust, shared workflows, and person-centered reentry planning that starts at intake rather than at the door on release.

Facilitator: Jessica Headley Ternes — Behavioral Health Director, Third Sector

Presenters:

- Janene Delmundo — Deputy Director, California Department of Corrections and Rehabilitation, California Correctional Health Care Services
- Sarah Eberhardt-Rios — Director, Sutter County Health and Human Services
- Dr. Phuong Luu — Bi-County Health Officer, Sutter County and Yuba County
- Christa McCauley — CalAIM JI Program Manager, Sutter County Health and Human Services

All speaker biographies are available on the dedicated 2025 convening website

Session Goals:

- Describe the CalAIM Justice-Involved policy framework and operational requirements for pre-release and post-release services.
- Highlight early implementation lessons from a rural, northern California jail (Sutter) utilizing CalAIM JI to strengthen re-entry
- Identify concrete strategies counties can use to align Sheriff Department/Corrections, jail health, county behavioral health, probation, community safety net providers, and Medi-Cal Managed Care

plans around person-centered re-entry care planning.

Presentation Materials and Resources:

- Meeting materials posted on 2025 convening website
- Release of Information (See ***Appendix Item 4***)

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

CalAIM Justice-Involved (JI) is transformative when integrated beyond a billing change. CalAIM JI offers a first-in-the-nation opportunity to use Medi-Cal for coordinated pre- and post-release services. It becomes true reentry infrastructure reform when corrections departments redesign workflows, clarify roles with managed care plans, and align jail and prison operations around continuity of care rather than treating CalAIM JI as a narrow aid code.

> *"We are constantly navigating collectively across all kinds of different groups. This works because the region is one geographic area. We're separated by a bridge less than a mile long, we're given permission to collaborate by our elected folks and leadership, we're allowed to care about things beyond our own organizations, we seek to understand where there are systemic failure points and we have a 'do no harm' approach."*
>
> — Sarah Eberhardt-Rios, Director
> Sutter County Health and Human Services

Sutter County operates a replicable model for person-centered re-entry care planning. The approach to treat jail entry like hospital admission requires extensive assessments and investments in cross-team collaboration. Two key implementation recommendations are (i) screening for Medi-Cal status, behavioral health, housing, and traumatic brain injury (TBI) at intake and (ii) revisiting this information through regular multidisciplinary team (MDT) meetings. Data on medical, mental, SUD, and social determinants of health needs should be used to determine the appropriate re-entry coordination and case management needs in preparation for post-release.

Rural counties can leverage CalAIM JI by aligning billing mechanics and shared workflows. Sutter County implemented CalAIM JI within its jail on April 1, 2025. Workflow processes that have been effective include embedding a dedicated public assistance specialist for Medi-Cal eligibility/enrolment and JI aid code activations, using patient-specific prescriptions so that the prescriptions are billable via Medi-Cal Rx, and ensuring that the In-Reach Provider can maximize the five sets of re-entry care billing bundles. In addition, the daily MDTs ensure that there is trust, clear divisions of labor, and shared expectations across all participants: Corrections, Jail Medical, Probation, Behavioral Health, and the In-Reach Provider.

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Prison Reentry: California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) use the 90-day pre-release window as a clinical intervention period rather than an administrative countdown. Prison teams complete health risk assessments, document behavioral health and substance use patterns with tools such as the ASAM-based RISE assessment, and align care to appropriate levels before people exit custody. Months in advance, they initiate Medi-Cal applications and aim to activate the justice-involved aid code before pre-release services start. Roughly 20–30 days before release, warm-handoff meetings (often via telehealth) bring together the patient, prison pre-release staff, and community ECM providers to finalize a reentry care plan. Seven days before release, the person receives the plan so expectations are clear. Inside, CCHCS staff lead assessment and documentation, while community ECM providers schedule post-release appointments, coordinate Community Supports, and follow the person after release, preventing the "dropped baton" that occurs when prison and community providers meet someone for the first time at the gate.

> ***"Since we've started CalAIM, we have gone from lengthy wait times and fragmented processes to a more streamlined system that allows for earlier engagement and support. Our [Medi-Cal] application approval rate has improved at the time of release."***
>
> — Janene Delmundo, Deputy Director, California Department of Corrections and Rehabilitation, California Correctional Health Care Services

Jail reentry – CalAIM Justice-Involved in Sutter–Yuba. Sutter County turned its jail into a re-entry care hub by convening a daily MDT comprised of staff from Sheriff/Corrections, Jail Medical, Probation, Behavioral Health, and the In-Reach Provider, a local Federally Qualified Health Center (FQHC), to discuss each person in jail enrolled in CalAIM JI. Multiple times per week, the MDT reviews cases in custody, treats everyone as a reentry case, and uses CalAIM JI frameworks to identify re-entry needs across medical, mental health – including triaging between mild/moderate mental health versus severe mental illness, substance use disorder, social determinants of health, and TBI needs. Those with severe mental health needs are referred to county behavioral health while FQHC serves those with mild-to-moderate needs. The FQHC, which functions as the In-Reach provider, bills Medi-Cal Fee-for-Service for re-entry case management while individuals are incarcerated and then transitions to standard ECM and Community Supports billing through Medi-Cal Managed Care after release. Because many jail stays are short or unpredictable, Sutter's model includes a short-stay approach focused on rapid screening, medication continuity, and warm connections to community care.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Establish jail-based multidisciplinary reentry teams that include custody staff, county behavioral health, probation, FQHC In-Reach providers, and jail medical vendors.
- Treat reentry planning as starting at intake by screening early for Medi-Cal status, behavioral health needs, housing instability, and TBI, and building workflows that do not depend on a known release date.

- Clarify criteria for routing people with severe mental illness to county behavioral health and those with mild-to-moderate needs to FQHC or other community providers, and make warm handoffs to ECM and Community Supports a standard expectation in both adult and youth facilities.

Data and Resources for County Leadership

- Build shared CalAIM JI dashboards that track screening, enrollment, services, and outcomes across jails, behavioral health, FQHCs, and managed care plans.
- Standardize local definitions for "severe" versus "mild-to-moderate" behavioral health needs, housing instability, and TBI flags so data can guide triage decisions and support statewide learning.
- Use Medi-Cal Rx data, reentry care bundle claims, and managed care billing to quantify cost avoidance, and seek technical assistance from DHCS and statewide partners to refine billing practices and build capacity, especially in rural and small counties.

Q&A

Q: For counties that don't have embedded staff, how do we do re-entry planning when exit dates are unknown?

A: Do the best you can because re-entry care starts at intake, just like discharge planning starts at admission. We'll get 70% of these plans completed and those that are short-term stays, we rely on the in-reach provider to work with the MCPs to reach those who we could not have re-entry care plans completed.

– Dr. Phuong Luu, Bi-County Health Officer, Sutter County and Yuba County

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of CalAIM initiatives. Please see ***Appendix Item 4*** for suggested outcomes and use cases.

Session 5: The Power of Peers – Bridging Lived Experience into Forensic Behavioral Health

Session 5 focused on how justice-involved peers function as essential to the workforce, not add-ons, in forensic behavioral health. Speakers explained how Lake County intentionally recruits people with lived experience of justice-involvement and recovery, reforms hiring practices to enable employment for jobseekers with a conviction history, and embeds peers in diversion courts, crisis response, and reentry to improve engagement, trust, and outcomes.

Facilitator: Rayshell Chambers — Executive Director, Painted Brain; Commissioner, Commission for Behavioral Health

Presenters:

- April Giambra — Deputy Director of Clinical Services, Lake County Behavioral Health Services
- Elise Jones — Behavioral Health Director, Lake County Behavioral Health Services

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Share how peers with lived experience of incarceration, SUD, and behavioral health conditions improve engagement and outcomes in forensic and justice settings
- Identify policy, human resource, and funding strategies that enable counties to hire, support, and sustain justice-involved peer staff at scale

Presentation Materials and Resources:
Meeting materials posted on 2025 convening website

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Lived experience is a core qualification, not an add-on. Peers who have experienced incarceration, addiction, and system involvement bring credibility, hope, expertise, and practical insight that traditional providers often cannot. Their presence in diversion courts, reentry teams, and behavioral health programs signals that today's client can become tomorrow's colleague and leader, improving engagement and follow-through across justice and treatment settings.

Hiring and role design must deliberately center peer success. Moving beyond blanket felony exclusions for hiring requires structured discretion: clear criteria for disqualifying offenses, case-by-case review, and transparent appeal processes that balance opportunity with safety and public trust. Certification and access to a billing code are not enough. Peers need exam preparation support, trauma-informed supervision, and

defined roles on multidisciplinary teams with access to treatment plans to ensure their work is sustainable and valued.

Growing the peer workforce in small counties requires stable funding and culture change. Counties cited funding constraints, match requirements, legacy stigma, and under-developed billing systems as main bottlenecks. Upgrading electronic health records to capture peer encounters, aligning Medi-Cal peer benefits and BH Connect requirements, and updating AB 109 2011 Realignment budget allocations and match formulas are essential to sustaining peer roles over time. Equally important is leadership that normalizes peers at every level of the organization and addresses staff resistance directly.

> *"When you have high accountability [required by the state], you have to have high support [for the counties]."*
>
> — Elise Jones, Behavioral Health Director
> Lake County Behavioral Health Services

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Lake County is a model for "second chance employer" practices. Leadership uses policy and process—not slogans—to hire justice-involved staff. Agencies conduct background checks at the end of the hiring process, discuss circumstances with candidates, and jointly assess recency and severity of convictions with Human Resources and legal counsel. When they decline to hire, they explain options for appeal and what evidence of recovery and growth could change a future decision. Peers are embedded in diversion court and other high-impact settings, sitting beside participants, translating legal language, and providing emotional support. Lake County leaders also deploy various culture-change strategies: explicitly naming bias toward justice-involved staff, cross-training SUD and MH teams, and coaching or reassigning staff who cannot adapt to peers as professional colleagues.

Peer certification and the pipeline create both opportunity and barriers. The Medi-Cal peer benefit and state certification pathways open billable roles for justice-involved peers but also introduce new hurdles. The exam's rigor, documentation requirements, and the realities of recovery can be challenging for people with limited formal schooling or ongoing behavioral health conditions. Lake County used one-time Behavioral Health Transformation and COVID-19 recovery funds to expand peer roles, upgrade systems, and support candidates through multiple exam attempts. The central question now is how to fund exam preparation, coaching, supervision, and system upgrades on an ongoing basis so peers can enter, remain, and advance in roles that are clinically integrated and financially sustainable.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Treat lived experience of justice involvement, behavioral health conditions, and recovery as a valued qualification in job descriptions for peer, clinical, and leadership roles.
- Implement transparent, case-by-case background check and appeal processes, and embed peers at key forensic decision points (e.g., diversion and specialty courts, jail/prison in-reach, mobile crisis, and reentry teams) with clearly defined roles on multidisciplinary teams.

- Provide ongoing training and trauma-informed supervision for peers and non-peer staff to address stigma, support staff in recovery, and normalize peers as colleagues and leaders rather than exceptions.

Data and Resources for County Leadership

- Track and report peer workforce metrics (hiring, certification, retention, advancement) and upgrade electronic health records and billing to ensure peer services are linked to treatment plans and captured as billable encounters under the Medi-Cal peer benefit.
- Fund exam preparation, coaching, and paid study time for peer candidates, and offer technical assistance to help counties comply with BH Connect match requirements and optimize Medi-Cal reimbursement for peer services.
- Coordinate statewide advocacy to update 2011 Realignment allocations and match formulas and to expand use of State General Fund as local match for Medi-Cal-reimbursable peer services (including mobile crisis), with attention to small and rural county needs.

> ***"Our county increased Medi-Cal services by 66% during a very difficult transition period, but we are still trying to figure out how to come up with that money up front to add these Peer Support positions to our budget. It takes years."***
>
> — Elise Jones, Behavioral Health Director
> Lake County Behavioral Health Services

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of peer support workforce initiatives. Please see ***Appendix Item 5*** for suggested outcomes and use cases.

Session 6: Mobile Crisis Response & Co-Responder Models – Recent Successes and Challenges

Session 6 examined how mobile crisis response and co-responder models work in practice when behavioral health and law enforcement must jointly respond to people in crisis. Speakers described how Lake County built a trauma-informed mobile crisis team, developed strong partnerships with law enforcement, and used co-location, shared protocols, and data systems to improve safety, response times, and connections to care in a rural setting.

> *"Mobile crisis is the 'sleeper hit' of the Newsom administration's behavioral health transformation innovations [...] Part of that is because of the ways that it is really changing the landscape locally and providing a resource to our communities. This has not been easy."*
>
> — Michelle Cabrera, Executive Director
> County Behavioral Health Association of California

Facilitator: Michelle Cabrera — Executive Director, County Behavioral Health Association of California

Presenters:

- Alicia Adams — Mental Health Program Manager, Lake County Behavioral Health Services
- April Giambra — Deputy Director of Clinical Services, Lake County Behavioral Health Services
- Dale Stoebe — Chief of Police, Lakeport Police Department

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Share early lessons from Lake County's implementation of the Medi-Cal Mobile Crisis Benefit in partnership with law enforcement, dispatch, and peer staff
- Identify practical strategies for designing mobile crisis and co-responder models that improve safety, reduce harm, and strengthen trust in rural and small-county settings

Presentation Materials and Resources:
Meeting materials posted on 2025 convening website

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Mobile crisis is a system redesign opportunity. The Medi-Cal Mobile Crisis Benefit only fulfills its promise when counties redesign how behavioral health, 911/dispatch, law enforcement, and peers work together. Treating it as a narrow compliance task or a "behavioral health add-on" will not meaningfully shift public safety, reduce unnecessary arrests and holds, or improve community well-being.

Integrated, non-institutional responses can safely resolve most crises in the community. Mobile crisis teams that combine mental health, SUD, and peer support, and that have access to non-institutional "living room" or

respite-style spaces, can stabilize many people without law enforcement, jail, or hospital. Clear protocols that define when mobile teams lead, when co-response occurs, and when law enforcement must take primary lead help match the response to risk while protecting space for health-first resolutions.

> *"As the 9th poorest county in California, it was time to trust and figure out how to serve a large number of people who need behavioral health treatment. Everything kind of came together at the same time—new leadership in law enforcement and new leadership in behavioral health. I'm not too worried about being vulnerable. It was time to trust and time to really engage. Then everyone had to figure out how to work collaboratively to create the necessary changes."*
>
> — Dale Stoebe, Chief of Police
> Lakeport Police Department

Data, dispatch partnerships, and culture change with law enforcement make the model durable. Shared triage rules, crisis tracking tools, and real-time information about response times and outcomes allow partners to refine protocols and staffing. Embedding behavioral health expertise in law enforcement, conducting joint training, and reviewing outcome data together can shift officer attitudes over time, reducing unnecessary contacts, use-of-force incidents, and reliance on arrests or involuntary holds as "quick fixes."

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Lake County uses integrated teams and respite settings to keep people out of jail and hospitals. The county built a mobile crisis team that intentionally employs peers and SUD counselors with deep lived experience and prepared law enforcement to work alongside them. Mobile crisis staff can engage people, bring them to a safe, home-like space, and de-escalate most crises in the community. About three-quarters of contacts are resolved without law enforcement involvement or hospital transport, showing that integrated behavioral health and peer-led supports can be both safe and effective.

Dispatch and law enforcement partnerships, supported by real-time data, drive continuous improvement. Working with its dispatch platform provider, Trek Medics Beacon, Lake County can see where teams are, how long responses take, and which calls involve law enforcement, and can adjust staffing and protocols accordingly. By sitting with dispatchers to review call logs, partners built a shared language around what counts as a behavioral health crisis and clarified when mobile crisis should lead, when co-response is needed, and when law enforcement remains primary. Law enforcement agencies also embedded a behavioral health specialist, conduct regular joint training, and use data on arrests, use-of-force incidents, and repeat contacts to demonstrate the value of mobile crisis and reinforce more human-centered responses.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Treat mobile crisis as the default response for behavioral health crises, with law enforcement as a safety partner when weapons, immediate threats, or severe agitation are present, and embed peers and SUD expertise on mobile teams wherever possible.

- Conduct structured, recurring reviews of 911 and dispatch calls with law enforcement and dispatchers to define which calls go to mobile crisis, which require co-response, and which remain law enforcement only, and update protocols and training based on those findings.
- Embed behavioral health staff and, where feasible, peers within law enforcement agencies to build day-to-day trust, normalize joint responses, and give officers direct access to consultation and warm handoffs in the field.

Data and Resources for County Leadership

- Invest in crisis tracking tools and dispatch platforms that allow behavioral health and law enforcement to see crisis calls, response times, dispositions, and repeat contacts, and use these data to refine staffing, geography, and protocols.
- Monitor key outcomes such as arrests, use-of-force incidents, 5150 rates, and the breakdown of holds initiated by law enforcement versus mobile crisis, and use this information to reduce reliance on holds and arrest as default responses.
- Coordinate statewide advocacy and technical assistance so small and rural counties can braid Medi-Cal, behavioral health, and public safety funding to sustain mobile crisis staffing, co-responder roles, dispatch partnerships, and crisis respite facilities.

> *"We are fortunate to still have young men and women interested [in law enforcement]. One thing millennials and Gen Zers bring to the table is their tolerance — and not even that; it's just normal to them. We can capitalize on that. We have to make sure the people we hire understand the job. Part of our work is social work. It always has been [...] There are many benefits to [having behavioral health staff embedded in teams]."*
>
> — Dale Stoebe, Chief of Police
> Lakeport Police Department

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of mobile crisis response initiatives. Please see ***Appendix Item 6*** for suggested outcome metrics and use cases.

Session 7: Housing as Public Safety & Well-Being

Housing investments function as public safety and well-being strategies at both the entry and exit points of the criminal justice system. The conversation highlighted three complementary perspectives from Los Angeles and San Diego: a statewide prison reentry housing model (CDCR's Specialized Treatment for Optimized Programming, or STOP), a permanent supportive housing initiative in Los Angeles for people cycling between jail and emergency rooms (Just in Reach Pay for Success), and lived experience leadership that keeps housing from becoming a downstream afterthought.

Facilitator: Lahela Mattox — Chief Operations Officer, San Diego Regional Task Force on Homelessness

Presenters:

- Sarah Hunter — Senior Behavioral Scientist and Director, RAND Center on Housing and Homelessness
- Curtis Howard — Founder, LivEX; Board Member, San Diego Regional Task Force on Homelessness
- Barry Lindstrom — Vice President of Operations, Amity Foundation

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Understand which tools, practices, and resources can be adopted by any county to provide more responsive and coordinated reentry housing and support services
- Explore how supportive housing at jail/prison entry and exit can reduce homelessness, recidivism, and crisis system use for justice-involved people

Presentation Materials and Resources:

- Meeting materials posted on 2025 convening website
- RAND Evaluation: LA County Just in Reach Permanent Supportive Housing (PSH) for jail reentry

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Housing is core to public safety and behavioral health infrastructure. When housing is framed as a starting condition for safety and recovery rather than a downstream reward, agency leadership builds it into reentry planning, policy decisions, and cross-system strategy. Treating housing as "optional" or only for those who meet engagement benchmarks leaves people cycling between custody, shelters, and emergency rooms and undermines both public safety and recovery goals.

> *"At San Diego Regional Task Force on Homelessness, we simply believe that housing is key—and as one of the judges said yesterday—you can't really have anything else happen successfully without someone being housed [...] Housing means help them recover, help them to address their physical or mental health or substance abuse, their justice needs."*
>
> — Lahela Mattox, Chief Operations Officer
> San Diego Regional Task Force on Homelessness

Sustained stability requires integrated housing, services, and "rent-cliff" planning. Effective models combine interim or permanent housing with SUD and mental health treatment, case management, and peer support in "home-like" or community settings. Six- to 12-month subsidies under programs like STOP, Just in Reach, or CalAIM Community Supports are not sufficient on their own. Counties must plan early for income, benefits, layered subsidies, and higher-acuity housing options, especially for older adults and people receiving Supplemental Security Income/Social Security Disability Insurance, to avoid "rent cliffs" that return people to homelessness and crisis systems.

> *"Homelessness has the greater impact on whether a person succeeds or not when returning to the community from incarceration than people think. People said to me: 'Curtis you were a gang member who also experienced substance use. How come you didn't join the fight to end gang violence, or become a counselor against the war on drugs?' I said to them: 'Well, because homelessness had a greater impact on my life than any of those things.' "*
>
> — Curtis Howard, Founder, LivEX; Board Member, San Diego Regional Task Force on Homelessness

Cross-system governance and lived experience solve "wrong pockets" and blind spots. Because housing stability produces long-term benefits for corrections, health, homelessness systems, and courts, it is challenging for a single system to fund housing interventions at scale. Counties need shared tables and funding arrangements that align managed care plans, continuums of care, corrections, and behavioral health around long-term housing outcomes. Embedding people with lived experience in decisionmaking roles at those tables will further help clarify what types of housing, supports, and durations prevent returns to homelessness and incarceration.

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Prison reentry: STOP integrates housing and treatment, but must bridge gaps and rent cliffs. Amity Foundation operationalizes the vision of STOP by providing housing as a core reentry and public safety strategy through detox, longer-term residential treatment, reentry and recovery housing, outpatient SUD services, and "warm handoffs" from prison to community. Participants can receive up to one year of housing and services coordinated across multiple regions. Service providers must braid additional funding sources (e.g., rental assistance, SSI/SSDI, aging services) to help older adults and people on disability avoid rent cliffs at the end of the STOP-funded year.

Jail reentry: Housing First PSH is effective and cost-neutral. Just in Reach (JIR) identifies people in jail who are chronically homeless and enrolls them upon release into interim housing, then permanent supportive or enhanced residential housing without preconditions. Integrated housing and services reduce repeated jail bookings and high-cost crisis health system use. RAND's evaluation found that roughly 80% of participants achieved 12-month housing stability, along with reductions in jail days and emergency health use and increased outpatient

> *"Once people are stably housed, they tend to use less of crisis care and are more likely to engage in outpatient services. [In comparison to the] costs to the jail system and the costs of health services, as well as those of probation, even including the costs of housing, [Just in Reach] was cost neutral. It's a win-win."*
>
> — Sarah Hunter, Senior Behavioral Scientist and Director RAND Center on Housing and Homelessness

care. JIR is cost-neutral to the county when comparing cross-system costs and savings before and after housing.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Prioritize housing with supports as a first-line reentry response for state and county releases, not a downstream referral after supervision, treatment, or employment benchmarks.
- Design and fund reentry housing around the "rent cliff" by securing income, benefits, layered subsidies, and higher-acuity options that can sustain tenancy beyond the first funded year.
- Build formal multi-sector teams (i.e., CDCR, parole, probation, behavioral health, Continuum of Care bodies, housing authorities, managed care plans, service providers) to coordinate referrals, tenancy supports, and crisis responses for justice-involved residents.
- Empower people with lived experience in program design, advisory bodies, reentry partnerships, and hiring so they shape how housing is offered, how long it lasts, and what supports matter most.
- Structure contracts and partnership agreements to pay for outcomes. For service agreements like LA's JIR, that means compensating service providers for the achievement of long-term (6-24 months) housing stability, reduced jail, and emergency room use to incentivize more effective cross-sector collaboration.

Data and Resources for County Leadership

- Review evaluations such as RAND's LA JIR study and other supportive housing research to guide local program design and strengthen cases to Boards of Supervisors and state leaders.
- Map housing and support resources for justice-involved residents (e.g., STOP, AB 109/Post-Release Community Supervision housing, Continuum of Care/Emergency Solutions Grants, CalAIM Community Supports, flexible housing pools) and identify missing or time-limited case management, benefits navigation, mental health care, and tenancy supports.
- Develop blended and performance-based funding models that combine state reentry contracts with Medi-Cal, local housing measures, and philanthropy to fund long-term housing plus services.
- Leverage statewide opportunities such as managed care incentive payments and CBH's Innovation Partnership Fund (RFP to be released early 2026) to launch reentry housing pilots and strengthen data sharing across health, homelessness, and justice systems.

> *"Our system is cyclical. Part of [the sustainability answer] is we need to hold steady and true for what we know works for each of our sectors. Within this uncertain time is an opportunity for us to remain stable where we can, implement things where we can, but not be foolish enough to think that one new funding source or one new waiver is going to change everything."*
>
> — Lahela Mattox, Chief Operations Officer, San Diego Regional Task Force on Homelessness

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of reentry housing services. Please see ***Appendix Item 7*** for suggested outcomes and use cases.

Session 8: Care Court—Learnings from an Early Implementer

Care Court is one of California's most visible behavioral health and public safety reforms, but its impact depends on what counties build around it, not just what is written in statute. This session used Orange County's experience as an early implementer to show how Care Court operates as one tool within an existing continuum of care, grounded in Assisted Outpatient Treatment (AOT), collaborative courts, and jail reentry services rather than as a stand-alone program. County Health Care Agency leaders and the Public Defender described how they organized operations, outreach, and treatment pathways, and how they are defining success around voluntary engagement and person-level change.

At the time of the session, Orange County had just under 190 petitions, 65 active participants not yet on care agreements or plans, 13 active care agreements, one active care plan, one graduate, and additional graduations pending. Roughly 40 percent of petitioned individuals were unhoused at the time of petition. This was lower than early expectations, signaling that Care Court is reaching a mixed population rather than functioning exclusively as a homelessness intervention.

Facilitator: Frank Congine — Health Services Assistant Deputy Director, Orange County Health Care Agency

Presenters:

- Veronica Kelley — Director, Orange County Health Care Agency
- Ian Kemmer — Behavioral Health Director, Orange County Health Care Agency
- Sara Nakada — Orange County Public Defender

All speaker biographies are available on the dedicated 2025 convening website

Session Goals:

- Understand what is working well in Care Court and how other counties can adopt similar approaches to make progress
- Discuss challenges and gaps not yet accounted for in Care Court implementation
- Identify what is most needed to ensure the best outcomes for participants, families, and communities

Presentation Materials and Resources:
Meeting materials posted on 2025 convening website

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Care Court works best as a doorway into an existing system of care, not a standalone program. Orange County layered Care Court onto AOT, collaborative courts, and jail reentry rather than building a siloed court

track. Care-eligible individuals are brought "under the umbrella" of the Health Care Agency alongside Medi-Cal and privately insured clients, and staff help families move people into benefit pathways that unlock the full array of county behavioral health and housing supports. Success is measured by connection to care, stability, and step-downs from more restrictive settings, not by petition volume.

> *"Flexibility is really important. We really wanted to inform the process and work with the Judicial Council, Behavioral Health Services, and DHCS to create something that would really work. Orange County built upon its current system of care, so we leveraged that—Assisted Outpatient Treatment (AOT), which we knew we did really well. We learned that if somebody is voluntarily entering into services, the change that they will experience is more likely to be long-term rather than if it were more coercive."*
>
> — Veronica Kelly, Director
> Orange County Health Care Agency

Impact depends on deep cross-system relationships and shared definitions of success. Longstanding partnerships among judges, public defenders, and behavioral health leaders allow Orange County to staff cases jointly, flex statutory timelines when clinically appropriate, and make shared decisions about whether to continue, dismiss, or modify petitions. Weekly case conferences before court ensure that legal advocacy, clinical judgment, and reentry planning are aligned. These relationships make it possible to prioritize self-determination, maintain ethical practice, and resist pressure to use Care Court as a coercive tool.

Care Court capacity is defined by intensive, relational work, not docket size. Staff routinely make 10 to 50 outreach attempts per Care-eligible person, meeting people in community settings, and often maintain relationships beyond dismissal or graduation. Public defenders combine legal advocacy with social work, helping clients access benefits, housing, and basic needs even when they decline participation. This intensity means that seemingly small caseloads represent substantial field work and defines how many participants a county can realistically serve, reinforcing the need for realistic staffing models and data expectations that capture person-level change rather than just court milestones.

Highlightsi

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Orange County embeds Care Court within an existing behavioral health and reentry ecosystem. Jail Community Reentry Program staff inside the jail coordinate closely with Care teams and use shared technology to track custody status, transfers, and release dates so petitions and care plans can be timed around transitions. Weekly staffing meetings every Monday convene behavioral health, public defense, and reentry staff to review cases and align recommendations before Tuesday hearings, ensuring that court proceedings are a component of a larger treatment and housing strategy.

Engagement intensity and ethical practice shape Care Court operations. Orange County's teams describe Care Court as "relationships for eternity," where repeated field contacts, benefits navigation, and crisis support often continue after cases are dismissed. The Public Defender's Office invests significant time, respects a client's decision to decline participation when clearly expressed, and works to promote safety and stability outside court. The team regularly grapples with complex ethical scenarios—such as psychosis, ambivalence, or conflicting family preferences—and prioritizes self-determination in court while using relational, non-coercive strategies in the community to encourage safer choices over time.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Position Care Court as one access point within a continuum by mapping how Care-eligible individuals currently move through AOT, collaborative courts, crisis services, outpatient care, housing, and reentry to avoid creating a parallel treatment track.
- Plan staffing and caseloads around intensive, field-based engagement by building models that expect numerous outreach attempts, sustained relationships, and ongoing support beyond court participation. Providing supervision and wellness supports to staff is critical to sustain engagement without burnout.
- Co-design local practices with public defense, peers, families, and leaders with lived experience so referral criteria, outreach protocols, and courtroom practices prioritize self-determination and safety. This ensures dismissal, non-engagement, or graduation does not automatically end support from other programs.

> *"We understand our relationship with the client is basically for eternity. Even if they opt not to participate in the Care Court program, we're still involved with them in terms of 'What else do you need?' 'Do you need to get your benefits set up?' 'Do you need socks?' We continue to reach out to them and try to get their buy-in."*
>
> — Sara Nakada
> Orange County Public Defender

Data and Resources for County Leadership

- Develop metrics that capture engagement and person-level impact—not just petitions and care plans (e.g., contacts made, trust gained, services accepted, step-downs from higher levels of restriction, and changes in housing, hospitalization, and daily functioning).
- Invest in cross-system technology and data-sharing agreements to reduce missed client engagements and duplicative work. It is key for jails, courts, behavioral health, and reentry teams to share timely data on custody status, releases, and engagement.
- Seek philanthropic and technical assistance partners to strengthen analytics, evaluation, and facilitation capacity. These efforts will help counties build holistic evaluation frameworks, interpret their data, document qualitative change, and build budgets for sustaining outreach, relationship-building, navigation, and housing supports for Care Court.

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of Care Court services. Please see ***Appendix Item 8*** for suggested outcomes and use cases.

DATA SPOTLIGHT

Orange County defines successful implementation as:

- People who voluntarily enter treatment and remain engaged
- Individuals who are engaged in services even when they do not move into a formal care plan
- Clients "stepped down" from conservatorship into Care Court and eventually into voluntary care
- Participants whose hospitalizations dropped significantly after engagement, even if they did not "graduate" on a statutory timeline

Session 9: Integrating Peers into the Continuum of Care Workforce Pipeline & Training

All Words to Deeds sessions reinforce the need for counties to adequately support and expand the capacity of their workforce to deliver more effective substance use disorder (SUD) and co-occurring treatments. There is noteworthy progress, namely through the California Department of Health Care Access and Information's Medi-Cal Behavioral Health Student Loan Repayment Program, which received more than 5,000 applications requesting about $568 million in funding. Certified peer support specialists rank among the top five requested professions. This demand underscores the state's commitment to ensuring that peers are part of the core behavioral health workforce. Camden County, New Jersey's NuEntry Opportunity Specialists (NOS) peer-led reentry model and Amity Foundation's workforce training model in Los Angeles illustrate how counties can move from ad hoc peer roles to structured pipelines that train, support, and retain peers and clinicians in forensic and reentry settings.

> *"The Power of Peers presentation on Day 1 of Words to Deeds set the context for today's session around Peer workforce development. A comprehensive workforce strategy must include peers, individuals with lived experience with incarceration and recovery, and trained behavioral health professionals."*
>
> — Sharmil Shah, Branch Chief
> Behavioral Health & Policy,
> Health Workforce Development
> Department of Health Care Access and Information

Facilitator: Sharmil Shah — Branch Chief, Behavioral Health & Policy, Health Workforce Development, Department of Health Care Access and Information

Presenters:

- Sharon Bean — Jail Population Manager, Camden County, New Jersey
- Tedman Cheung — Senior Clinical Director, Amity Foundation

All speaker biographies are available on the dedicated 2025 convening website.

Session Goals:

- Explore workforce infrastructure, training, and support models that integrate peers and non-peer professionals into a continuum of care
- Identify practical strategies to build pipelines into forensic and reentry settings, including partnerships with universities and community-based organizations

Presentation Materials and Resources:
Meeting materials posted on 2025 convening website

Words – Insights & Themes

Portable lessons applicable to any county and are replicable beyond the session.

Peers are core members of the workforce, not add-ons, when integrated with clinicians as one team. Camden County and Amity Foundation show that peers with lived experience are most effective when they are treated

as essential staff with defined roles in outreach, navigation, and decisionmaking, not as volunteers or occasional supports. When peers and clinicians share practice frameworks (e.g., co-occurring care, harm reduction, "rule-out" assessments) and participate in the same case conferences, they respond coherently to complex crises, increase engagement, and bring real-time insights to service delivery.

> *"Our peers relive their own experiences, drawing from them over and over again to help others with their reentry and recovery journeys [... NuEntry] is peer-led in every way. This model allowed us to hire individuals who could relate to what our clients were going through. Making that one simple change in the structure and dynamics made a world of difference when it came to engagement in jail and most importantly, upon release home."*
>
> — Sharon Bean, Jail Population Manager
> Camden County, New Jersey

Policy, HR, and clearance reforms unlock peer leadership and diversity. Counties cannot build a justice-involved peer workforce if their own hiring and clearance rules restrict those employed individuals jail entry and promotions into leadership roles. Camden used its authority over jail clearance to move from blanket denials to provisional badges and full clearance after time in the community, now employing more than 40 peers. Amity operates with contracts that define lived experience as expertise, allowing candidates without traditional work histories to qualify when paired with appropriate support. These policy choices and intentional culture-change efforts convert "peer-friendly" rhetoric into actual peer-led teams.

Intentional pipelines and infrastructure turn one-off peer projects into durable systems. Workforce capacity does not emerge from isolated grants. Camden built its peer-led reentry network over years, starting with federal Second Chance Act funding, and now sustains a social work internship inside the jail. Amity grew its diversion and reentry unit to about 50 trained staff (three-quarters with justice or recovery histories) while building internship partnerships with universities. Camden and Amity rely on multidisciplinary case conferencing and governance structures that place peers at the center of reentry committees, contract/RFP drafting, and program design to ensure that integrated peer-clinical teams are embedded at the system level and not confined to a single program.

Highlights

Session-specific insights to inform improvement, replication, expansion, or advocacy.

Camden County: peer-led, jail-based reentry workforce. Camden's Department of Corrections adopted the philosophy that reentry is a core jail responsibility. NuEntry Opportunity Specialists (NOS) are a formal staff function serving as community liaisons to support navigation to housing, treatment, Medication Assisted Treatment, and employment and reduce stigma through outreach. Camden empowered peers to lead the Peer Reentry Support Program, with case managers and supervisors in support roles, and rewrite RFPs to require peers and credible messengers in all youth, emerging adult, and adult services. Peers co-lead the county reentry committee, design "Meet 'Em at the Gates" welcomes, and influence policy.

Amity Foundation: co-occurring workforce and integrated clinical training. Amity uses destigmatizing language for its clients ("students," "campuses of learning," "advocates") to immediately set a culture of growth for its peers and clinicians. Staff train together in a "rule-out" assessment model that asks whether

behaviors stem from mental health, substance use, medical issues, or situational stressors and pairs each with a specific intervention, from medication changes and Intensive Outpatient Program to safety planning and housing support. Staff maintain detailed contact tracking sheets and build collaborative networks around each student to appropriately integrate public defenders, probation, courts, housing providers, and family. Amity also builds a formal pipeline for MSW interns, including those with criminal records (e.g., through the University of Southern California's Unchained Scholars), demonstrating how justice-informed and law-enforcement-informed lived experience can strengthen the workforce.

Deeds – Calls To Action & Requests

Practices and Behavior Change for Public Safety and Behavioral Health Staff

- Treat peers with lived experience as core staff within jails, reentry programs, and community-based teams, with clear responsibilities for outreach, navigation, mentoring, and designing programs.
- Reform HR, background check, and jail clearance policies to enable provisional and then full clearance for qualified justice-involved candidates. This enables structured pathways for peers to move into supervisory and leadership roles in county agencies and contracted service providers.
- Provide joint training and routine multidisciplinary case conferencing for peers and clinicians on co-occurring disorders, harm reduction, trauma-informed care, and justice-involved engagement, utilizing shared tools (e.g., rule-out assessments and team-based care plans) to ensure the whole team applies a coherent practice framework.

Data and Resources for County Leadership

- Map current peer and clinical workforce capacity across jails, reentry programs, and community services (positions, vacancies, peer representation) and use this information to target new FTEs, training, and supervision where co-occurring care is most needed.
- Align Medi-Cal, county general funds, reentry grants, BHSA/BH Connect workforce initiatives, and philanthropy to pay for peer salaries, supervision, training, and internships, so peer roles and pipelines do not disappear when grants end.
- Develop shared tracking tools and participate in regional learning networks to capture medication and crisis histories, follow-up contacts, and housing status. Peer-to-peer forums will enable counties to avoid reinventing their own peer integration strategy by adopting provisional clearance approaches, and internship and training practices.

> *"I often tell everyone who I interview for our teams that this will be the most challenging population you can work with [...] This is why we need a lot of integrated services. Our job is to break them out of the cycle they are caught in."*
>
> — Tedman Cheung, Senior Clinical Director Amity Foundation

Speakers and attendees also recommended metrics for counties and the state to measure and assess the effectiveness of workforce training and pipeline development efforts. Please see ***Appendix Item 9*** for suggested outcomes and use cases.

Convening Assessment

The 2025 convening met its core goal: it connected civil servants across behavioral health and public safety systems to strengthen coordination and improve outcomes for Californians.

More than 100 people attended W2D 2025 in person, including 36 facilitators or presenters. Most facilitators and presenters stayed for at least one full day, which strengthened peer learning and informal problem-solving. Attendance held steady across both days: 102 attendees participated on Day 1 and 104 on Day 2, alongside five experts who presented virtually. Ninety-five participants attended both days.

Co

Diverse and Active Participant Engagement

Attendees represented a mix of leaders and implementers who can translate shared learning into operational change. Two-thirds of participants attended W2D for the first time (66%), indicating continued demand for a practical, cross-system learning space.

W2D convened an intentionally sized, high-engagement cohort. The event aims to stay intimate while maintaining diversity of roles and perspectives, with a target of no more than 100 participants to support peer-to-peer dialogue during sessions, question and answer periods, breaks, and informal networking. This year's convening exceeded capacity and quickly became oversubscribed, which led the convening planners to stop intentional registration outreach two weeks before the event date.

Representation reflected a strong coalition across California:

- **Geography and departmental:** Nineteen[1] of California's 58 counties participated, alongside 10 state departments, associations, and councils.[2]
- **Roles:** Attendees primarily included directors, managers, and senior staff positioned to influence policy, operations, and implementation.
- **Systems:** Outreach intentionally increased representation from public safety leaders after prior years skewed more heavily toward behavioral health. As a result, public safety represented 28% of attendees, including corrections, legal support, and law enforcement. Behavioral health represented 53% of attendees.
- **Implementers closest to delivery:** County government accounted for 67% of participants, which aligned with the convening's focus on local implementation and cross-agency coordination.

[1] Alameda, Contra Costa, Fresno, Imperial, Kings, Lake, Los Angeles, Orange, Marin, Merced, Nevada, Riverside, Santa Barbara, San Diego, San Joaquin, Sutter, Ventura, and Yuba Counties

[2] Behavioral Health Services Oversight & Accountability Commission (Commission for Behavioral Health), Board of State and Community Corrections (BSCC), California Behavioral Health Planning Council, California Department of Corrections and Rehabilitation (CDCR), California Department of Health Care Access and Information (HCAI), California Department of State Hospitals, California District Attorneys Association (CDAA), California State Association of Counties (CSAC), County Behavioral Health Directors Association of California (CBHDA), and Judicial Council of California.

Action-Oriented Attendee Commitments

Attendees left with clear, practical next steps and reinforced a shared mandate: break down silos and build durable cross-system routines that support justice-involved people with complex behavioral health needs.

Commitments captured through in-session polling showed concrete intent to act:

- **Cross-sector Collaboration:** 50% of respondents from the relevant session committed to initiating or strengthening cross-sector meetings between behavioral health and law enforcement.
- **Care Court Improvements:** 57% of respondents indicated they intend to build cross-system strategies that keep Care Court participants connected to necessary treatment.

Attendees also affirmed the convening's central theme of shared responsibility. As participants stated during the event, "No one organization was designed to support the needs of our people. We need to work shoulder to shoulder," and "No department can do this alone." These reflections reinforced that collaboration is not optional. It is the primary requirement for sustained systems change.

Original responses to all assessment questions available upon request.

Broad Commitment to Strengthen the Workforce

Attendees repeatedly emphasized that implementation hinges on workforce capacity, role clarity, and cross-system legitimacy for staff working with justice-involved populations. Commitments reflected an especially strong focus on building and normalizing peer and clinical roles across behavioral health and carceral or reentry settings.

Key workforce-related commitments included:

- **Embedding forensic peer roles:** 40% of respondents intend to initiate or strengthen cross-system conversations specifically about embedding forensic peer roles.
- **Expanding licensed clinical pathways:** 53.3% of respondents from *Session 9: Integrating Peers into the Continuum of Care Workforce Pipeline & Training* intend to establish or improve pathways for licensed behavioral health professionals to work in carceral or reentry settings.
- **Investing in peer training and certification:** 40% of respondents reported an intention to invest in training and certifying their peers.

Data and Methods Limitations

As is typically the case with any large in-person gathering, this assessment reflects meaningful but incomplete data. Response rates varied by instrument and by day, and the convening planners encountered technical constraints that limited consistent session-by-session measurement. As highlighted below, response rates varied by method, day, and session.

- **Pre-conference survey:** 35 participants responded.

- **Day 1 Mentimeter polls (Sessions 3 to 5):** an average of 35 participants responded per session (range 27 to 38).
- **Day 2 surveys (Sessions 6 to 9):** 15 participants responded via SurveyMonkey.
- **Post-convening survey:** 2 participants responded within one month following the event. We did not include these responses in the assessment because they do not represent the collective experience of attendees.

We tested in-room, real-time assessment using Mentimeter polls advanced by presenters after each session, so participants could respond and see group results. Recurring access, connectivity, and hardware issues disrupted administration and eliminated data collection for the first two Day 1 sessions.

On Day 2, we streamlined data collection to align with the agenda and minimize the burden. Sessions ran long, so planners consolidated assessments into two surveys (lunch for morning sessions; end-of-day for afternoon sessions) and shifted from Mentimeter to SurveyMonkey, so participants could respond during breaks.

Despite these constraints, the data and qualitative feedback align: W2D 2025 strengthened cross-system connection and produced actionable commitments centered on coordination and workforce capacity.

Calls To Action

At Words to Deeds 2025, leaders across behavioral health, justice, and housing systems came together to drive change for Californians with complex needs. This year's convening focused on how counties are moving from policy to practice.

Behavior Change Opportunities

Across two days of sessions, four clear calls to action emerged from speakers and attendees:

1. Keep People at the Center of Cross-Sector Collaboration: Effective implementation only matters if it reduces harm and improves outcomes for Individuals.

Guiding principles for leaders from counties or community-based organizations:

- Match individuals to appropriate levels of care
- Embed peers into treatment and reentry supports
- Ensure that outcome measures reflect lived experience

> *"Really keeping people at the center of all of this work that we do… at the end of the day, It's those people who we are here to serve and impact and make their lives better."*
> *— Brenda Grealish, Executive Director, Commission for Behavioral Health*

2. Build Trust Across Systems: Success requires empathy and strong relationships between behavioral health, reentry, housing, and public safety systems.

Guiding principles for leaders from counties or community-based organizations:

- Develop multi-sector collaborations (law enforcement, behavioral health, housing, and reentry)
- Establish regular cross-agency meetings
- Integrate service planning to prevent silos

> *"We've had to sit down, build trust, and reimagine partnerships. It's hard work, but the results are far better for our communities."*
> *— Michelle Cabrera, Executive Director, County Behavioral Health Directors Association of California*

3. Bridge Policy to Implementation: Counties need tools, data, and capacity to turn policy wins into sustained impact across county systems.

Guiding principles for leaders from state and county agencies:

- Use statewide initiatives (Prop 36, CARE Court, IST, CalAIM JIR) to push for local data-sharing outcome-tracking, and real-time problem-solving
- Prioritize structures that incentivize treatment participation over punishment

> *A big part of what we do at Third Sector is bridge the gap from policy to implementation, from impact and idea to actual reality on the ground."*
> *— Caroline Whistler, CEO & Co-Founder, Third Sector*

4. Invest in Workforce & Peers With Lived Experience: Sustainable reform depends on building a behavioral health workforce and integrating peers with lived experience.

Guiding principles for leaders from state and county agencies:

- Expand training pipelines for both licensed behavioral health staff and forensic peers
- Align funding streams to sustain peer roles
- Embed peers into crisis response, reentry, and treatment teams

> *"Peers are not an add-on. They are the glue that builds trust in systems that have historically failed people." — Elise Jones, Director, Lake County Behavioral Health Services*

Funding and Partnership Opportunities

Speakers discussed various funding streams detailed in each of the sessions. Agency leaders should prioritize two catalytic state opportunities to improve system-wide collaboration and service delivery:

- Familiarize your teams with DHCS' Medi-Cal Managed Care Plan Incentive Payment Program (IPP). While the IPP program ended in 2024, there may be cost savings (or unallocated funds) within your county's managed care plan administration that may sustain any of the initiatives discussed during W2D 2025. More information and resources on the work performed can be found on the Cal-AIM IPP website.
- Review and consider pursuing CBH's Innovation Partnership Fund (IPF) to improve or expand services that address behavioral health and public safety needs. The RFP for $100 million will be released after the January 2026 Full Commission Meeting.

Lastly, speakers identified the important roles and expertise of philanthropy and researchers to ensure successful implementation of various initiatives throughout California. Two themes emerged from most sessions:

For Philanthropic Partners: Fund the "glue" capacity counties cannot easily procure, namely implementation support, data infrastructure, change management, and training. These investments can result in multi-county learning and evidence-building that compares models and documents operational playbooks.

For Researchers and Evaluators: Right-size evaluation to implementation maturity with rapid-cycle learning questions, then scale to rigorous designs. Building common measures across sites will enable credible cross-county comparisons and transferable lessons.

APPENDIX:

Metrics for Counties and the State to Measure and Assess (By Session)

Appendix Item 1: A Glance at the Numbers Statewide: Full-Service Partnerships

Outcome	Metric	Use
Recidivism	New arrest, or conviction of a new felony or misdemeanor at 1 or 3 years after FSP enrollment for justice-involved FSP clients	Assess public safety outcomes and compare across diagnostic groups and demographics
Treatment Access	Time from FSP enrollment to first mental health or substance use appointment	Assess service engagement rates and early access challenges
Housing Stability	Percent of justice-involved FSP clients maintaining permanent housing at 6 and 12 months	Determine effectiveness of housing supports layered into FSP care plans
Disparity Assessment	Demographic breakdown of FSP enrollees with justice-involvement vs. total enrollees	Ensure equity in access and avoid disproportionate service gaps
Cross-System Coordination	Number of counties with formalized agreements between justice entities and FSPs (e.g., MOUs, shared staffing, data use agreements)	Document institutional progress in cross-system alignment

Appendix Item 2: Prop 36 - Early Lessons Learned on Drug Offenses

Outcome	Metric	Use
Treatment Access	Percent of individuals mandated to treatment under Prop 36 who: o Initiate treatment o Remain engaged through designated milestones o Complete a defined program duration	Assess whether treatment-mandated felonies are leading to actual service engagement. This will also help define success beyond "program completion," including "treatment progress" and "step-down progress."
Recidivism	New arrest, or conviction of a new felony or misdemeanor at 1 or 3 years after Prop 36 sentencing, segmented by: o Type of treatment received o Number of prior offenses o County of adjudication	Measure long-term public safety outcomes and treatment effectiveness.
Judicial Discretion & Plea Patterns	Percent of cases resolved through mandated treatment vs. plea to incarceration	Understand how courts are using their discretion and whether treatment pathways are being utilized, especially in light of disaggregated insights by race/ethnicity and representation status (public defender vs. private).
Cross-System Coordination	Frequency of multi-agency implementation meetings (e.g., courts, BH, public defenders, sheriffs)	Assess how well counties are aligning Prop 36 implementation strategies, including documentation of protocols, MOUs, or standard operating procedures.

Appendix Item 3: Building on Incompetent to Stand Trial (IST) Solutions Workgroup Recommendations & Strengthening the Continuum of Care

Outcome	Metric	Use
IST Flow & Timeliness	Average time from IST declaration to placement in a restoration setting (jail-based, community-based, or state hospital)	Assess whether reforms are shortening harmful delays in custody and improving access to treatment
Custody Length Of Stay	Average number of days spent in jail awaiting restoration, and total length of stay in restoration settings	Monitor whether IST processes are reducing unnecessary incarceration and institutionalization
Restoration	Percent of individuals successfully restored to competency within specified timeframes, and percent who return to IST protocols within one or two years	Evaluate the effectiveness and durability of restoration services
	Percent of people who, within 6 and 12 months of restoration and case resolution, are: o Connected to ongoing behavioral health treatment o Housed in stable settings o Not re-booked into jail or re-referred for IST	Determine whether the continuum supports long-term safety and recovery
Cross-System Coordination	Number of counties with formalized IST coordination structures (MOUs, regular joint meetings, designated leads) and active participation from core justice and behavioral health partners	Assess institutional progress in building and sustaining cross-system governance for the IST continuum

Appendix Item 4: Early Lessons Learned in CalAIM's Justice-Involved Reentry Initiative Implementation

Attendees requested a copy of simplified release of information form to authorize the exchange of personal health information to inform case planning and case management for an individual supported by various agencies.

Enclosed is the template authorized by Sutter County Health and Human Services, the Sheriff's Department, and County Counsel for other counties to consider adapting.

wellpath
To hope and healing.

Authorization for Use or Disclosure of Protected Health Information

Name:	DOB:	ID#:
Date/Time:	Allergies:	Gender:

Completion of this document authorizes the disclosure and/or use of individually identifiable protected health information (PHI). All sections of the form must be completed to be valid.

I authorize:

Wellpath at __Sutter County Jail_____ (County/State)

_____

_____

(Name/Address/Phone)

To disclose my health information to:

Name/Company:	Ampla Health	Sutter-Yuba Behavioral Health	Sutter County Probation
Address:	608 J Street Marysville CA 95901	1965 Live Oak Blvd Yuba City, CA 95991	595 Boyd St. Yuba City, CA 9599
Phone/Fax:	530-749-4180	530-822-7200	530-822-7320

Description of information to be released:

✓ All Records (excluding protected class)

✓ Pharmacy records

✓ Discharge Summary

Other: _____

Protected Class Information: Special approval is required before protected classes of information can be released. These types of records may or may not be contained in the medical record. This information will be disclosed only if I place my initials in the applicable space next to the type of information:

_____ Drug and Alcohol Records, diagnosis, treatment, or referral information

_____ Mental Health Records, including provider notes

_____ HIV/AIDS related information and testing

_____ Genetic testing information

The purpose or need for the disclosure of this information is:

✓ Treatment or Consultation At patient request Other: _____

This authorization will be valid for the time below unless it is revoked in writing by the patient.

✓ One (1) year from signature date Completion of this request (one time disclosure)

On specific date _____ Other: _____

You may revoke this authorization in writing at any time by sending a notice canceling this authorization to the provider(s) listed on page 1 of this form. Cancelation of this authorization will not apply to information that has already be released based on this authorization

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA).
(***California law prohibits recipients of these records from re-disclosure unless another authorization for such disclosure is obtained, or unless such disclosure is specifically requir or permitted by law.)***

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment, payment, or to enroll or be eligible for benefits.

Fees may be charged for copy services.

_____ _____

Signature of Individual Date

_____ Relationship: Parent
Signature of Authorized Representative Guardian
Conservator
_____

Form Folder and Number: Consents and Refusals CR06.2	Form Owner: Hannah Bernard	Accreditation: All	Active / Last Revision Date: January 10, 2023	Page 2 of 2

Outcome	Metric	Use
Medi-Cal Access	Percent of people booked into jail who have active Medi-Cal at intake, and percent who have the JI "aid code" activated at any point during custody.	Assess how well counties are identifying coverage gaps and leveraging CalAIM JI eligibility, particularly for people with longer stays.
Pre-Release Service Reach	Number and percent of JI-eligible individuals who receive a health risk assessment, a documented reentry plan, and at least one pre-release encounter with ECM or a comparable care manager.	Measure whether the jail is being used as a platform for coordinated care rather than a pause in services.
Post-Release Treatment and ECM Engagement	Percent of people with a CalAIM JI reentry plan who attend an outpatient medical or behavioral health visit, engage with ECM, or access a Community Support within 30 and 90 days of release.	Evaluate whether pre-release planning translates into real-world connection to care and reductions in gaps after release.
Housing Stability	Percent of people identified as housing insecure who enter stable housing (including board and care, supportive housing, or other appropriate settings) within 30, 90, and 180 days of release.	Assess the extent to which CalAIM JI is helping counties address housing instability as a core driver of recidivism.
Recidivism	New arrest or conviction of a new felony or misdemeanor for people who receive CalAIM JI services at 1 or 3 years of release from custody, compared to similar individuals without those services	Assess whether integrated, person-centered reentry approaches are reducing returns to jail and improving public safety
Cross-System Coordination	Frequency of MDT meetings, participation rates by sector (justice, behavioral health, FQHC, probation, managed care), and presence of written protocols or MOUs that govern CalAIM JI workflows	Monitor the strength and durability of collaborative structures that underpin successful implementation

Appendix Item 5: The Power of Peers – Bridging Lived Experience into Forensic Behavioral Health

Outcome	Metric	Use
Employment	Proportion of county and CBO behavioral health staff with self-identified lived experience of justice-involvement and/or behavioral health conditions.	Gauge whether hiring and promotion practices are expanding opportunities for people with lived experience and shifting organizational culture
	Recruitment, retention, promotion, and disciplinary rates for peer-designated staff vs. non-peer staff.	Test assumptions about risk, identify supportive practices, and spot structural barriers to peer advancement.
Program Engagement	Participation and completion rates of (i) Diversion and specialty court and (ii) SUD and mental health services where peers are embedded in engagement	Assess the impact of peers on justice engagement, successful completion, reduced revocations or sanctions, and recovery outcomes for justice-involved clients.
Funding	Number of certified peer support specialists integrated into billable treatment teams, and annual Medi-Cal revenue attributed to peer services.	Monitor implementation of the peer benefit and quantify financial impact to inform staffing and budget decisions.
	Share of peer-related funding that is ongoing vs. one-time, including investments in electronic health record, training, and supervision infrastructure.	Identify sustainability gaps and support joint county–state planning to stabilize funding for peers in forensic behavioral health.

Appendix Item 6: Mobile Crisis Response & Co-Responder Models – Recent Successes and Challenges

Outcome	Metric	Use
Responsivity	Call volume handled by mobile crisis teams, co-responder teams, and law enforcement-only response, including average acknowledgment, deployment, and arrival times.	Monitor whether calls are being appropriately shifted toward behavioral health-led or co-response models while maintaining timely response in geographically large or rural counties.
	Rate of crises resolved in the community without arrest, hospitalization, or law enforcement involvement, and use of "living room" or crisis respite services.	Evaluate the degree to which mobile crisis is keeping people in the least restrictive setting and reducing reliance on hospital emergency departments and jails.
Engagement	Number of people contacted by mobile crisis who are successfully connected to housing or attend at least two follow-up mental health or SUD appointments.	Measure whether mobile crisis is improving linkage to ongoing services and supporting longer-term recovery beyond the immediate crisis event.
Public Safety	Arrests for resisting arrest, use-of-force incidents, and officer injuries for defined cohorts (for example, people experiencing homelessness or repeat crises) before and after mobile crisis and co-responder implementation.	Determine whether mobile crisis and co-response are reducing harm for both community members and officers, and identify where additional training or protocol changes are needed.
	Number and proportion of 5150 holds initiated by law enforcement versus mobile crisis, including repeat holds for the same individuals.	Understand how shared response is affecting the use of involuntary holds and whether earlier engagement by behavioral health teams is preventing repeat crises.
Cross-System Coordination	Frequency of structured cross-sector meetings (behavioral health, law enforcement, dispatch, EMS, peers) focused on crisis response, and the proportion of agreed protocols that are reviewed or updated each year.	Assess whether mobile crisis is embedded in ongoing collaboration and continuous improvement rather than operating as a stand-alone behavioral health program

Appendix Item 7: Housing as Public Safety & Well-Being

Outcome	Metric	Use
Housing Access	Number and proportion of people exiting prison or jail (state and county) who are connected to interim or permanent housing within 30 days of release; disaggregated by referral source	Assess whether housing is treated as a core component of reentry planning rather than an optional benefit for a small subset.
	Housing retention at 6, 12, and 24 months after placement for justice-involved participants.	Measure whether programs are supporting sustained stability beyond initial subsidies and detect risk periods such as the "rent cliff."
Recidivism	New arrest, or conviction of a new felony or misdemeanor at 1 or 3 years after housing placement	Evaluate the public safety impact of reentry housing and justify continued or expanded investment. When possible, compare results with individuals with similar needs and risk assessments but without housing supports.
Health Care Utilization	Emergency department visits, inpatient psychiatric or SUD stays, and crisis service use before and after housing placement.	Determine whether supportive housing and reentry programs reduce high-cost crisis utilization and improve overall well-being.
Cross-System Coordination	Number of formal agreements (MOUs, contracts, shared-data arrangements) among corrections, behavioral health, Continuum of Care bodies, managed care plans, and CBOs focused on reentry housing and tenancy supports.	Assess progress toward multi-sector collaboration and identify where relationships or infrastructure remain siloed.
	Amount and mix of funding (Medi-Cal, state reentry contracts, local housing funds, philanthropy, federal Housing and Urban Development dollars) dedicated to justice-focused housing and tenancy support.	Understand the sustainability of reentry housing initiatives and inform advocacy for more flexible, long-term funding that treats housing as health care.

Appendix Item 8: Care Court - Learnings from an Early Implementer

Outcome	Metric	Use
Access and Referrals	Number and proportion of Care Court referrals by source (family or roommate, community provider, law enforcement, jail, emergency department, other)	Assess whether Care Court is functioning as an upstream, community-based pathway into care or remains primarily driven by carceral and crisis systems. Target outreach, education, and navigation supports accordingly.
	Percent of Care-involved individuals who have at least one treatment, housing, or support contact within 14 days of petition or first hearing, and who remain engaged at 30, 90, and 180 days; segment by: o voluntary basis o court orders o conservatorship	Determine whether Care Court and related outreach are successfully connecting people to services and sustaining engagement, and inform investments in peers, navigators, and outreach models where drop-off is high.
Health Care Utilization	Changes in psychiatric hospitalizations, emergency department visits, crisis calls, and jail bookings for Care-involved individuals in the 12 months before versus after initial engagement.	Evaluate whether Care-linked outreach and services are stabilizing participants and reducing high-cost utilization. Use findings to support advocacy for sustained funding of housing, treatment, and navigation supports connected to Care Court.
	Individual-level progression (e.g., reductions in hospitalizations, improved adherence to medications or appointments, or functional gains documented in clinical notes), even when formal graduation is not achieved	Capture nuanced progress for individuals with long histories of illness and system contact, reinforcing that success may look like fewer crises and better functioning rather than case closure alone.

Outcome	Metric	Use
Cross-System Coordination	Number and scope of formal agreements (MOUs, contracts, data-sharing arrangements) among courts, behavioral health, managed care plans, housing agencies, and justice partners that explicitly describe Care Court roles, responsibilities, and information flows.	Track progress toward multi-sector governance of Care Court and identify where relationships or infrastructure remain siloed.
	Estimated proportion of clinician and social worker time spent on Care-related data entry and reporting versus direct client care.	Inform state and county decisions about simplifying reporting requirements, investing in administrative support or technology, and ensuring that data expectations do not undermine the relational work that makes Care Court effective.
	Average time from petition to first hearing, and from first hearing to initiation of services, along with continuance rates and participant representation and attendance rates at hearings.	Provide counties with a shared view of whether Care Court processes are timely, flexible, and rights-respecting, and highlight where additional training or procedural adjustments are needed.

Appendix Item 9: Integrating Peers into the Continuum of Care Workforce Pipeline & Training

Outcome	Metric	Use
Peer and Clinical Workforce Capacity	The number of peer staff (FTE) and licensed or registered behavioral health staff (FTE) who work with justice-involved populations across jail, reentry, and community settings over time.	To monitor whether the county expands and sustains integrated workforce capacity and to identify gaps that limit co-occurring care.
	Staff-to-participant ratios for peer and clinical staff in key programs such as jail-based reentry, housing programs, and community SUD treatment	To assess whether caseloads match the intensive relational work that reentry and co-occurring care require and to inform funding and hiring targets.
Pipeline and Training	The number of peers and clinicians who complete specialized training or certification on co-occurring disorders, harm reduction, and justice-involved practice each year.	To measure the growth of a specialized workforce and to assess the reach and effectiveness of training investments.
	The number of active partnerships with universities, training programs, and certification bodies that provide internships or pipelines into justice-focused behavioral health roles.	To gauge the strength of long-term workforce pipelines and to identify opportunities to expand or replicate successful partnerships.
Integration and Team-Based Practice	The proportion of justice-involved clients who have a multidisciplinary team, including at least one peer and one clinical staff member, documented in their care or reentry plan.	To determine how fully programs integrate peer and clinical roles into team-based care rather than leaving them in silos.

Outcome	Metric	Use
Cross-System Coordination	Staff retention rates for peer and clinical positions in justice-involved programs, including average tenure and top reasons for turnover.	To monitor workforce stability, identify burnout or structural barriers, and adjust supervision, compensation, and career pathways.
	The amount and mix of funding that supports peer and clinical workforce development, including training budgets, supervision time, internship support, and salaries across county and state sources.	To understand how counties finance workforce investments and to guide advocacy for flexible, long-term funding that treats peers and clinicians as shared infrastructure for reform.