Sonoma County JMHCP

Expansion Grant Evaluation

RDA CONSULTING

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This report was developed by Resource Development Associates under contract with Sonoma County Probation Department.

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Table of Contents

Introduction

Sonoma County JMHCP Background

As is the case across the United States, a growing number of individuals in Sonoma County jails have identified mental health challenges and co-occurring substance use disorders. As of 2020, Sonoma County stakeholders estimated that over 40% of individuals booked into jail have mental health needs.[1] Individuals with identified serious mental illness (SMI) are often detained in custody longer than individuals who are not experiencing mental health challenges. For example, in other counties across the country attempting to address this issue through the Stepping Up Initiative (see textbox for more information on Sonoma County's involvement in this initiative), the average length of jail stay for individuals with identified SMI was eight to nine days longer than the overall jail population.[2]

In response to this nationwide issue, the Department of Justice's Bureau of Justice Assistance (BJA) released a grant opportunity for local, state, and federally recognized Indian tribal governments to submit applications for projects that support innovative cross-system collaboration for individuals with mental illnesses or co-occurring substance use disorders who come into contact with the justice system. The Justice and Mental Health Collaboration Program (JMHCP) seeks to:

- Increase public safety by facilitating collaboration among criminal justice and behavioral healthcare systems to increase access to treatment services.
- Maximize diversion opportunities.
- Promote training for justice and treatment professionals.
- Facilitate communication, collaboration, and the delivery of support services to justice-

Related Sonoma County Programs and Initiatives

- **Stepping Up Initiative:** In 2016, the County joined the national initiative to reduce the number of individuals with mental illness in jail. The County's efforts through this initiative are overseen by the Stepping Up Workgroup, which comprises representatives from various county departments and community stakeholders.
- **ACCESS Sonoma County Interdepartmental Multidisciplinary Team (IMDT):** In 2017, the County established the ACCESS initiative to focus on addressing the needs of the County's most vulnerable residents, including those with mental health challenges. The IMDT is a care coordination, advisory team with members from various departments and programs that collaborate to develop integrated care plans for ACCESS participants across six different population cohorts, including the Mental Health Diversion cohort.
- **Mental Health Diversion:** In 2019, the County established a diversion program for individuals with qualifying mental health conditions. Individuals receive services such as case management, counseling, housing, and substance use screening. JMHCP participants who qualify may participate in Mental Health Diversion after exiting JMHCP.

[1] Chambers et al. (2020, January). Sonoma County Mental Health Services Act (MHSA) FY 2016–2019 capacity assessment report. **https://sonomacounty.ca.gov/Health/Behavioral-Health/Mental-Health-Services-Act/**

[2] Noggle, D., Cotter, R., and Cortez, M. (2016, July). *The jail population with a serious mental illness (SMI): Understanding the issue and working towards addressing the needs in Maricopa County.* **https://cabhp.asu.edu/sites/default/files/session_29b-exiting_the_revolving_door.pdf**; Comartin, E. (2020). *Stepping Up technical assistance: Comparing outcomes of Stepping Up counties to jail diversion pilots.* **https://behaviorhealthjustice.wayne.edu/jd_2020_summit/2020_jail_diversion_summit_slides.pdf**

involved individuals with mental illness and co-occurring substance use disorders.

Sonoma County applied for the BJA's Fiscal Year 2016 JMHCP grant and received funding for a Pretrial Case Manager to support the supervised pretrial release of individuals with serious mental illness and co-occurring disorders and to provide dedicated housing for some of these individuals who are released. The grant also included funding for planning to expand Mobile Support Team (MST) services to rural communities. With the program successfully releasing individuals who would have otherwise remained in custody pretrial, the County applied and received funding for the Fiscal Year 2018 JMHCP expansion grant to address gaps identified during program implementation. The expansion grant period is from January 2020 through December 2021. Sonoma County applied for and received a one-year extension to the grant period through December 2022. However, the County expects to have expended all its grant funds by March 2022 and close the grant by June 2022.

Evaluation Overview

Sonoma County contracted with RDA Consulting (RDA) to conduct an evaluation of the JMHCP expansion program for the original grant period of January 2020 through December 2021. This evaluation assessed program implementation, including the project's expansion and implementation of new resources and components, and the program's outcomes. This evaluation focused on the following process evaluation and outcome evaluation questions.

Process Evaluation Questions

1. How has the JMHCP expansion been implemented?
    a. To what extent has the implementation followed the original program model? What, if any, changes were necessary?
    b. What services did individuals served by the JMHCP expansion receive?
2. Who is being served by the JMHCP expansion?
    a. To what extent, if any, are there differences in the racial and ethnic characteristics of individuals enrolled in JMHCP versus Sonoma County's Pretrial Services?[3]

Outcome Evaluation Questions

3. What proportion of JMHCP participants experience failures to appear (FTAs) or re-arrests while enrolled in the program?
4. Following exit from JMHCP, what proportion of JMHCP participants transition to ongoing behavioral health services and are housed?

[3] This evaluation initially sought to determine if there were differences between eligible JMHCP participants who were referred to the program and released versus those who were referred to the program but not released. Specifically, the intention was to examine demographic and pretrial risk assessment differences between these two groups. However, the required data was not available. As a result, this evaluation pivoted to examine if there were racial and ethnic differences between JMHCP enrolled individuals and Sonoma's pretrial services population, as well as individuals who decline JMHCP involvement.

Methods

RDA conducted a mixed-methods evaluation collecting detailed qualitative and quantitative data on program processes and outcomes. A mixed-method design maximizes validity with both quantitative and qualitative data sources, provides different perspectives on complex, multi-dimensional issues, and offers insights that might be overlooked by one approach alone. RDA utilized the following data sources:

- **Quantitative Data Collection:** RDA analyzed de-identified participant-level data for all individuals released and/or served through JMHCP during the expansion grant period. Additionally, RDA analyzed de-identified participant-level data for all individuals declining JMHCP involvement in 2021. Data were provided from Sonoma County Probation, the JMHCP Access Database, and the contracted provider InterFaith Shelter Network's (IFSN) Homeless Management Information System (HMIS). Data provided included participant demographics, enrollment data, service referral and engagement data, pretrial monitoring contacts, completion status, and data on new bookings, violations, and failures to appear.
- **Qualitative Data Collection:** RDA conducted interviews and focus groups with 12 JMHCP administrators, staff, cross-system partners, or community stakeholders. This included representatives from Sonoma County Probation, Sonoma County Behavioral Health, Public Defender's Office, ISFN, and the JMHCP Implementation Team. RDA also conducted phone interviews with seven JMHCP participants who were provided gift cards as compensation for their time. Interviews and focus groups focused on program implementation, successes and challenges, collaboration across partners, environmental and system-level contexts, services provided, and the perceived impact of the program on participants.

Limitations and Considerations

Selection and response bias. Although RDA made an effort to speak with a variety of JMHCP stakeholders, interview participation was voluntary. Therefore, the views presented here may not be representative of all program administrators, staff, cross-system partners, community stakeholders, and participants. In particular, RDA only spoke with participants actively engaged in JMHCP and IFSN services. RDA did not interview individuals who were eligible for JMHCP but declined to participate, individuals who unsuccessfully exited JMHCP, or stakeholders representing the court. Participants engaged with IFSN and able to communicate with interviewers have likely been stabilized and engaged in services to a greater extent than the general population of JMHCP participants.

Additionally, JMHCP stakeholders noted during the review process that the participants who take part in evaluation interviews might feel the need to selectively share only positive comments. They expressed that a significant power differential exists between JMHCP/Probation Department staff and JMHCP participants and this likely affects the willingness of the participants to share negative impressions or experiences with the program. This is because of the perceived risk to be denied program benefits – or even face reincarceration – if the individual shares something negative or something they think program staff disagree with or would feel shows them in a negative light. In other words, there could be the belief that self-censorship of negative comments about the program or its staff would protect against retaliatory action on the part of the agencies involved in JMHCP. While participant interviews were conducted by RDA staff and participants were assured that all information shared with RDA was confidential and would not be shared with program staff, this response bias may still exist given the power differential, particularly for actively engaged participants.[4]

[4] During the review process, stakeholders shared that it is a value of JMHCP to involve the voices of the individuals served in planning, monitoring, and improving services and their quality and that this is a growing edge for the program. For future data collection, potential response bias might be ameliorated by involving peers in data collection, ensuring participants understand

Limited quantitative data. Gaps in data obtained from Sonoma County Probation, the JMHCP Access Database, and ISFN's HMIS and limitations in obtaining data recorded by Sonoma County's Behavioral Health Division prevented a complete analysis of previously planned evaluation questions and related topics. Highlighted in the report when relevant, these gaps in data included the following: JMHCP participant referral source, Adult Needs and Strengths (ANSA) assessment results, mental health diagnoses, reasons for declining JMHCP involvement, program participation information for individuals not served by IFSN, IFSN client warm hand-offs to Sonoma County Behavioral Health, and IFSN client housing outcomes. While some of these data are tracked in case notes, they are not easily extractable and, therefore, were not able to be included in this evaluation. Additionally, there are limitations in how some demographic data was collected by Sonoma County Probation. Specifically, demographic data only includes two sex categories and limited race and ethnicity categories (e.g., does not include multiracial), and race/ethnicity data are generally not self-reported by participants. Therefore, other sex and gender identities (e.g., transgender, non-binary) or some race and ethnicities are not reflected or distinctly presented in analyses in this report.

Attributing causality. RDA's analysis of JMHCP and its impact on participants does not include a control or comparison group (i.e., participants with similar characteristics as JMHCP participants but who did not receive treatment). While this report includes outcomes that JMHCP participants experienced while participating in the program (e.g., new arrests, violations, FTAs), we are unable to determine whether these outcomes are caused by participation in JMHCP.

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that neither negative nor positive responses will affect their participation in the program, and/or interviewing only people who have completed the program.

Evaluation Findings

The following sections provide the key findings and recommendations for the evaluation of Sonoma County's JMHCP Expansion—assessing the program's implementation and outcomes, describing its impact on participants, and providing considerations for future implementation.

- **Process Evaluation** provides an overview of the program and how the model changed, describes who was served through JMHCP and the services participants received, and discusses the program's implementation successes and challenges.
- **Outcome Evaluation** assesses JMHCP outcomes related to participants' completion of the program, justice system involvement, health, and housing.
- **Conclusion** highlights key evaluation findings and provides considerations for future implementation of JMHCP.

Process Evaluation

JMHCP Model

KEY FINDINGS: JMHCP MODEL

- The JMHCP expansion funding aimed to provide additional housing and supports in the community to help individuals with mental illness and co-occurring substance use disorders maintain stability during the pretrial period to achieve better outcomes.
- The JMHCP expansion was largely implemented in alignment with the original model, offering both supportive housing and community case management to individuals living with moderate to severe mental illness.
- In order to refine the program model, the program expanded which stakeholders can initiate referrals into the JMHCP and transitioned all JMHCP participants to one pretrial officer's caseload.
- Due to the COVID-19 pandemic, the program had some staffing shortages and was unable to provide treatment groups for a portion of the grant period.

The following sections provide an overview of the services funded by the expansion grant, program processes, and changes that were made to implementation model.

Expansion
The JMHCP expansion grant funding aimed to provide additional housing and supports in the community to help individuals with mental illness and co-occurring substance use disorders maintain stability during the pretrial period to achieve better outcomes. This included:

- Eight supportive housing beds provided by InterFaith Shelter Network (IFSN).
- Cognitive Behavioral Intervention (CBI) classes targeting criminogenic needs.
- Evidence-based, gender-responsive substance abuse treatment and case management services for female participants.
- One part-time case manager who provides on-site management for individuals in supportive housing.
- One full-time intensive community case manager, a mental health practitioner based at IFSN, who provides ongoing support and service coordination for participants.

Target Population
Sonoma County's target population for the JHMCP expansion was adults of any age or gender living with moderate to severe mental illness, with or without co-occurring substance use disorder, who are booked into the Main Adult Detention Facility (main county jail) and charged with statutorily non-violent misdemeanors or felonies.

Referral and Release Processes
The process for determining program eligibility begins when individuals are first booked into custody at Sonoma County's Main Adult Detention Facility. Each step in the referral and release process is detailed below.

Participant Identification and Screening. To identify individuals eligible for release through JMHCP, the mental health case manager in the jail (a clinician employed by Sonoma County Behavioral Health Division) conducts an initial screening on those individuals identified as having a mental health need during the booking process. The mental health case manager refers potential candidates identified through the screening process to the judge overseeing the case. The screening includes a review of:

- **Booking charges** to ensure individuals were not booked for an ineligible statutorily violent offense.[5]
- **Indicators of serious and persistent mental illness**, including booking notes related to the individual's mental health, mental health records from the jail, records of prior contact with the County's Behavioral Health Department, and other information provided by the County's Mobile Support Team.

Judicial Referral. The judge and attorneys from the District Attorney's Office and Public Defender's Office review the individual's pretrial risk assessment scores and the JMHCP screening results from the mental health case manager to inform pretrial release determinations. Judges may also consider any mental health information that an individual's attorney chooses to share. At this juncture, the judge refers individuals they would not be inclined to release pretrial due to safety concerns around their mental health status back to the mental health case manager in the jail.

Judges or attorneys involved in the case can also directly refer potential participants who were not initially screened for JMHCP to the mental health case manager in the jail for a full screening.

Full Screening, Assessment, and Discharge Plan. The mental health case manager in the jail conducts a full in-person screening and brief assessment of the individual and develops a discharge plan to share with the court. As part of the assessment process, the mental health case manager in the jail has each individual sign a Release of Information, interviews them, administers the Outreach Adult Needs and Strengths Assessment (ANSA) and, if needed, the CAGE-AID Substance Abuse Screening Tool (or collects information from a previously administered assessment if appropriate information is already in the electronic records). The ANSA is a tool used to support decision making, including level of care and service planning, while the CAGE-AID is used to determine if the need to assess for substance use disorder exists. Once the assessment is completed, the mental health case manager in the jail develops a discharge plan—which includes plans for housing, connection to mental health services, obtaining medications, and connection to a community case manager.

Court Determination. The mental health case manager sends the discharge plan to the court for a final determination. In many cases the mental health case manager in the jail also attends court to answer questions and advocate for a participant's release. At this point the judge determines whether or not to grant an individual pretrial release through JMHCP.

Release. The mental health case manager in the jail works with all individuals being released to ensure they have appropriate medications and prescriptions upon release, coordinate appropriate referrals and transportation to services and/or housing identified in the discharge plan, and facilitate a connection to the individual's community case manager. Once released, individuals are monitored by Pretrial Services and expected to engage in treatment services as directed by the Court and the County's Behavioral Health Division as well as comply with other terms and conditions ordered by the Court. Individuals are expected to attend all court hearings and are considered to have successfully exited the program once their pending case is resolved.[6]

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[5] Violent offenses as defined in California Penal Code 667.5 subdivision (c).
[6] JMHCP participants can still receive community-based services after their case is resolved.

Supportive Services

The County contracts with IFSN to provide supportive services to individuals released through JMHCP. IFSN offers two types of support services:

- **Community-based case management (CCM):** JMHCP participants are connected with a case manager to help them stabilize through connections to needed services and resources, navigate challenging public systems, develop goals, and successfully complete pretrial monitoring. When individuals are referred to community-based case management, the community case manager completes an intake process that includes a psychosocial assessment and the development of an individualized treatment plan. In addition to case management, JMHCP participants can receive transportation services, court accompaniment, mental health counseling, and referrals to needed services through CCM.
- **Supportive housing:** IFSN operates an eight-bed temporary housing facility—Hill House (HH)—through which part-time in-house case management is provided. Individuals who reside at Hill House also complete an intake process comprising a psychosocial assessment, individualized treatment plan development, and support to meet the individual's basic needs, such as food, clothing, and medication. Residents can also receive other services, such as life skill classes, mental health counseling, court accompaniment, and transportation services.

Individuals may not be referred to IFSN if they have preexisting connections to community-based support services with a higher level of care.

Model Changes

The JMHCP expansion was largely implemented in alignment with the original model for the expansion, offering both supportive housing and community case management to individuals living with moderate to severe mental illness. However, **there were some key changes to the implementation model, including:**

- **Staffing:** The JMHCP model relies on having a mental health case manager in the jail to screen and refer individuals for JMCHP and to develop discharge plans for their release. The program's prior mental health case manager in the jail left during the COVID-19 pandemic, and due to a county-level hiring freeze, the County could not immediately hire new staff to fill the position. As a result, between July and December 2020, the JMHCP did not have a case manager in the jail to facilitate referrals and releases, instead relying on other Behavioral Health staff to cover these responsibilities. IFSN also had several staff members leave during the pandemic, which impacted the program's case management capacity.
- **Referral process:** As described above, JMHCP's model was for referrals to originate from the mental health case manager in the jail. However, with increased awareness of JMHCP and trust in the program among court-system partners, many referrals to JMHCP are now initiated from judges and other court-system partners. This shift was intended to facilitate uptake in JMHCP by encouraging more individuals to agree to assessments, since they are now ordered by a judge. The program also allows for referrals into JMHCP after an individual has already been released from custody. For example, a pretrial monitoring officer may refer an individual on their caseload who may qualify for JMHCP and benefit from JMHCP services.
- **Pretrial monitoring caseload:** Although not part of the original model, in 2021, Pretrial Services transitioned all JMHCP participants to one pretrial officer's caseload. The single Pretrial Services point of contact for JMHCP participants helped to streamline communication with other program providers.
- **Cognitive Behavioral Intervention (CBI) classes and gender responsive substance abuse treatment:** The County intended to provide CBI classes targeting criminogenic needs to JMHCP participants residing at Hill House and evidence-based, gender-responsive substance abuse treatment for female participants. However, these group classes were never fully implemented due to pandemic safety restrictions, though CBI classes did begin recently. COVID-19 public health measures also complicated how to conduct therapy sessions and limited the available venues where community case management could be provided.

As the program has adapted to environmental challenges and changing system conditions resulting in deviations from the original program model, these process changes have not always been documented and consistently shared with all program stakeholders. **The JMHCP Implementation Team and other stakeholders should consider reviewing current program processes and identify process changes and program adaptations that need to be documented to ensure a shared understanding of JMHCP processes.**

JMHCP Participants

The following sections describe who participated in JMHCP and who declined to enroll in JMHCP and provide information on participant mental health diagnoses and scored pretrial release levels.

KEY FINDINGS: JMHCP PARTICIPANTS

- Sonoma JMHCP served 146 distinct participants from January 2020 to December 2021. Since the current mental health case manager started in January 2021, new enrollments have increased, with approximately 22 enrollments each quarter.
- 60% of individuals who were offered the opportunity to participate in JMHCP in 2021 chose to enroll.
- Most JMHCP participants were White (61%) and male (70%). Relative to Sonoma County's pretrial monitoring population, there is a greater proportion of White individuals in JMHCP and a lesser proportion of Latinx individuals.
- Approximately two-thirds (65%) of JMHCP participants experienced housing insecurity or homelessness at the time of enrollment.
- The County's release matrix places half of JMHCP participants at the highest level of pretrial monitoring.

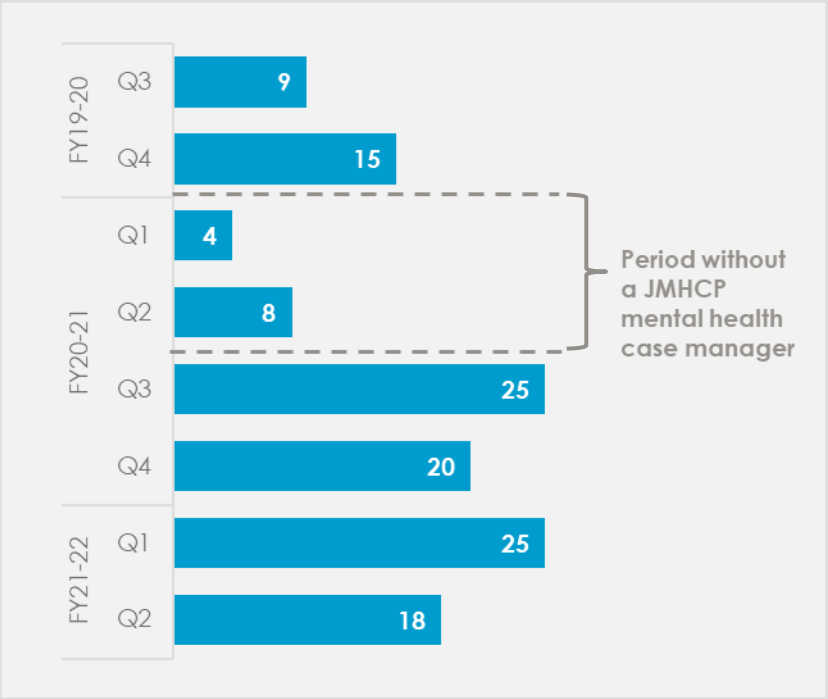
Participant Enrollment and Referral

Enrollment. Sonoma JMHCP served 146 distinct participants from January 2020 through December 2021, representing 150 total enrollments.[7]

Among distinct participants served, 15% (n=22) were enrolled prior to 2020. Shown in Figure 1, enrollments noticeably dipped between July and December 2020 when there was no JMHCP mental health case manager in the jail dedicated to screening and refering individuals for enrollment. **Since the current case manager started in January 2021, new enrollments have increased, with approximately 22 new enrollments each quarter.**

Screening. In programs like JMHCP, all individuals booked should be screened for mental health needs. Universal screening for mental health needs helps program staff determine if they are reaching the program's intended population and if individuals with identified mental health needs are

Figure 1. JMHCP Enrollment (2020-2021)



Note: An additional 22 individuals participated in JMHCP between January 2020 and December 2021 but enrolled prior to 2020. The first date of enrollment is reflected for individuals with more than one enrollment in JMHCP.

[7] Four individuals enrolled into the JMHCP program twice between 2020 and 2021.

being connected to services.[8] Having staff to facilitate the screening and identification of potentially eligible individuals shortly after booking and having accurate screening information are key to reducing the amount of time that individuals with serious mental illness and co-occurring disorders spend in custody.

The County contracts with WellPath to conduct mental health screenings in the jail, which is used as a source for the JMHCP mental health case manager to identify potential JMHCP participants. However, during the grant period, WellPath did not employ any Spanish-speaking clinicians, and clinicians must rely on phone translation services to translate the screening questions and responses. This has impacted the accuracy of screening of monolingual Spanish speakers booked into the jail, which may have limited the ability of the JMHCP mental health case manager to identify these individuals as potential participants. The County's Stepping Up Workgroup planned to address this issue in February 2022.

Referrals. Referrals for JMHCP enrollment can come from a variety of sources, including court referrals, pretrial services, the JMHCP mental health case manager in the main county jail, and self-referrals. **As awareness of JMHCP in the court system has improved, stakeholders report that more referrals have been initiated by judges overseeing the cases, which has helped to increase the number of referrals into the program.**[9] However, judges have also been referring individuals for JMHCP screening that do not have serious mental illness, such as individuals with only substance use challenges, dementia, traumatic brain injury, or developmental disabilities. **Ongoing communication and information sharing—such as through the continuation of ongoing presentations and trainings and the continued use of the bench card for judges—may help judges, public defenders, and prosecutors remain knowledgeable of JMHCP through staff transitions.**[10]

Enrollment Decisions. JMHCP is a voluntary program, therefore individuals can choose whether they want to participate in the program. Only 60% of individuals who were offered the opportunity to participate in JMHCP in 2021 chose to enroll. Data is limited to understand the reasons why individuals decline participation; however, program stakeholders suggested this may be due to lack of trust and willingness to be monitored by Pretrial Services or unwillingness to participate in mental health services.

Length of Participation. Participants served between 2020 and 2021 were enrolled in JMHCP for an average of five months. Length of enrollment differed for participants exiting successfully and unsuccessfully. Individuals completing successfully were enrolled for an average of six months while those exiting unsuccessfully were enrolled for an average of three months. By the end of 2021, 8% of the JMHCP cohort had been enrolled for a year or longer.

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[8] Fader-Towe, H. & Osher, F.C. (2015). *Improving responses to people with mental illnesses at the pretrial stage: Essential elements.* The Council of State Governments Justice Center. **https://csgjusticecenter.org/wp-content/uploads/2020/02/Improving_Responses_to_People_with_Mental_Illnesses_at_the_Pretrial_Stage_Essential_Elements.pdf**; Haneberg, R., Fabelo, T., Osher, F., & Thompson, M. (2017, January). *Reducing the number of people with mental illness in jail: Six questions county leaders need to ask.* The Stepping Up Initiative. **https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf**

[9] This evaluation is unable to quantify this increase because referral sources are missing for 64% of the 150 JMHCP enrollments.

[10] Fader-Towe & Osher, 2015.

Participant Profile

Table 1 displays the demographic profile of distinct JMHCP participants (n=146). Most participants were **White (61%)** and **male (70%)**, with an **average age of 39 years old.** Approximately **two-thirds (65%) of JMHCP participants experienced housing insecurity or homelessness** at the time of enrollment. Both White and female JMHCP participants were more likely to experience housing insecurity or homelessness.[11]

Race and Ethnicity. As shown in Table 1, the majority of JMHCP participants were White (61%), with 24% Latinx, 9% Black, and 6% Other/Unknown.

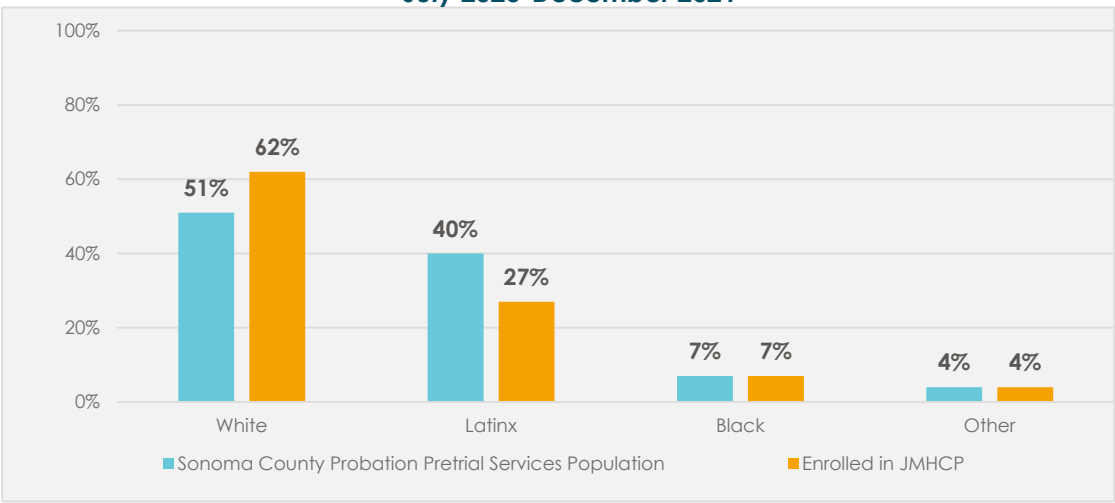
Table 1. JMHCP Participant Characteristics (N=146)

Characteristic	n (%)
Race/Ethnicity	
White	89 (61%)
Latinx	35 (24%)
Black	13 (9%)
Other/Unknown	9 (6%)
Sex	
Male	102 (70%)
Female	44 (30%)
Age at Enrollment	
18-24	15 (10%)
25-34	47 (33%)
35-44	3 (25%)
45-54	25 (17%)
55+	22 (15%)
Homelessness or Housing Insecurity at Enrollment	
Yes	95 (65%)
No	51 (35%)

Note: Data collected by Sonoma County Probation includes two sex categories, therefore other sex and gender identities (e.g., transgender, non-binary) are not reflected in this table.

Between July 2020 and December 2021, the Sonoma County pretrial monitoring population was 51% White, 40% Latinx, 7% Black, and 4% Other. Figure 2 compares the racial/ethnic composition of JMHCP participants who enrolled in the program between July 2020 and December 2021 to the pretrial monitoring population at that time.[12] As shown in Figure 2, **relative to the pretrial monitoring population, there is a greater proportion of White individuals and a lesser proportion of Latinx individuals in JMHCP.** Specifically, White individuals' enrollment into JMHCP is 122% of their share of the pretrial monitoring population, while Latinx individuals' enrollment is 68% of their share of the pretrial monitoring population. JMHCP would have to increase Latinx enrollment from 27 to 40 individuals to reach parity with the pretrial monitoring population's share of Latinx individuals in Figure 2. The distribution of Black individuals and individuals with an "Other" race or ethnicity are identical.

Figure 2. Pretrial Monitoring Population & JMHCP Participant Race/Ethnicity Comparison, July 2020-December 2021

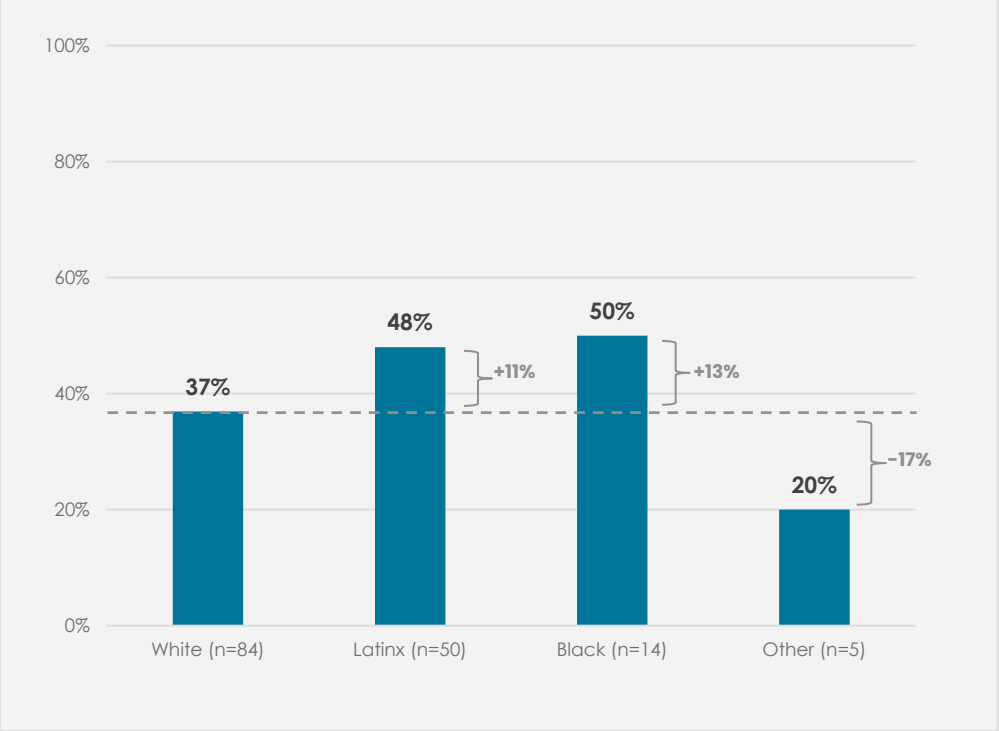


[11] Almost three-quarters (74%) of White JMHCP participants experienced housing insecurity or homelessness at enrollment. Approximately 80% of female JMHCP participants experienced housing insecurity or homelessness at enrollment compared to 59% of male JMHCP participants.

[12] Approximately 70% of JMHCP enrollments took place between July 2020 and December 2021.

White individuals referred to JMHCP appear to voluntarily enroll in the program at a higher rate than referred individuals of color. Figure 3 displays the decline rate for each racial and ethnic group along with the gap in Latinx, Black, and "Other" decline rates relative to the White decline rate.[13] Latinx individuals declined involvement about half the time, a higher rate than White individuals. Black individuals were also more likely to decline JMHCP involvement than White individuals. However, the low number of potential Black participants (n=14) in 2021 makes this rate highly sensitive to minor changes in enrollments.

Figure 3. Share of Distinct Individuals Declining JMHCP Involvement by Race/Ethnicity in 2021 (n=153)



[13] Individuals are considered to have declined JMHCP involvement if they declined a JMHCP screening interview or if they declined to participate in the JMHCP program.

Mental Health Diagnoses. Sonoma's JMHCP program is designed to serve individuals experiencing moderate to severe mental health challenges. Although the JMHCP mental health case manager conducts ANSA assessments for all JMHCP participants, staff were not required to record this data in the JMHCP database during the grant period. ANSA assessment results measuring mental impairment were not recorded in the JMHCP database for 59% of distinct JMHCP participants (n=146), so it is difficult to determine the extent to which the program served this population as intended.[14]

Among distinct individuals with known ANSA results (n=60), two-thirds had a moderate-severe impairment and the remaining third had a mild-moderate impairment. While the program prioritizes serving individuals with a higher level of need, JMHCP accepts individuals with all levels of mental impairment and needs if the program has the capacity to serve them.

Mental health diagnoses were also not recorded in the JMHCP database for more than three-quarters (79%) of all distinct participants. Of participants with a recorded mental health diagnosis (n=30), **schizophrenia** was most often diagnosed (n=12, 40%), followed by **bipolar disorder** (n=9, 30%), and **schizoaffective disorder** (n=7, 23%) (see text box below for more information on these diagnoses).

Mental Health Diagnoses

Schizophrenia is a serious mental illness that impacts an individual's ability to process information clearly, make decisions, and manage their emotions. Symptoms include persistent delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and other negative symptoms in the context of reduced functioning.

Bipolar disorder is a mental illness that causes individuals to experience significantly dramatic shifts in their mood, energy, and ability to think clearly. These high and low states are known as mania and depression and in severe episodes may include psychotic symptoms, such as delusions or hallucinations, or thoughts of suicide.

Schizoaffective disorder is a less well-studied mental illness that causes both symptoms of schizophrenia—including hallucinations, delusions, and disorganized thinking—and symptoms of a mood disorder—including depressive and manic episodes. As schizoaffective disorder includes symptoms of schizophrenia, bipolar disorder, and depression, it is often misdiagnosed.

Source: National Alliance on Mental Illness. (2022). *Mental health conditions.* **https://nami.org/About-Mental-Illness/Mental-Health-Conditions**

[14] ANSA assessment results and mental health diagnoses may be recorded in the Behavioral Health Division's database. However, Behavioral Health Division data are not easily accessible by outside parties, and, therefore, were not available for this evaluation.

Pretrial Assessment and Monitoring

Since July 2020, Sonoma County has used the Public Safety Assessment (PSA) tool to inform pretrial release decisions.[15] The PSA predicts individuals' likelihood to appear at court, have a new arrest, and have a new violent arrest during the pretrial period. Sonoma County has developed a release conditions matrix that uses PSA scores to place individuals in one of three scored release levels that inform the level of monitoring and conditions ordered:

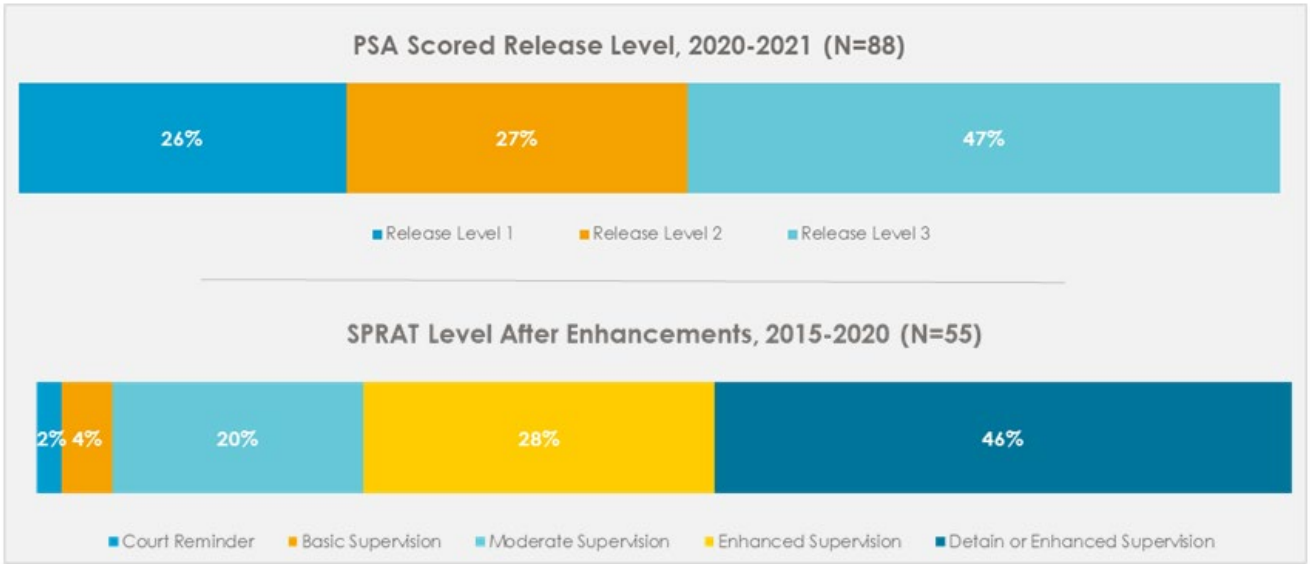
- **Release Level 1:** Mandatory statutory conditions with no prescribed monthly check ins.
- **Release Level 2:** Mandatory statutory conditions, other case specific conditions (if applicable), and a monthly phone check in.
- **Release Level 3:** Mandatory statutory conditions, other case specific conditions with pretrial monitoring required, and monthly phone and face-to-face (e.g., in-person) check ins.

Pretrial Assessment. As shown in Figure 4, almost half (47%) of JMHCP participants released since July 2020 had a PSA Scored Release Level 3 according to the release conditions matrix.

Prior to July 2020, Sonoma County used the Sonoma Pretrial Risk Assessment Tool (SPRAT) to inform an individual's eligibility for pretrial release. Displayed in Figure 4, JMHCP participants' SPRAT level after enhancements followed a similar pattern as the PSA, with almost half (46%) of participants having a SPRAT recommendation of "detain or enhanced supervision," which is the highest level.

Monitoring. As of July 1, 2021, all JMHCP participants, regardless of scored release level, are now released and monitored at PSA scored release level 3.[16]

Figure 4. Scored Release Levels for JMHCP Participants (N=143)[14]



[15] In July 2020, Sonoma County made a number of changes to its pretrial monitoring program, including allowing the opportunity for pre-arraignment release for individuals booked into custody. The new program also transitioned the administration of the pretrial risk assessment from the Sonoma County Sheriff's Office to the Probation Department, and the pretrial risk assessment tool was changed from the Sonoma County Pretrial Risk Assessment Tool (SPRAT) to the Public Safety Assessment (PSA).

[16] This change was made in order to ensure that JMHCP participants would receive a monthly face-to-face check-in.

JMHCP Services

The following sections describe the community-based support services and referrals provided to participants, engagement in referrals, and frequency of pretrial monitoring contacts JMHCP participants received.

KEY FINDINGS: JMHCP SERVICES

- Supportive housing and case management are a large part of JMHCP's expansion implementation, helping to connect people to supportive services when they are released from custody.
- Almost half of JMHCP participants served between 2020 and 2021 received services through IFSN. Some of these individuals received services through other programs and others were unable to be contacted upon release.
- Almost all community case management clients received at least one service referral. Referral engagement varied across service areas—while a high proportion of participants (81%) received services to support their basic needs, less than half of individuals referred for mental health and housing services engaged in these services.
- The lack of available housing and behavioral health services in the community, compounded by natural disasters, remains a challenge to timely connecting JMHCP participants to services.
- Participants reported feeling respected, cared for, and heard by program staff.
- JMHCP participants were contacted by pretrial officers on average three times a month, most typically by phone call.
- In 2021, Pretrial Services moved all JMHCP participants to one officer's caseload, which facilitated strong collaboration with the mental health case manager in the jail and IFSN staff.

Community-based Supportive Services

Timely connection to community-based care, including behavioral health services, housing, and other resources, is crucial for participant success in programs like JMHCP.[17] **Supportive housing and case management are a large part of JMHCP's expansion implementation, helping to connect people to supportive services when they are released from custody.** JMHCP's expansion offers an opportunity to connect individuals with mental health needs to these and other critical services as part of Sonoma County's system-wide strategy. JMHCP provides an earlier intercept point to identify and connect individuals who are eligible for the County's mental health diversion program to services during their pretrial period.

Many stakeholders and participants noted challenges in getting JMHCP participants connected to behavioral health services in a timely manner. Stakeholders estimated it can take over a month to connect with services. In one case, a JMHCP participant reported being on a waiting list for several months to see a mental health counselor. As a result of delays, IFSN staff reported incidences in which they had to take decompensating clients to the hospital.

[17] Fader-Towe & Osher, 2015.

"It has been really challenging. People ask for help and you want to help them, and you take them to services, and they can't get services. You just have to take them back to Hill House, and that's really hard." – JMHCP stakeholder

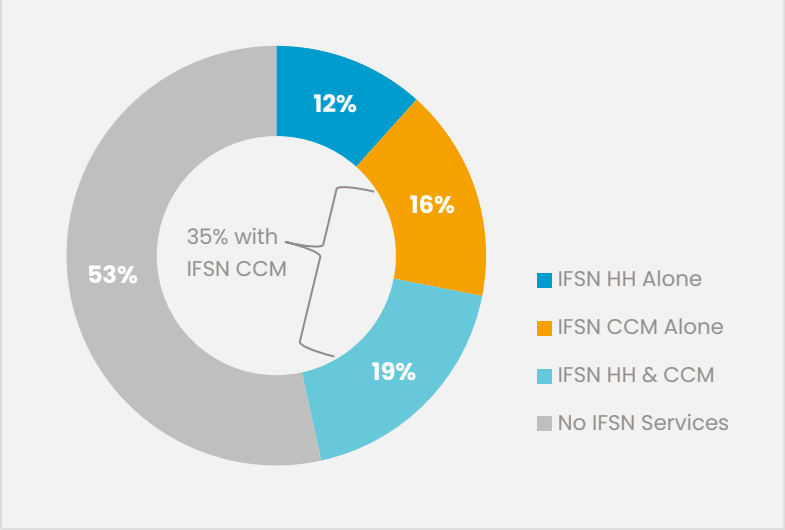
It is important that wait times for access to housing, treatment, or other supportive resources do not result in longer detention for participants, which may have negative impacts on the individual's health and stability.[18] While significant wildfires and flooding increased demand for available shelter space, COVID-19 safety protocols also decreased available bed space. Both forces have increased difficulty in finding beds for unhoused participants. **The lack of available housing in the community, compounded by natural disasters remains a challenge to timely connecting JMHCP participants to services.** Due to limitations in available data, this evaluation did not assess the length of time individuals eligible for release through JMHCP spent in custody or determine the increased length of detention for individuals waiting on access to housing. However, **JMHCP partners should collect data on detention times for individuals eligible for release through JMHCP with a particular focus on identifying delays in release due to limited community-based residential services. JMHCP partners could use these data to help identify gaps in available services and prioritize solutions based on impact to participants.**

"I would love more funding [for housing]. Direct financial support, so we are able to help clients directly and not refer them out. Rental assistance would be a huge benefit for everyone who comes out of the program." – JMHCP stakeholder

"Ideally we'd be operating at a point where nobody was waiting in custody for a bed." – JMHCP stakeholder

As part of the JMHCP program expansion, Sonoma County contracted InterFaith Shelter Network (IFSN) to provide community-based case management and housing to JMHCP participants. **Among the 146 JMHCP participants served between 2020 and 2021, almost half (47%, n=68) received services through IFSN.** This includes 44 JMHCP participants (30%) who lived in IFSN's Hill House (HH) and 51 participants (35%) who received IFSN community case management (CCM). Overlap exists between these two groups, with 27 participants who at different points received services from both CCM and HH (the periods of receiving services from the different program components did not overlap).

Figure 5. Share of Distinct JMHCP Participants Receiving IFSN Community-based Supportive Services (N=146)



[18] Fader-Towe & Osher, 2015.

Although the JMHCP expansion model aimed to connect all individuals who participate in the program to community-based supportive services, not every JMHCP participant has participated in CCM or HH. While on pretrial release, the JMHCP mental health case manager refers participants to the service provider who can offer them the highest level of care. As a result, some JMHCP participants who have a preexisting connection to a higher level of supportive services are not referred to IFSN upon release. For participants served in Sonoma County's Department Behavioral Health, the highest level of care is Sonoma's Telecare program for assertive community treatment (ACT). Other individuals may enter treatment programs, a crisis stabilization unit (CSU), or a crisis residential unit (CRU) directly upon their release from custody. Some of these individuals may complete their intake with IFSN after exiting a program offering a higher level of care. Others have their case resolved and pretrial release completed prior to IFSN intake.

Some JMHCP participants lose contact with program staff before completing an intake with IFSN. Stakeholders described how COVID-19 procedures in the jail prevented service providers, such as IFSN case managers, from visiting participants in person to establish a relationship prior to their release from custody. Additionally, the pandemic created transportation barriers for JMHCP participants being released from jail, which impacted staff's ability to facilitate a warm-hand to community-based services. Facilitating a warm handoff can also be challenging when individuals are released outside of program staff's operating hours. To adapt to these challenges, JMHCP utilized Uber ride sharing to provide transportation to participants and provided participants a card with their community case manager's contact information prior to their release from custody. If a warm handoff, including transportation to IFSN for an intake process, is not possible, IFSN staff can have difficulty contacting and/or locating the participant upon their release from custody.

If they are not arrested, individuals who do not connect with IFSN services are still considered enrolled in JMHCP and can be engaged in services at a later point in their enrollment.

Community Case Management

Interviewed participants noted that JMHCP services were well-coordinated and case management staff were excellent communicators (e.g., clear in their communications and available outside of regular business hours). **Participants also expressed that they felt respected, cared for by program staff, and heard.** They also reported that IFSN staff made appropriate accommodations for them based on their needs (e.g., holding participant meetings with staff in a quiet space).

"I was in jail and talked to visitor. I was kind of skeptical, but she said she was here to help and get released. I was surprised and then got hooked up with [my community case manager] and was still skeptical until it all started happening and I started pulling my weight." — JMHCP participant

"I really appreciate the fact that I was able to be so open and feel comfortable when it comes to all my problems. The more I can be open, the more help I can receive." — JMHCP participant

"If they don't know something they get the information right away. If you have a question, they're on it. They're very honest and upfront. They're on your side, they want to see you do well, make it to court on time and get your vouchers. They do care." — JMHCP participant

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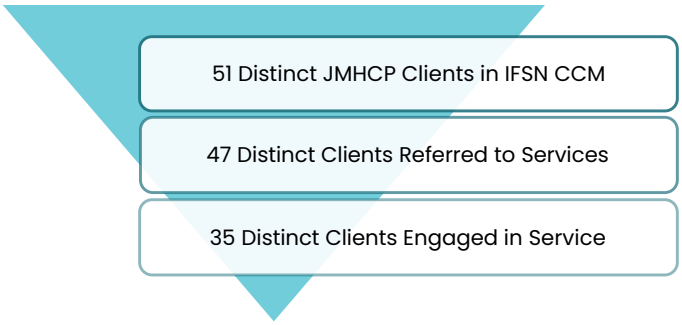
Drawn from IFSN's HMIS data, Figure 6 shows the number of individuals in IFSN's community case management services (CCM) referred to other supportive services and the number who engaged in those services. **Of the 51 JMHCP clients in CCM, 47 (92%) received at least one service referral.** Of those receiving at least one service referral, 35 (74%) engaged in at least one service.

Figure 6. JMHCP CCM Client Service Engagement Process, 2020-2021 (N=51)



Community Case Management Client Profile. IFSN CCM clients had a similar demographic composition as the overall JMHCP population, with slightly more experiencing housing insecurity or homelessness at enrollment (73% compared to 65%). As shown in Table 2, the share of clients referred to and engaging in other supportive services was largely comparable across demographic groups with two notable exceptions (highlighted in blue). Individuals who had secure housing at the time of JMHCP enrollment received CCM referrals to other services at a lower rate. This may be because the CCM intentionally takes a lower-touch approach to working with individuals who are more stable and well-resourced. Additionally, individuals identifying as Latinx, Black, or an "Other" race or ethnicity engaged in services at a rate 34 percentage points lower than their White counterparts.

Table 2. IFSN CCM Referrals & Engagements, 2020-2021 (N=51)

	Distinct CCM Clients	Share of Clients Referred to Any Service	Share of Clients Engaging in Any Service After Referral
Overall	**51**	**92%**	**74%**
Race/Ethnicity			
White	32	94%	87%
Latinx, Black, or "Other"	19	89%	53%
Sex			
Male	34	94%	72%
Female	17	88%	80%
Age			
25-34	17	88%	80%
35-44	11	100%	73%
45-54	11	82%	78%
55+	9	100%	67%
Housing Insecurity or Homelessness			
Yes	37	97%	75%
No	14	79%	73%

Note: The small number of Black individuals and individuals of an "Other" race or ethnicity served through CCM were combined into a single categor y with Latinx individuals to maintain their privacy. Individuals aged 18-24 were similarly omitted to maintain the privacy for the small number of clients in that age category.

Service Area Referrals & Engagements. Displayed in Table 3, **CCM clients were most likely to be referred to basic needs (65%), mental health (61%), and housing services (55%).** On average, CCM clients received five referrals and 74% of CCM participants engaged in at least one referred service. Referral engagement varied across service areas. While a high proportion of participants (81%) received services to support their basic needs; less than half of individuals referred for mental health and housing services engaged in these services.

Table 3. IFSN CCM Referrals & Engagements by Service Area, 2020-2021

Service Area	No. Distinct IFSN CCM Clients Referred to Service Area (Max. 51)	Share of Distinct IFSN CCM Clients Referred to Service Area (N=51)	Share of Referrals Leading to Service Engagement
Basic Needs	32	63%	81%
Mental Health	31	61%	42%
Housing	28	55%	43%
Other (generally transportation for non-court appointments)	22	43%	50%
Substance Use Disorder (SUD) Services	10	20%	50%
Crisis Intervention	6	12%	83%

Note: Basic needs is inclusive of food, medical, and financial services; Mental health is inclusive of co-occurring disorder services and mental health services from IFSN or another source; Housing is inclusive of housing services provided by IFSN or another source; Other services were typically indicated for IFSN-provided transportation services for non-court appointments, moving clients to a different shelter, bus passes, etc.

Program stakeholders reported several factors contributing to the generally low referred service engagement rate among JMHCP participants.

- **Participants must be ready to engage in voluntary services.** Although IFSN case management staff attempts to refer and connect participants to additional services as frequently as is appropriate, engagement in these additional services is voluntary for participants, and participants will only engage when they are ready to do so.
- **Case management communication can become difficult.** Stakeholders reported that technological challenges, such as when a participant's phone is stolen or out of battery, can create barriers to contacting and engaging participants.
- **Transportation barriers can prevent participants from accessing services.** While IFSN does provide some transportation services, limited and time consuming public transportation within Sonoma County can exacerbate challenges for JMHCP participants to access services.
- **Participants' highest-level needs must be met first.** Noted in the preceding community case management client profile section, almost three-quarters (73%) of IFSN CCM clients experienced housing insecurity or homelessness at enrollment. Program stakeholders shared that before participants can begin to address their mental health and housing needs, they first need to meet their basic needs with food, medical, and financial services. This insight is reinforced by the findings in Table 3, which show that basic needs have the highest referral rate as well as one of the highest engagement rates.

Program stakeholders further raised that service engagements do not capture success for these individuals who are functioning at different levels. Participants with debilitating mental health needs

may struggle to attend weekly case management meetings, and success for them can be attending their meetings and engaging with their case manager.

Pretrial Monitoring

As part of JMHCP participation, participants are required to engage in pretrial monitoring. All seven participants interviewed for this evaluation reported that, **overall, their pretrial officers were respectful, responsive to their needs, and eager to see participant improvements.**

Pretrial monitoring officers contacted JMHCP participants through phone calls, automated court date reminder calls, in-person visits, and email.[19] **JMHCP participants were contacted by pretrial officers an average of three times a month**. Pretrial officers most typically contacted participants via phone call, with 98% of all contacted JMHCP participants (n=139) receiving at least one phone call. Only 7% of contacted JMHCP participants had an in-person, face-to-face contact, and stakeholders noted pandemic health and safety protocols reduced the amount of in-person contacts. Seven JMHCP participants had no pretrial contact while enrolled in JMHCP, almost three-quarters (71%) of these individuals were enrolled in JMHCP for one month or less.

Regular reporting requirements may be particularly difficult for those with serious mental health challenges, so specialized units where pretrial staff have been trained on the signs and symptoms of mental illnesses and effective communication strategies can help support positive participant pretrial outcomes.[20] **In 2021, Pretrial Services moved all JMHCP participants to one officer's caseload, which aligns with this best practice and facilitated strong collaboration with the mental health case manager in the jail and IFSN staff.** However, there was recent turnover in this position, with a new pretrial officer identified in March 2022. **JMHCP partners should ensure practices remain in place to facilitate strong collaboration with other JMHCP staff and the officer is equipped with training and effective strategies for working with this specialized population.**

[19] Phone call communications are inclusive of call from Pretrial Services and Probation staff. In-person and email communication were not collected as distinct contact types until June 2020.

[20] Fader-Towe & Osher, 2015.

Collaboration and Communication

KEY FINDINGS: COLLABORATION AND COMMUNICATION

- A system-wide vision and collaboration has helped to decrease silos between partners and improve coordination and service delivery.
- Dedicated JMHCP staff from IFSN, Probation, and Behavioral Health work well together to support service delivery for participants.

System-wide collaboration and a representative county-wide committee/planning team are key to successful service delivery in multi-partner programs like JMHCP and to support a system-wide approach to reducing the number of individuals with mental health needs in jail.[21] Sonoma County partners, including county departments and social service providers, have a shared vision for the County's JMHCP and other programs/initiatives to support individuals with behavioral health needs. **This system-wide vision and collaboration has helped to decrease silos between partners and improve coordination and service delivery.** The County and its partners have demonstrated this collaboration not only through their work on JMHCP but also through the County's other related efforts, including its participation in the national Stepping Up Initiative, development of the ACCESS Sonoma County Interdepartmental Multidisciplinary Team, hosting of a workshop on the sequential intercept model, and implementation of its pretrial release and mental health diversion programs.

"Sonoma County is one of the most collaborative governments I've worked for. Departments share resources, information, and staff." - JMHCP stakeholder

"Over the past two years, we've had the opportunity to do cross-collaboration. We can look at clients together and discuss potential referrals across programs." - JMHCP stakeholder

Dedicated JMHCP staff from IFSN, Probation, and Behavioral Health work well together to support service delivery. Staff from JMHCP's cross-system partners work together to help participants to overcome challenges navigating Sonoma's system of services to achieve positive outcomes, especially during the pandemic. For example, the JMHCP mental health case manager in the jail and IFSN staff work together to resolve difficulties with obtaining medication or personal protective equipment for participants in custody and coordinate to ensure participants receive their community-based case manager contact information before their release.

Sonoma County has established multiple venues to collaborate on JMHCP implementation and share resources and information, including the monthly JMHCP Implementation Team meetings and case consultation spaces focused on coordination of care and service delivery. Developed as an oversight mechanism, the JMHCP Implementation Team comprises various JMHCP administrators, staff, stakeholders, and peer representatives. The team meets monthly to share information, discuss program updates, and review processes related to the JMHCP implementation.

"It's been cool to see how malleable the program is. It feels like we're constantly trying to improve all the components of the program…it's been nice to have larger-scale meetings to problem solve and understand what would make things better." - JMHCP stakeholder

[21] The Council of State Governments Justice Center. (2019, October). *Behavioral health diversion interventions: Moving from individual programs to a systems-wide strategy*. **https://csgjusticecenter.org/wp-content/uploads/2020/02/Diversion-conecept-paper.pdf**; Fader-Towe & Osher, 2015; Haneberg et al., 2017.

Outcome Evaluation

JMHCP is intended to release individuals with SMI who would otherwise be detained pretrial and support them while on pretrial release. Therefore, goals of the program include keeping individuals in the community while their case is resolved and connecting them to services.

KEY FINDINGS: OUTCOME EVALUATION

- Among all JMHCP participants, 77% had no new arrests, 82% had no new violations, and 77% had no failures to appear (FTAs) in court. These rates are similar to the overall Sonoma County pretrial monitoring population's outcomes during the same time.
- Participants successfully complete JMHCP if they remain in the program through the resolution of their case. Approximately half (49%) of JMHCP participants served between 2020 and 2021 successfully completed the program
- Arrest, violation, FTA, and program completion rates are similar across racial/ethnic groups. Female JMHCP participants had a higher rate of new arrests and violations than men.
- JMHCP participants experiencing housing insecurity or homelessness at enrollment had a significantly higher rate of arrests and a lower rate of completion than individuals with stable housing.
- Almost three-quarters (72%) of IFSN Hill House residents with known exit destinations remained housed after leaving the program.
- Participants shared that JMHCP gave them hope for the future and experienced personal growth from IFSN staff encouraging them to advocate for themselves.
- Both participants and stakeholders described positive impacts in connecting individuals to support and services to help them stabilize and change their future.

New Arrests, Violations, and Failures to Appear (FTAs)

The following sections assess participant justice system outcomes, including rates of new arrests, violations, and failures to appear and compares these to the overall Sonoma County pretrial monitoring population as well as within different demographic groups.

Overall Rate. Among all JMHCP participants, 77% had no new arrests, 82% had no new violations, and 77% had no FTAs (see Table 4).[22] The majority of participants with any new bookings, violations, or FTAs most often had just one new booking, violation, or FTA.

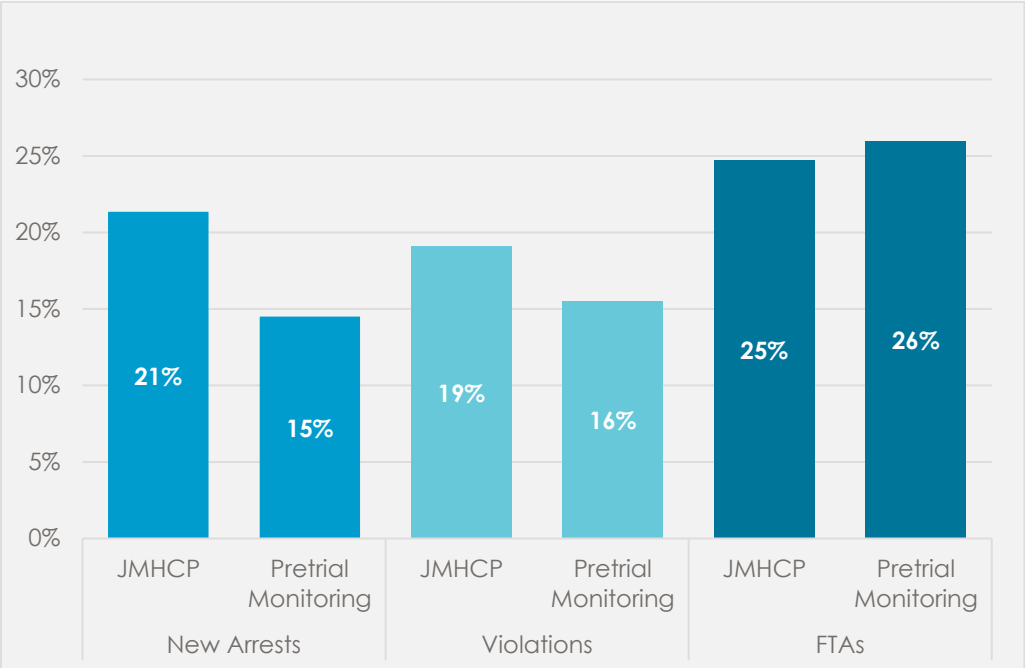
Table 4. JMHCP Participant New Arrests, Violations, & FTA Rates, 2019-2021 (N=146)

	New Arrests	Violations	FTAs
None	77%	82%	77%
One or more	23%	18%	23%

[22] Failing to appear in court could result in a violation and/or a new arrest for the warrant issued as a result of the FTA. For these reasons, there is a degree of overlap between the new arrests, violations, and FTA outcomes.

Comparison to Pretrial Monitoring Population. Figure 7 compares arrest, violation, and FTA outcomes between the JMHCP population and the overall Sonoma County pretrial monitoring population.[23] Since JMHCP targets individuals with moderate to severe mental illness—a population that has been found to have higher rates of recidivism[24]—we would expect that JMHCP clients would have higher arrest, violation, and FTA rates. However, **individuals enrolled in JMHCP between July 2020 and December 2021 had similar rates of new arrests, violations, and FTAs as the Sonoma County pretrial monitoring population during the same time.** The largest difference between the populations is the arrest rate, with new JMHCP arrests exceeding the pretrial monitoring population by six percentage points. The rate of JMHCP violations is three percentage points higher than the pretrial monitoring population and one percentage point lower for FTAs.

Figure 7. New Arrests, Violations, FTAs for JMHCP Participants and Pretrial Monitoring Population, July 2020-December 2021



Note: JMHCP rates for new arrests, violations, and FTAs are only included for individuals who between July 2020 and December 2021(n=89). Pretrial monitoring population rates for new arrests, violations, and FTAs are the average for FY20-21 and the first half of FY21-22.

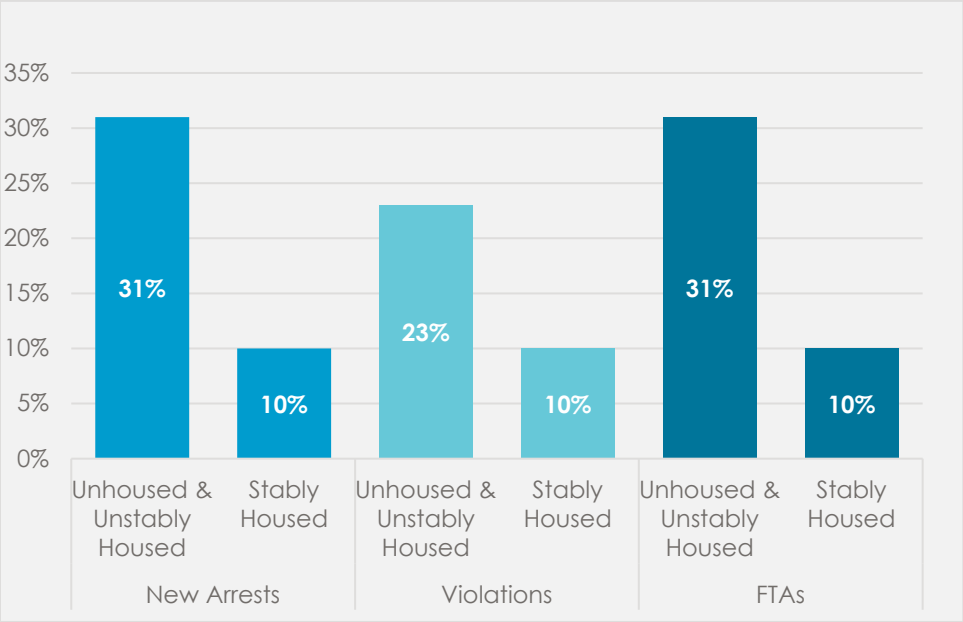
[23] The analysis was limited to individuals who first enrolled in JMHCP between July 2020 and December 2021 to enable a comparison between JMHCP participants and their pretrial monitoring counterparts.
[24] Baillargeon, J., Binswanger, I.A., Penn, J. V., & Murray, O.J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. The American Journal of Psychiatry, 166(1), 103-9.

Demographics. New arrest, violation, and FTA rates appeared similar across different races and ethnicities. Arrest rates, violations, and FTAs, however, did vary significantly based on individuals' sex. **Female JMHCP participants had a higher rate of new arrests and violations than men**. About one-third (34%) of female JMHCP participants (n=44) had at least one new arrest compared to 19% of male participants (n=102). Additionally, one-quarter of female JMHCP participants (25%) had at least one violation compared to 16% of male participants.

Housing Status. JMHCP participants experiencing housing insecurity or homelessness at enrollment had a higher rate of new arrests, violations, and FTAs than individuals with stable housing. As shown in Figure 8, individuals experiencing housing insecurity or homelessness at enrollment had new arrests and FTAs at a rate three times greater than individuals with secure housing (31% compared to 10%).[25]

Stakeholders suggested that housing insecurity or homelessness may lead to arrests when charges are due to "quality of life" offenses related to being unhoused. For example, stakeholders reported that charges for individuals experiencing homelessness have included being too close to railroad tracks and utility theft for charging their phone at a business.

Figure 8. Comparison of New Arrests, Violations, and FTAs by Housing Status at Enrollment, July 2020- December 2021



Note: Unhoused & unstably housed (i.e., experiencing homelessness or housing insecurity at enrollment), N=95; Stably housed, N=51.

[25] A Fisher's exact test of association showed that housing status at enrollment has a statistically significant relationship with a participant having any new arrests or FTAs at the 0.01 alpha level (P-value: 0.004). This finding indicates there is less than a 1% probability that the observed difference in new arrest and FTA rates shown in Figure 8 are due to chance alone.

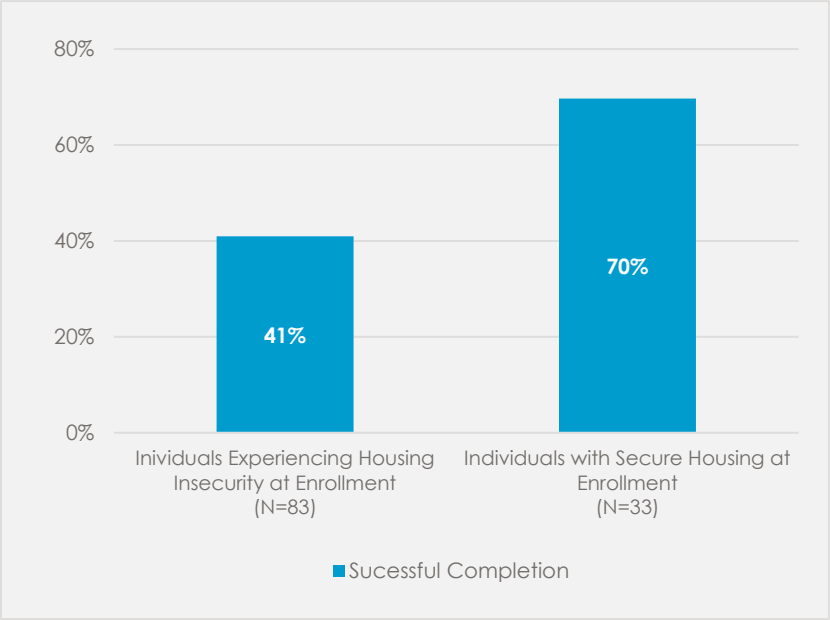
JMHCP Completion

Participants successfully complete JMHCP if they remain in the program through the resolution of their case. The following sections assess participant rates of successful completion and analyzes these rates within different participant demographic groups and levels of service engagement.

Overall Completion Rate. Approximately half (49%) of JMHCP participants served between 2020 and 2021 successfully completed the program.[26] New arrests do not automatically trigger program expulsion. In the case of a new arrest, the judge may re-release the participant back onto JMHCP, which would be considered a continuation of their enrollment. Overall, one-fifth of completed JMHCP participants with new charges (n=30) ultimately finished JMHCP successfully.

Completion Rates by Demographics and Needs. JMHCP participants with different demographic characteristics completed successfully at roughly similar rates. However, **individuals experiencing housing insecurity or homelessness at enrollment were significantly less likely to complete successfully.** Among participants who exited JMHCP, only 41% of individuals who experienced housing insecurity at enrollment completed successfully (see Figure 9), which is 29 percentage points lower than the successful completion rate for participants with secure housing at enrollment.[27]

Figure 9. Comparison of Completion Rate by Housing Status, 2020-2021 (N=116)

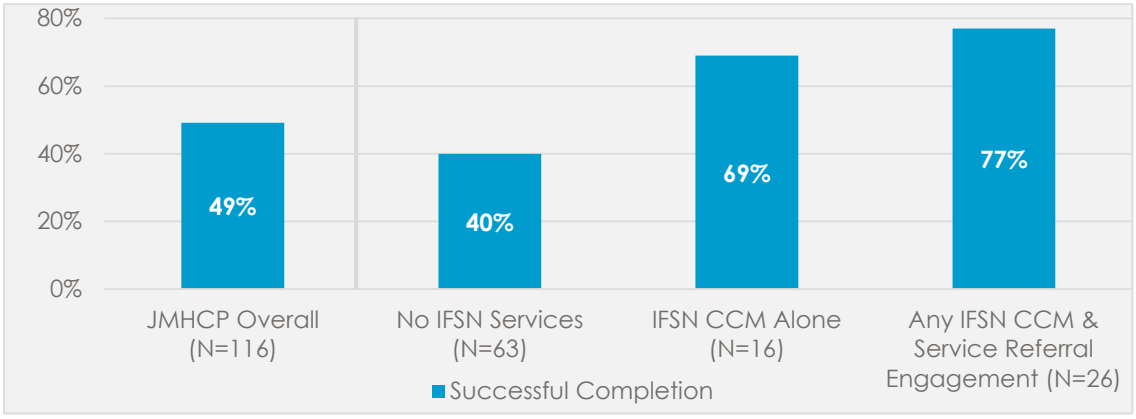


[26] Of the 146 participants engaged in JMHCP between July 2020 and July 2021, 116 have exited and 30 were still enrolled in the program as of January 1, 2022. For individuals with multiple enrollments, the completion status for the most recent enrollment was included.

[27] Housing status at enrollment and exiting unsuccessfully had a strong statistically significant relationship at the 0.01 alpha level (P-value: 0.005). This result indicates that there is less than a 1% probability that the observed difference in successful completion rates shown in Figure 9 are due to chance alone.

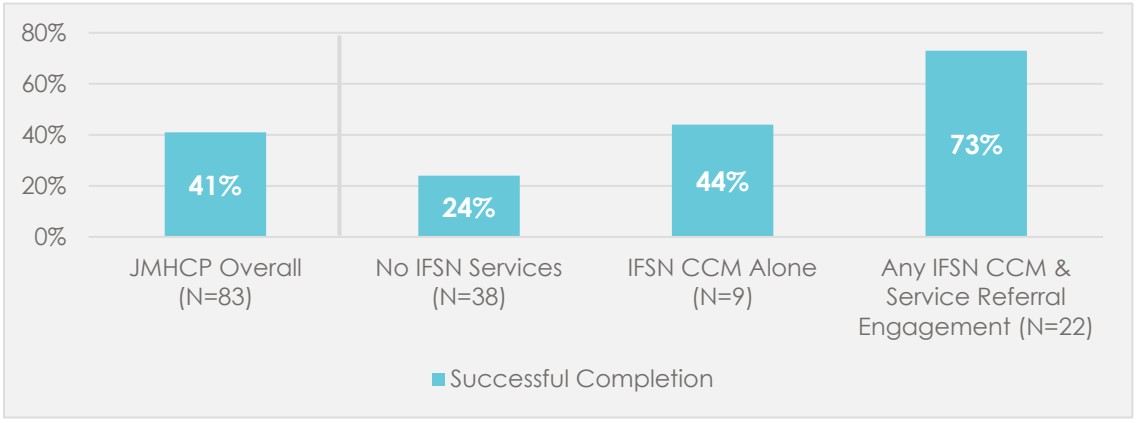
Completion Rate by IFSN Service Engagement. Completion rates significantly varied based on the types of services that participants received. **As shown in Figure 10, the successful completion rate increased with higher levels of IFSN case management engagement.** The successful participation rate for exited participants with CCM and service referral engagement (77%) was 37 percentage points higher than individuals with no IFSN services (40%). The relationship between receiving any CCM and completing JMHCP successfully is statistically significant.[28] While this finding is promising, it is also possible that individuals who engaged with CCM had higher levels of stability and motivation than individuals who did not engage with CCM.

Figure 10. JMHCP Successful Completion Rate by Service Engagement, 2020-2021



Case management engagement is also associated with higher completion rates for individuals experiencing housing insecurity or homelessness at the time of enrollment. Limiting our analysis to individuals experiencing housing insecurity or homelessness at the time of enrollment, as shown in Figure 11, the successful completion rate (71%) for participants in this group with IFSN CCM and service referral engagement was 30 percentage points higher than for exited participants experiencing housing insecurity or homelessness at enrollment overall (41%) and 49 percentage points higher than individuals with no IFSN services.[29]

Figure 11. JMHCP Successful Completion Rate for Participants Experiencing Housing Insecurity or Homelessness at Enrollment by Service Engagement, 2020-2021



[28] A chi-square test for association further found a strong statistically significant relationship at the 0.01 alpha level (P-value: 0.002). These results indicate there is less than a 1% probability that differences in successful completions by IFSN CCM status are due to chance alone.

[29] A chi-square test for association finds a strong statistically significant relationship between receiving any IFSN community case management (n=83) and completing JMHCP successfully for individuals experiencing housing insecurity or homelessness at the 0.01 alpha level (P-value: 0.002). These results also indicate there is less than a 1% probability that differences in successful completions by IFSN CCM status are due to chance alone for the cohort.

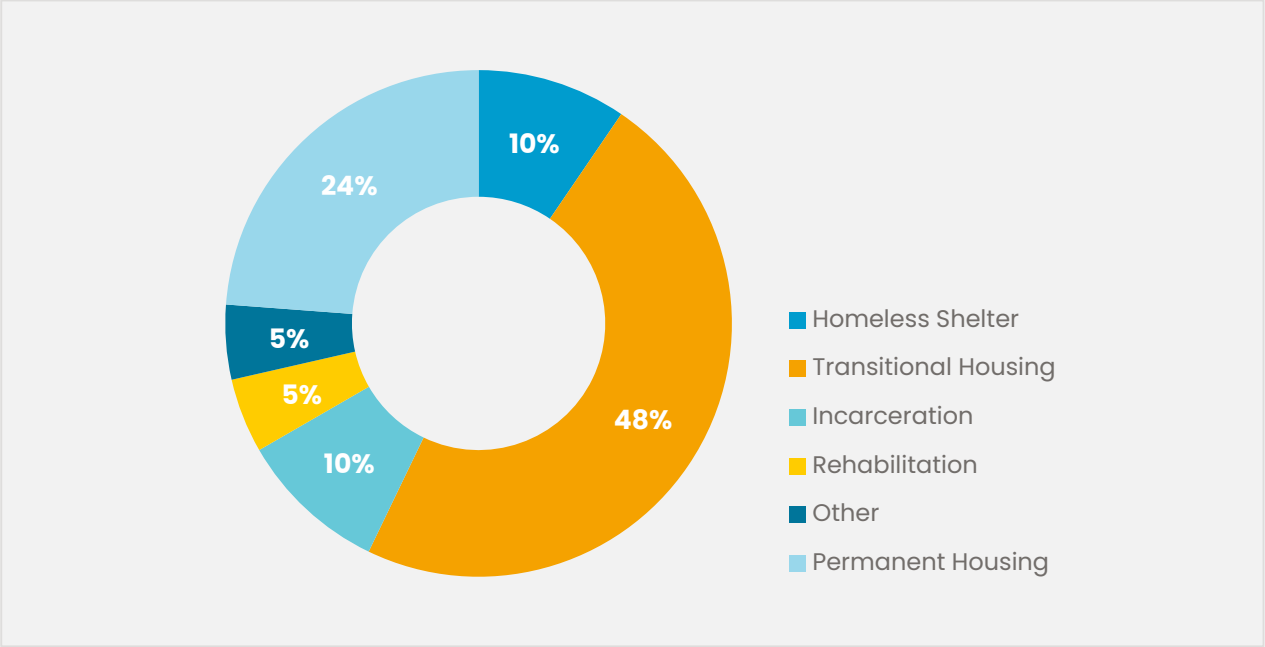
Health & Housing Outcomes

The following sections assess participant health and housing outcomes, including connections to behavioral health services and housing after exiting JMHCP.

Behavioral Health Services. Due to data limitations, this evaluation is unable to report on the proportion of all distinct JMHCP participants who transitioned to ongoing behavioral health services after exiting JMHCP.

Housing Destinations. Among unique Hill House residents experiencing housing insecurity or homelessness at enrollment with known exit destinations (n=21), almost half (48%) exited to transitional housing provided by IFSN, and approximately one-quarter exited to permanent housing (24%).[30] These findings are limited relative to the number of all JMHCP participants (n=146), Hill House residents (n=44), and JMHCP participants experiencing housing insecurity or homelessness at enrollment (n=95). However, it appears promising that **almost three-quarters (72%) of IFSN HH residents with known exit destinations remained housed after leaving the program.**

Figure 12. Known Exit Destinations for IFSN Hill House JMHCP Residents Experiencing Housing Insecurity or Homelessness at Enrollment, 2019-2021 (N=21)



[30] Exit destinations were either unknown or missing for an additional eight Hill House residents who were experiencing homelessness or insecure housing at the time of JMHCP enrollment.

Participant Impact

JMHCP participants who were interviewed for this evaluation[31] reported that the program offered them a supportive way to get out of jail quickly, connecting them with a wide variety of supportive services and housing to create changes in their life. Some participants noted that their participation in JMHCP helped with suicide ideation and improved their relationship with family and friends. **While case management staff work hard to connect JMHCP participants to resources, participants shared that part of their personal growth during the program has come from IFSN staff encouraging them to advocate for themselves.** The JMHCP program has also given participants hope for the future.

"I'm glad I got the chance to qualify for [JMHCP]. I think it's a good program for people who are in the court system and having mental health issues."
– JMHCP Participant

"Every time my case manager needs something from me, I help her out and she helps me. To the point where I'm not going to need her help, and I can stand on my feet now. With their support, I learned to advocate for myself. Even my daughter has seen changes in me, and I told her I got this program. They can see I'm making more progress than in the last 3 years."
– JMHCP Participant

"It's made me see that there could a light at the end of the tunnel for housing. Without this program I'd probably have new charges. Because I'm in the program I feel I can work with Downtown Street Teams, something more than just revolving door of jail time that I was a part of for a long time." – JMHCP Participant

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Interviewed JMHCP participants shared great appreciation and thanks for the program, with one individual sharing they wish the program had been in place sooner. Believing in the real help and change JMHCP can offer, many interviewed participants wanted to recommend the program to their friends and increase awareness of it. Stakeholders also noted the importance of having a program like JMHCP available to individuals in Sonoma County.

"Knowing how people are doing now and knowing how they were doing in the past, their long history in and out of homelessness . . . It's powerful knowing how giving them some stability with resources and support can really impact their lives into the future. It's a great program and it's working for people." – JMHCP Stakeholder

" [One client] was in this hopeless state, I don't think he had any hope of anything. We gave him this news [that we had a housing voucher for him], and . . . his mood is completely different…Being able to provide resources to people who think there isn't anything out there, for people who can't see past the hopelessness, incredible to help them." – JMHCP Stakeholder

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[31] As part of this evaluation, we spoke with seven participants who were actively engaged in the program. Interviewed participants may not be reflective of the whole participant population and, as noted in the limitations section, response bias may have limited the negative perspectives shared by participants.

Conclusion

Sonoma County's JMHCP expansion acts as a key intercept point to connect individuals with serious and persistent mental illness to community-based supportive services. Despite individuals with serious mental illness having traditionally higher rates of recidivism, JMHCP participants experienced similar rates of FTAs, new arrests, and violations compared to Sonoma County's overall pretrial population. Additionally, participants' engagement with case management services was associated with higher completion rates, even for individuals with insecure housing at the time of their enrollment.

Strong collaboration across JMHCP partners has supported the program's progress as it has continued to add services and staff. However, as the County considers continued implementation of JMHCP, it should work to increase the proportion of individuals who enroll in the program, focusing specifically on Latinx and Black individuals, and identify ways to connect participants to community-based and housing supports. The following section provides a summary of considerations for future implementation of JMHCP.

Considerations for Future Implementation

Program Implementation

- JMHCP partners should work to **increase the number of Latinx and Black participants**. Efforts to consider include hiring Spanish-speaking staff to conduct mental health screening in jail; engaging successful Latinx and Black participants to assist with program outreach; collecting data to assess why Latinx and Black individuals decline to enroll in the program; and revisiting the list of disqualifying charges for JMHCP participation.[32]
- JMHCP partners should **explore how requiring JMHCP participants to be released on the highest monitoring level impacts participant enrollment and outcomes** and determine if action steps or changes would help increase enrollment, particularly for individuals in scored release level one or two.
- JMHCP stakeholders, including the program's cross-system partners, **should work together to identify a cross-system process to engage individuals released through JMHCP who are not immediately connected to IFSN or another service provider**, such as identifying the steps for JMHCP and other system partners to take when individuals have not been connected to services through JMHCP after set periods of time.
- Since individuals with insecure housing experience significantly worse outcomes than individuals who are stably housed and Hill House supported 41 of the 95 individuals in this situation, JMHCP partners should **identify ways to increase housing support available through the program.** For example, other supports could include allocating funding to rapid rehousing or dedicated women's housing to support the higher proportion of women experiencing housing insecurity or homelessness.

[32] JMHCP stakeholders suggested that the current list of disqualifying charges may disproportionately impact Black and Latinx participants, due to racial bias in charging decisions.

Collaboration and Communication

- The JMHCP Implementation Team and other stakeholders should consider reviewing current program processes and **identify process changes and program adaptations that need to be documented to ensure a shared understanding of JMHCP processes**—such as the referral process or pretrial monitoring caseload policy—across all stakeholders**.**
- **Ongoing communication and information sharing—such as through the continuation of ongoing presentations and trainings and the continued use of the bench card for judges**—may help judges, public defenders, and prosecutors remain knowledgeable of JMHCP through staff transitions. These efforts have been successful to increase awareness of JMHCP and should be continued to ensure ongoing support.
- **Strengthen the relationship between JMHCP and Sonoma County's Behavioral Health Division's community-based services** to address delays in services such as psychiatrist appointments and enrollment in the ACCESS initiative's IMDT program (see page 4 for more information about ACCESS).
- As the County recently filled the JMHCP pretrial officer position, JMHCP partners should **ensure practices remain in place to facilitate strong collaboration between JMHCP staff and the pretrial officer and that the officer is equipped with training and effective strategies for working with this specialized population.**
- JMHCP partners should **consider steps to reduce the number of JMHCP participants who experience adverse outcomes as a direct result of their homelessness**, including new arrests for offenses related to being unhoused and possible unsuccessful exits from JMHCP. These steps could include additional cross-system collaboration and training programs to address the causes of these adverse outcomes, including the reasons for these arrests and if these arrests should trigger an unsuccessful program exit.

Data Collection

- JMHCP partners should consider developing a process to consistently **collect referral source data to understand partners' role in enrolling JMHCP participants** and to gauge the success of communication and collaboration efforts with the courts.
- To measure JMHCP's ability to serve its target population, JMHCP partners should **ensure mental health assessment results and diagnoses are shared with the program.**
- JMHCP partners should consider **collecting data on detention times for individuals eligible for release through JMHCP** with a particular focus on identifying delays in release due to limited community-based services. JMHCP partners could use these data to help identify gaps in available services and prioritize solutions based on impact to participants.
- To better gauge the program's success in connecting participants to services after program participation, JMHCP partners should consider developing processes to consistently **collect data on a participant's connection to housing and behavioral health services at the time of exit**.