Cassie Cordell Trueblood, et al., v. Washington State Department of Social and Health Services, et al.
Case No. C14-1178 MJP

Semi-Annual Report

September 29, 2023

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

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List of Abbreviations in this Document

AAG-assistant attorney general

AHAB-Affordable Housing Advisory Board

ASO-administrative service organization

ASPD-antisocial personality disorder

BHA-Behavioral Health Administration, part of DSHS

BHASO-behavioral health administrative service organization

BPD-borderline personality disorder

CIT-Crisis Intervention Training

CJTC-Criminal Justice Training Commission

CMS-Centers for Medicare and Medicaid Services

CPC-certified peer counselor

CS/CT-crisis stabilization/crisis triage

DBHR-Division of Behavioral Health and Recovery, part of HCA

DCR-designated crisis responder

DSHS-Department of Social and Health Services

DOH-Department of Health

DRW-Disability Rights Washington

ESH-Eastern State Hospital

ETP-exception to policy

FDS-Forensic Data System

FRA-forensic risk assessment

HARPS-Housing and Recovery through Peer Services

HCA-Health Care Authority

MCR-mobile crisis response

MOCT-mobile outreach crisis team

MOU-memorandum of understanding

OCRP-Outpatient Competency Restoration Program

OFMHS-Office of Forensic Mental Health Services, part of DSHS

PATH-Projects for Assistance in Transition from Homelessness

PHS-Pioneer Human Services

RDA-Research and Data Analysis, part of DSHS

RFP-request for proposals
RTF-residential treatment facility
SAR-semi-annual report
SRSC-Spokane Regional Stabilization Center
SUD-substance use disorder
VTC-video technology conferencing
WASPC-Washington Association of Sheriffs and Police Chiefs
WSH-Western State Hospital

Preamble

Each March and September, a semi-annual report is published to review the implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress during January through June 2023. The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new Trueblood programs initially launched during the Phase 1 implementation of the Settlement Agreement and those operations are ongoing. Additionally, work to implement Phase 2 of the Settlement Agreement in the King region is arriving at completion. Phase 3 of the Settlement Agreement became effective on July 1, 2023.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes, where possible. For this SAR, the King region is included in the Crisis Housing Voucher and Outpatient Competency Restoration Program cumulative data counts for the first time. As a result, the number of people served in the King region is now included in all program tables. Additional details will be available when minimal reporting thresholds are met.

Most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. As programs continue their operations and mature, this report will expand over time to include more data and reporting elements. With a few exceptions noted in the report, the data is current through June 30, 2023. Data from new regions will typically be included in the SAR following at least two calendar quarters of operation, assuming sufficient counts to preserve confidentiality.

Background

All criminal defendants have a constitutional right to assist in their own defense. If a court believes a mental disability may prevent a defendant from assisting in their own defense, the court puts the criminal case on hold while an evaluation is completed to determine the defendant's competency. Generally, if the evaluation finds the defendant competent, they are returned to stand trial; but if the court finds the evaluation shows the person is not competent, the court may order the defendant to receive competency restoration services. The Department of Social and Health Services is the state agency tasked with providing such competency services in Washington state.

In April 2015, a federal court found in *Trueblood et al. v. Washington State DSHS* that the Department of Social and Health Services was taking too long to provide these competency evaluation and restoration services. As a result of this case, the state was ordered to provide court-ordered in-jail competency evaluations within 14 days and inpatient competency evaluation and restoration services within seven days of receipt of a court order. Now that state-contracted outpatient competency restoration services began July 2020, outpatient restoration services must likewise be provided to class members within seven days of receipt of a court order. Trueblood's class members, referred to throughout this report, are those who are detained in jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of Trueblood also target people who have previously received competency evaluation and restoration services, who are released and at risk for re-arrest or re-institutionalization.

Many of the problems with untimely competency services can be prevented if fewer people experiencing mental illness enter the criminal court system and instead receive community-based treatment. People who get the treatment they need when they need it are less likely to become involved with the criminal court system. A major goal of many of the programs covered in this report is providing variable levels of care to prevent overuse of the highest and most intensive level of care and providing care in the community whenever possible and appropriate.

On Dec. 11, 2018, the Court approved a settlement agreement related to the contempt findings in this case. The Settlement Agreement is designed to move the state closer to compliance with the Court's injunction. The Settlement Agreement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified geographic regions. The Settlement Agreement includes three initial phases of two years each and can continue to additional phases. Services and regions implemented in each phase are evaluated and continued into future phases of the settlement.

Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium. Phase 1 completed as of June 30, 2021. Phase 2 just concluded on June 30, 2023. Phase 3 is the current active settlement phase and targets the Thurston/Mason and Salish (Clallam, Jefferson, and Kitsap Counties) regions.

The reports contained herein detail how each program is contributing to the goals of compliance with the Court's orders and diversion of potential class members.

Definitions

Throughout this report several names and titles are referred to frequently. The definitions below provide common usage and understanding throughout the report.

Agreement: Trueblood Contempt Settlement Agreement or Settlement Agreement

Certified peer counselor or CPC: A person who self identifies as a consumer of behavioral health services, is grounded in their recovery, and who has completed the specialized state training and passed a state exam. CPCs use their personal lived experience of recovery from behavioral health challenges to build rapport, promote recovery, empower, and inspire hope to the individuals they serve. CPCs who have lived experience with criminal court involvement are especially valuable to individuals who are served on Trueblood service teams.

CJTC or the Commission: Washington State Criminal Justice Training Commission

Crisis housing vouchers: Allow unhoused or unstably housed persons in behavioral health crisis to obtain short-term housing assistance for up to 14 days post discharge from crisis triage/stabilization facilities and who have criminal court involvement or referred by law enforcement.

Department, the department, or DSHS: Washington State Department of Social and Health Services

Diversion navigator: The diversion navigator seeks to assist individuals who are in custody for an alleged charge and have had two competency evaluations in the past 24 months that have been dismissed. Individuals who meet the criteria will be recommended to engage in the diversion options to avoid a RCW 10.77 evaluation being ordered.

Enhanced crisis triage/stabilization services: Services intended to create the capacity for community behavioral health agencies to receive law enforcement referrals, drop-offs or holds.

Forensic Housing and Recovery through Peer Services or FHARPS: Staff teams with lived experience with behavioral health challenges that provide unstably housed and recently forensically involved individuals with supports to access supportive housing and recovery services. FHARPS is a combination of services and rental assistance with the long-term goal of stable housing but will employ several strategies to ensure people are sheltered.

Forensic Projects for Assistance in Transition from Homelessness or FPATH: An intensive case management program that identifies people most at risk of referral for competency

restoration. Individuals identified on a referral list generated by Research and Data Analysis have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those individuals most vulnerable to access housing, treatment and resources in an effort to divert them from future intersections with law enforcement. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

Forensic Data System or FDS: Since Aug. 1, 2018, the data entry and reporting system of record for Office of Forensic Mental Health Services and Trueblood related data.

Forensic Navigator Program: This program seeks to divert forensically involved criminal defendants out of jails and inpatient treatment settings and into community-based treatment settings. For clients who are conditionally released, navigators work to ensure their adherence to release conditions and to connect them to supportive services in their community. Forensic navigators act as agents of the court to ensure individuals are participating in outpatient competency restoration.

Health Care Authority or HCA: Washington State Health Care Authority

Master leasing projects: An umbrella term for when a company, agency, or entity rents all available or some available space from a landlord and is allowed to sublease the space to third parties.

Mobile crisis response or MCR: Enhancements to the current crisis delivery system, which promote early intervention in behavioral health crisis situations to prevent arrests, and incarceration, and to quickly connect clients to needed treatment.

Outpatient Competency Restoration Program or OCRP: A competency restoration program located in the community, providing restoration services to those ordered by a judge to be appropriate and with attached conditions of release. OCRP classes are coupled with mental health treatment.

Residential Treatment Facilities or RTFs: (1) DSHS usage refers to an inpatient facility that treats forensic clients without indication of acute violent behavior to self or others, or otherwise complex treatment needs, which require a level of care provided in the state hospitals; and

(2) HCA usage refers to facilities that serve their communities by providing least restrictive alternatives to care for the purpose of diverting individuals from arrest, detention, and lengthy hospitalizations. Services within these facilities are short term and focus on stabilizing and returning the individual back to their community.

COVID-19 Procedures Update for Q1 & Q2 2023

Washington state officially re-opened from pandemic-related closures on June 30, 2021, subject to limited restrictions, and the Governor's COVID-19 State of Emergency ended on October 31, 2022. As of July 2023, BHA's Western State Hospital, Eastern State Hospital, Fort Steilacoom Competency Restoration Program, and Maple Lane's competency restoration program (DSHS Behavioral Health & Treatment Center - Maple Lane Campus – Cascade) are operating without any COVID-19 related admissions restrictions.

On March 30, 2023, Kevin Bovenkamp, assistant secretary for BHA, issued updated guidance on masking in BHA facilities. On April 3, 2023, the Washington State Department of Health ended the Secretary of Health Mask Order. In certain circumstances, mask-wearing may again become mandatory: when community transmission of COVID-19 is high according to CDC county community transmission rates; or when a ward or other area of a facility is on restriction due to COVID-19 cases. This updated guidance is in compliance with the Washington State Labor and Industries standards and with the federal Centers for Disease Control and Prevention guidance.

COVID-19 Cases All BHA Facilities

Client and Staff

- As of August 31, 2023, there were 1,454 cumulative cases of COVID-19 in BHA clients and 2,399 cumulative cases in BHA staff across all facilities.
- COVID-19 continues to impact facility operations. Between yearend 2022 and September 26, 2023, there were 284 covid cases among clients in BHA facilities and 451 cases among staff.

Data Source: BHA 24-7 Staff-Client Counts Weekly COVID-19 Report

Note: "All facilities" includes several BHA facilities that do not serve Trueblood clients. However, as of Aug. 31, 2023, more than 87 percent of all COVID-19 staff cases and more than 89 percent of all COVID-19 client cases involve the state hospitals or RTFs.

Impacts of Civil Conversion Cases on the Inpatient Forensic Bed Supply

Court-ordered felony civil conversion cases have grown rapidly and substantially, leading to significantly fewer restoration beds available for Trueblood class members. Felony conversion cases increased 20 percent from 2019-2020, seven percent from 2020-2021, and 40 percent from 2021-2022. This is a cumulative 79 percent increase between 2019-2022[1].

Court-ordered Civil Conversion Cases Removes Department Control over Beds Intended for Forensic Use

As indicated in the department's court filing below, ordering a felony civil conversion client to civil commitment removes restoration beds from regular use in forensic restoration cases.

> "Felony conversions" or "felony flips" are persons whose felony criminal charges have been dismissed for reasons of incompetency, and where the criminal court then decides to "order the defendant to be committed to a state hospital . . . for the purpose of filing a civil commitment petition under chapter 71.05 RCW." Wash. Rev. Code § 10.77.086(5). This statute mandates state hospitals to accept these patients, with no statutory discretion for alternate placements. Id. Only those patients facing a felony charge may be ordered to a state hospital. Id. . . . Any felony charge is eligible for such an order, and the Department receives patients who have very serious charges dismissed, such as murder, sexual violence perpetrated against children, sexual assaults, and serious physical violence. Bovenkamp Decl. at 3[2]. Historically, the Department has also received less serious felonies through this process, such as malicious mischief and theft, for example. Id. The civil commitment hearing for these patients includes a factual question as to whether the individual "committed acts constituting a felony," Wash. Rev. Code § 71.05.280(3), meaning that the underlying criminal conduct is an issue to be proven by admissible evidence at the civil commitment hearings[3].

Civil Conversion Cases Often Require Extended Commitment

Forensic restoration cases that include Trueblood class members have specified statutory time limits determining their occupancy of inpatient beds. Civilly committed patients have different standards governing their commitment, and this results in significant decreases to patient throughput and bed turnover as indicated in the court filing below:

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[1] Document 943. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023, p. 9.

[2] Document 944. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Declaration of Kevin Bovenkamp, p. 3. As cited in Dkt. 943, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023, p. 9.

[3] Document 943. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023, pp. 8-9.

> For many of these cases, the criminal court enters the dismissal while the class member remains at the state hospital for restoration treatment, without the patient ever leaving the treatment bed they are in. It is not uncommon for a patient to start the day as a class member undergoing restoration treatment, but end the day as a civil conversion patient. Bovenkamp Decl. at 3[4]. The number of former class members who have been court-ordered into state hospitals as conversion cases has risen dramatically in the last several years. Id. This places even more demand on the state hospital system. Id. Unlike restoration cases, which have strict time limits on how long a patient can be committed to a state hospital, conversion cases are subject to extended commitment under Wash. Rev. Code 71.05 until they can be safely discharged to the community, and have a much higher average length of stay, often a year or longer. Id[5].

Behavioral Health Administration – State Hospitals Admissions Crisis and Steps to Address

In response to the ongoing demand surge for restoration beds, and the lack of available beds for forensic admissions and especially admissions for Trueblood class members, BHA Assistant secretary Kevin Bovenkamp issued a letter dated Dec. 14, 2022 detailing new emergency admissions procedures in effect at the state hospitals and residential treatment facilities. These new procedures evaluate individual clients with civil orders to determine whether it is possible to serve those clients at the state hospital. When it is not possible to admit them, the patients, their legal team, and the court are issued "no admit" letters informing them of the decision to not offer civil admission to the client. The full text of Assistant Secretary Bovenkamp's letter is available in Appendix H. Additionally, even greater emphasis was placed on prioritizing Trueblood class members waiting for state hospital inpatient restoration services relative to non-class members awaiting services in the community.

New Treatment Beds Expected for Forensic and Felony Civil Conversion Patients in 2023

The Department was able to open 74 new beds for class members. Thirty additional new beds are expected to open later in 2023. A detailed list of recently opened facilities and currently projected opening dates follows:

- The new 16-bed Oak Unit at Maple Lane opened to civil patients in April 2023.
- Two new 29-bed forensic competency restoration wards opened at WSH in May 2023.

[4] Document 944. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Declaration of Kevin Bovenkamp, p. 3. As cited in Dkt. 943, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023, pp. 9-10.

[5] Document 943. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023, pp. 9-10.

- Maple Lane's Columbia Cottage, a newly remodeled 30-bed facility for NGRI patients from WSH. As of June 30, the estimated opening date is October 25.

- In summer 2023, DSHS purchased a private mental health hospital in Tukwila to re-open as Olympic Heritage Behavioral Health and use initially for civil conversion patients. Beds that open at Olympic Heritage will free up space for Trueblood Class Members at WSH. These beds are not included in the 30-bed total that is opening in fall 2023 or the 104-bed all- bed opening total for calendar year 2023.

Gaining at least 104 new beds in calendar year 2023 does not solve the admissions crisis outright; however, it allows OFMHS and the state hospitals greater flexibility with new types of facilities coming online to provide a more diverse and responsive care environment to better meet the needs of each patient. As civil and NGRI patients can shift to these new facilities, new bed space opens for Trueblood class members at WSH and ESH. Critically, this allows the department to better serve civil patients as well as forensic class members. It provides additional approaches to treating various patient types, and it begins a period of realizing the governor's vision for significant growth in inpatient restoration capacity around the state, as additional, similar facilities and hundreds of new beds are brought online from 2023 until approximately 2028. This ultimately allows patients the potential to receive restoration treatment closer to their home communities, enabling access to family support and critical community resources that are vital for successful restoration and return to the community.

Breach Motion

Plaintiffs to the *Trueblood et al. v. Washington State DSHS* lawsuit filed a motion with the Court on Dec. 22, 2022, requesting that the department be found in material breach of the Contempt Settlement Agreement for an alleged ongoing lack of compliance with the Contempt Settlement Agreement's terms. Among other items, the Plaintiff's motion requested:

- Fine amounts imposed but suspended under the current Contempt Settlement Agreement potentially be foreclosed upon and

- Significant additional conditions and sanctions be applied to the department.

The department filed its response to the Plaintiff's motion on Jan. 11, 2023, and the Plaintiff's filed their counter-response on January 16. During the Court's regularly scheduled Trueblood Quarterly Status Hearing in January, the Court scheduled a series of hearings from March 28-31, 2023 to understand the alleged issues more fully and come to a decision on the Plaintiff's motion. Due to a key participant's illness, the March 28-31 hearings were cancelled and re-scheduled for June 12-15. The judge issued her initial ruling on July 7. As part of the Court's July 7 order, the State and the Plaintiffs met and conferred on various aspects of the order and jointly proposed modified language. A hearing on the modification language was held on August 7 and the court

issued a second order on August 14. This order of August 14 clarified the original July 7 order in certain respects. Notably, the August 14 order specifically excludes defendants charged with non-violent criminal acts from being admitted into either state hospital on a civil conversion order. The state filed notice of appeal to the Ninth Circuit Court of Appeals, and the case awaits further proceedings in late fall 2023.

Workforce Challenges-Recruitment and Retention

Competing for staff talent with the private sector in the context of the well-publicized post-pandemic workforce challenges has left many positions, especially at our treatment facilities, chronically unfilled. BHA has identified and implemented creative solutions within our existing authority and partnered with executive leadership, state human resources, labor, and other partners to develop and implement innovative approaches to recruiting and retaining critical staff positions. In spring and summer 2022, DSHS completed several steps to alleviate staffing challenges. Steps taken included hiring more contractors and travel nurses, adding hiring recruitment resources to both WSH and ESH, especially to hire nurses, partnering with the Washington State Office of Financial Management to adjust pay ranges for certain positions, expanding our successful forensic evaluator training and recruitment post-doctoral program from three to five interns, and engaging a successful demand to bargain with labor partners to allow for contract evaluations to take place until vacancies can be filled. Implementing new policies and practices to attract and retain passionate, talented staff remains critical to success, and BHA has continued this critical focus through 2022 and well into 2023. Even with these successful actions, BHA continues to face high vacancy rates in several critical patient-centered job classes. As of early July, vacancies in these classes now range between 27-38 percent. The ability to maintain current restoration capacity is a challenge, and staffing new facilities' capacity is also very challenging.

BHA has established a HQ-based staffing and outreach team focused on filling the newly established positions for the additional facilities being built as well as providing recruitment, outreach, and hiring support for vacancies within existing facilities and programs. This team has increased the partnerships, job fairs, and outreach connections with a focus on high schools, community colleges, trade schools, tribal governments, and professional, and community organizations. Some of the strategic recruitment and outreach activities include:

- Program/facility-specific job fairs
- Position/discipline-specific job fairs (nursing, psychology, security guard)
- Veteran-focused hiring events
- Sending statewide letters to all licensed psychologists
- Paid recruitment ads in professional journals

Effective July 1, 2023, several new staff retention measures take effect with implementation of the 2023-2025 biennial budget and collective bargaining agreements.

- Staff who were hired on or before July 1, 2022 and remain employed on July 1, 2023 qualify for a one-time lump sum retention payment. Most employees receive $1,000. Certain represented employees may receive $1,500.

- All employees in Washington General Service and Washington Management Service positions, working at our 24/7 facilities receive a five-percent wage premium for hours worked on-site at the facilities.

- All employees received a four-percent cost of living adjustment. Effective July 1, 2024, all employees are scheduled to receive an additional three-percent cost of living adjustment.

- Enacted targeted wage scale adjustments for critical positions.

- Extra duty pay for forensic evaluators and psychiatric social workers (At the regular rate)

- Extra duty pay for ARNPs (1 ¼ times the regular rate)

- Extra duty pay for physicians and psychiatrists (1 ¼ times the regular rate)

Evaluation and Monitoring Overview

This section provides an overview of the monitoring and evaluation activities that will be completed by DSHS' RDA for settlement activities implemented by the department and HCA.

Project Monitoring

The department provides ongoing project monitoring analyses through monthly and semi-annual reporting. Monthly monitoring reports provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness goals and slowing the rate of growth in competency evaluation referral volume. Most commonly, this information is available as part of the monthly reports to the court-appointed monitor and can be found on DSHS' Trueblood website[6]. Semi-annual reporting on implementation elements (e.g., FPATH and the Forensic Navigator Program) provides timely information on client engagement in implementation programs. Monitoring measures include:

- Monthly metrics derived directly from the Forensic Data System
- Number of competency evaluation referrals by region
- Number of competency restoration referrals by region
- Substantial compliance (and related) timeliness metrics by region

Trueblood semi-annual dashboards contain client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for all Trueblood implementation programs but mobile crisis response (see MCR section). Data come from a range of sources and data collection systems are under continuous development. Additional program measures may be added as feasible.

RDA continues work with various teams within DSHS and HCA to establish a reliable and efficient processing system for reporting data. This requires establishing a coordinated infrastructure including, but not limited to, secure data transmission and storage; automated data error checks; a framework to download, merge, and package data; data definitions and counting rules; and validated code and templates for data analyses and reporting. Building this infrastructure is complex due to the number of data sources, different collection/reporting methods, data quality issues, and ongoing program and data changes.

Data collection continues to evolve. The Navigator Case Management system managed by DSHS was updated to include data collected from the HCA Outpatient Competency Restoration programs. Historical OCRP data from Excel trackers was migrated into the NCM system at the end of July 2023.

[6] The *Trueblood* et al. v. Washington State DSHS website is available at: www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs .

The forensic navigator quarterly report dashboard is currently in the governance review cycle and the department intends to utilize this data dashboard in subsequent semi-annual reports. Similar dashboards are under development for the crisis housing voucher and the FHARPS programs.

In all public reports, client-level data is aggregated and suppressed when necessary to protect individual confidentiality. Additional data will be provided over time as data quality improves and the numbers served increase.

Longer-term Impact Analyses

RDA committed to assess the impact of Settlement Agreement activities on (a) substantial compliance timeliness metrics; (b) overall competency evaluation and restoration volume; and (c) related outcomes for current and former class members including:

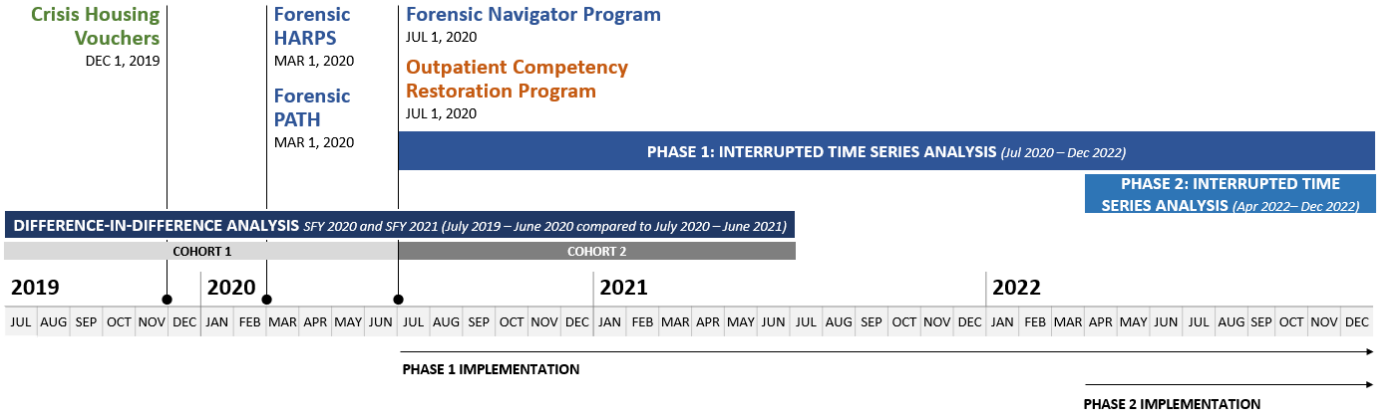
- Use of mental health and substance use disorder treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

Evaluations include assessments of the overall phased regional impact of Settlement Agreement components on outcomes through two methods: (1) an interrupted time series analysis to assess the impact of the Trueblood implementation programs on the number of competency referrals; and (2) a difference-in-difference analysis to assess impacts on behavioral health access and social outcome metrics. The interrupted time series was updated in Spring 2023 and findings for three analysis periods are included in this report. The difference-in-difference analysis will be updated as resources allow. Figure 1 shows the reference periods for the analysis previously reported, and the following sections outline the method and findings from each approach.

FIGURE 1.

Trueblood Evaluation Reference Periods

Trueblood Evaluation Analysis Timelines: Interrupted Time Series and Difference-in-Difference



Interrupted Time Series Analysis

RDA used an interrupted time series analysis (ITA) to compare order rates in Trueblood Phase 1 regions to the balance of the state (regions where new programs had not yet been implemented). ITA is a quasi-experimental design to evaluate the effects of an intervention (in this case the full set of regional Trueblood programs) by comparing outcome measures before and after the intervention.

Three iterations of the interrupted time series analysis have been completed, the most recent of which was in Spring 2023. Findings from each analysis are summarized below.

Analysis 1: First 9 months of full implementation, July 2020 to March 2021, included in the September 2021 report:

- No significant impact on orders - There was a small decrease in the rate of competency evaluation orders (not statistically significant) in Phase 1 regions compared to the balance of the state, no change in the rate of competency restoration orders, and no change in the rate of orders for other sub-populations (Trueblood in-jail orders and inpatient orders).

Analysis 2: First 18-months of implementation, July 2020 to December 2021, included in the September 2022 report:

- Competency Evaluations – There was a decrease in the rate of competency evaluation orders in Phase 1 regions of 1.6 per 100,000 residents relative to the expected rate. This was significant at p<.05.[7]

- Competency Restorations – There was a small increase in the rate of *overall* competency restoration orders of 0.59 per 100,000 residents relative to expected, significant at p<.05.

    - There was no significant impact on restoration orders for Trueblood class members.

- Inpatient Restorations – No significant program impact on inpatient restoration orders.

Analysis 3: The model was updated to allow for separate Phase 1 and Phase 2 analyses.

- Phase 1 period: First 30 months of full implementation, July 2020 to December 2022.

    - Competency Evaluations – There was a decrease in the rate of competency evaluation orders in Phase 1 regions of 1.5 per 100,000 residents relative to the expected rate, significant at p<.05. There was a similar decrease for Trueblood class members, p<.05.

    - Competency Restoration – There was no significant impact for competency restorations overall or for Trueblood class members.

- Phase 2 period: Nine months of partial implementation, April 2022 to December 2022 (note 3 of 5 programs were implemented by April; crisis housing vouchers and OCRP were not yet available):

    - Competency Evaluations – There was no significant impact on orders (similar to early findings for Phase 1)

    - Competency Restoration – There was a decrease in the rate of orders for competency restoration in Phase 2 region of 1.9 per 100,000 residents relative to the expected rate, significant at p<.0001. There was a similar decrease in orders for Trueblood class members, p<.0001.

        - Findings are based on limited data and two influential data points. Subsequent analysis may yield different results.

[7] p<.05 = a level of 95% confidence there is a statistically significant difference in Phase 1 regions compared to the balance of the state.

Overall, this extended analysis of the impact of these programs in the Phase 1 region showed similar impacts to the earlier analysis. The significant decline in Phase 1 competency evaluation orders remained, and there was no significant impact on restoration orders.

Early findings for Phase 2 King region showed no impact on competency orders and a significant decrease in restoration orders. The next analysis, expected in Spring 2024, will reveal if this impact is an artifact of a few data points or a consistent finding in King region.

Difference-in-Difference Analysis

Difference-in-difference testing detects significant differences in the rate of change between groups on specific metrics. Medicaid-enrolled people with a history of at least one competency order among Phase 1 regions and the balance of the state were compared on the rate of change for a series of outcome measures between Fiscal Year 2020 and 2021. Findings originally reported in the September 2022 report include:

- Mental Health Treatment: There was a significant increase in the rate of mental health treatment among people with at least one competency evaluation order in Phase 1 regions compared to the balance of the state at p<.0001.[8]

- Substance Use Disorder Treatment: There was an increase in the rate of SUD treatment among those with at least one competency evaluation order and SUD treatment need in Phase 1 regions compared to the balance of the state. This was approaching statistical significance at p<.0553. When the analysis was restricted to Trueblood class members (those in jail while awaiting competency services), the difference was significant at p<.05.

- No difference was found between Phase 1 and the balance of state on other outcome measures, including homelessness, incarceration, state hospital admissions, emergency department visits, or hospitalizations.

Overall, a larger proportion of people needing treatment in Trueblood Phase 1 regions are receiving treatment than those in other areas. This aligns with the intent to better address individual treatment needs through programs such as forensic navigators, Outpatient Competency Restoration, and FPATH. There were no effects detected on other outcomes. Impacting outcomes like homelessness and incarceration is more difficult to achieve given the complexities (e.g., individual, community, and governmental) that contribute to these issues, many of which are outside the influence of Trueblood initiatives. This analysis will be updated periodically as data and resources allow.

[8] P<.0001 = a level of 99.999% confidence in a statistically significant different in Phase 1 regions compared to the balance of the state.

Forthcoming: Individual Program Evaluation(s)
In the research plan drafted in January 2020, RDA estimated the first Settlement Agreement program evaluation utilizing a propensity-score matching method would be available no earlier than March 2022. This assumed sufficient study populations, with a minimum six-months of data in the follow-up period, seven months for data maturity, and at least two months for data integration, analysis, and reporting.

FHARPS will be the first program evaluated. Acquiring a sufficient pool of FHARPS participants followed by an adequate follow-up period to measure outcomes took longer than anticipated. Data are being compiled for the evaluation, which requires identifying appropriate matched comparison groups and utilizing multiple data sources with different lag times (that is, the time for the data to be complete). RDA expects to complete the FHARPS evaluation in Spring 2024.

Implementation Plan Elements

The sections that follow detail the 14 elements that serve as a services enhancement framework to implement Phases 1 and 2 of the Settlement Agreement.

Each element's report considers the following five items as they relate to the element specifically and to the Settlement Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) available data pertaining to the element. Data tables included in this report reflect data through June 30, 2023, with exceptions noted.

Competency Evaluation-Additional Evaluators

The Settlement Agreement required hiring 18 additional forensic evaluators over two years for Phase 1. Phase 2 did not have any requirements to hire additional staff; rather, the focus is on the amount of referral data and are enough evaluators hired to support this demand. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines for in-jail competency evaluations, evaluators can also be assigned to address the need of completing non-Trueblood forensic assessments (such as specialized forensic risk assessments for the NGRI population in forensic beds, not guilty by reason of insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state. Furthermore, with up-to-date forensic risk assessments, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity.

Current Status and Areas of Positive Impact

From July 1, 2019, to June 30, 2020, OFMHS hired 13 evaluators meeting the Settlement Agreement requirements for Fiscal Year 2020. In Fiscal Year 2021, OFMHS hired 10 additional forensic evaluators with start dates ranging from July 1, 2020, to June 1, 2021. Five of these positions were elements of the Settlement Agreement while the additional five evaluators filled pre-existing vacancies. With staff movement naturally occurring, as of June 30, 2023, 65 of the 77 positions are filled. Recruitment is occurring to fill the remaining vacancies with an emphasis on filling positions located in the east side of the state. Aided in part by OFMHS' training programs, WSH continues to staff clinical psychologists that complete civil commitment treatment reports for the court, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations). During the January-June 2023 reporting period, 69 FRAs were completed at WSH. Now that there is no longer any backlog of forensic risk assessments to complete at WSH, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. Additionally, OFMHS is working with ESH to have all forensic risk assessments caught up and on the same evaluation schedule as WSH. ESH completed 14 FRAs during the January-June 2023 reporting period; However, due to staffing challenges, the department is currently recruiting contractors to help have the new system in place as currently each patient has an FRA. The next phase, where annual updates will be completed, is now underway. This is in addition to continuing to recruit to fill vacant positions and the addition of two post-doctoral positions in the eastern region. While completion of risk assessments for the NGRI population at the state hospitals assists in vacating forensic beds that can be occupied by those in need of inpatient competency restoration services, completion of competency evaluations for class members remains prioritized over other types of evaluations, including forensic risk assessments.

Areas of Concern

In Fiscal Year 2023, Washington state had its highest number of referrals for all competency evaluations (6,794[9]). Compared to FY22, referral levels increased by an additional 302 orders and 4.7 percent, which is a significant slowdown in growth compared to the FY21 to FY22 39 percent year-over-year increase for all competency evaluation orders. This growth came despite the 12 fine-funded[10] diversion programs, three state-funded prosecutorial diversion programs that continued operating, and the statistically significant impact of Trueblood interventions demonstrated in the Phase 1 regions. Without these programs, demand for evaluations likely would have increased even more in the past. The arrival of COVID-19 in early winter 2020, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for months during the pandemic. Even after the criminal court system re-opened, COVID-19 infections continued to result in decreased in-person access to clients and fewer beds to serve our clients, especially with the Delta and Omicron variants. With those effects largely diminished, the competency system operates more normally now; however, occasional COVID-19 outbreaks continue to require constant vigilance.

Recommendations to Address Concerns

OFMHS continues developing and implementing telehealth resources for jails throughout the state. Establishing this technology in multiple locations around the state (especially in rural areas) allows OFMHS to conduct more evaluations, thereby helping to meet court-ordered requirements, making it easier for attorneys to be present for their clients' interviews, and minimizing lost productivity due to time spent on the road. As part of this initiative, OFMHS worked with IT to reorganize the telehealth committee, so that IT became a committee co-chair, taking a more active role in the process and more immediately responding to issues in the field. OFMHS' staff development and operations administrator has also assisted in staffing the telehealth committee and in becoming part of BHA's telehealth governance committee. This has increased information flow as well as allow for more communication pertaining to allocation of resources toward improved telehealth.

To date, OFMHS has reached out to all county jails in the state as well as tribal and municipal jails to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). Currently, additional jails with telehealth capacity on the west side of the state include the Nisqually Indian Tribe's Nisqually Corrections Center as well as city jails in Aberdeen, Enumclaw, Forks, Hoquiam, Issaquah, Kent, and Puyallup, SCORE in Des Moines (contracted with several cities and towns in King County and elsewhere in the state for local-level inmates), and county jails in Clallam, Clark, Cowlitz, Jefferson, King (King County

[9] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2023.
[10] The fine-funded diversion programs transitioned to longer-term funding sources or discontinued operations in a few instances. The programs continuing to operate do so under HCA oversight now for a second year (including both FY23-24) while receiving a bridge appropriation for from the state legislature.

Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and SCORE in Des Moines for county-level inmates), Kitsap, Pacific, Skagit, Skamania, Thurston, Wahkiakum, and Whatcom counties. Additional jails on the east side with telehealth capacity now include those in Benton, Ferry, Franklin, Grant, Klickitat, Okanogan, Spokane, Stevens, Walla Walla, and Whitman counties as well as the City of Sunnyside jail, and Yakima city jail. In addition, Airway Heights Corrections and the Colville Tribal Jail now have VTC capabilities.

Data-Competency Evaluation-Additional Evaluators

DSHS continues to use data from FDS to determine whether the evaluator capacity (current and funded increase) maintains substantial compliance with the injunction with respect to in-jail competency evaluations. Timeliness metrics are shown in Figure 2. Overall, compliance rates for jail-based evaluations remains high. Currently, data reflects that in June 2023, 92 percent of evaluation orders were completed within court-ordered time limits, with 92 percent of orders in the WSH catchment area and 94 percent of orders in the ESH catchment area completed within court-ordered time limits. Note, these numbers may continue to evolve as the good cause extensions ("GCEs") are recomputed based upon the court's order entered on September 7. During summer 2022, the compliance rate at ESH declined. The reasons for the decline in compliance on the east side were threefold: (1) near record high numbers of evaluation referrals; (2) staff vacancies; and (3) scheduling issues that involved new processes and working out telehealth connectivity disruptions. To address vacancies, robust recruitment has continued through fall 2022. While vacancies remain an issue, several new evaluators and other staff began positions throughout fall 2022, and evaluators assigned to westside evaluations have taken on extra work to help complete eastside evaluations, when possible. The recently bargained allowance for forensic contractors to assist in completing evaluations has allowed OFMHS to begin contracting as well. Furthermore, the scheduling issues have been addressed and are monitored to ensure disruptions to the evaluation process are minimized or a good cause exception is submitted. Improvements in these areas has resulted in substantial improvement in ESH's evaluation timeliness rate during fall 2022. ESH improved from 43 percent completed within court-order time limits in September 2022 to 94 percent in June 2023.

The department examined the number of orders filed by the courts between July 2018 and June 2023 and projected the number of evaluation orders through June 2027 using an exponential smoothing forecast model[11]. Data over the 12-month period corresponding to the start of the COVID-19 pandemic (March 2020-March 2021) was interpolated to account for pandemic-related effects. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood Agreement and Engrossed Substitute Senate Bill 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

[11] A statistical method designed to forecast future values (i.e., expected number of court orders) by weighting the averages of past known values.

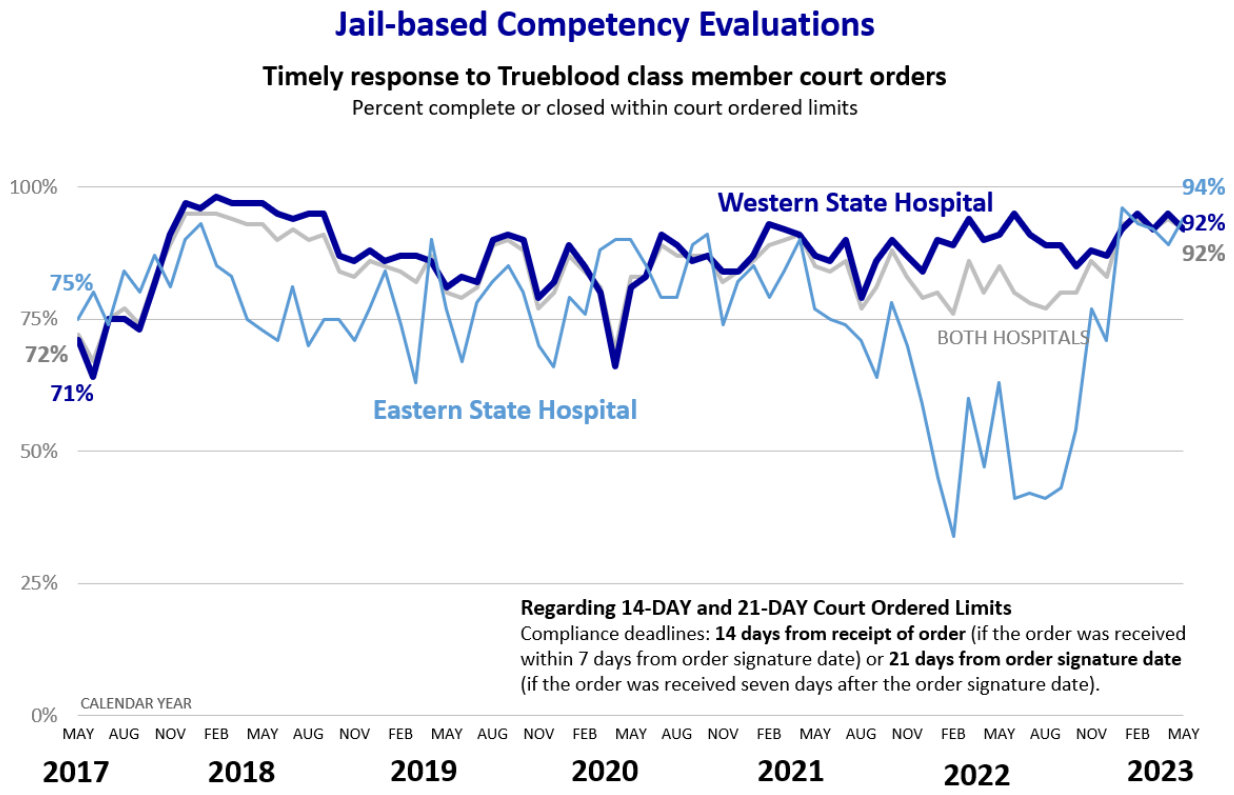
Projections indicate that the number of Trueblood competency evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 86.0 FTE in the FY2024 budget and 96.0 FTE in the FY2025 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, which may present evaluation capacity challenges in peak months. The department continues to monitor caseloads regularly, and during periods of increased demand, OFMHS management/staff prioritize jail-based cases. These calculations do not account for evaluations for forensic risk assessments (both initial evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks.

FIGURE 2.

Jail-based Competency Evaluations: Timely Response to Trueblood Class Member Court Orders

Percent complete or closed within court-ordered limits

MAY 2023



DATA SOURCE: FES modules in Cache database (WSH) and MILO database (ESH) and the Forensic Data System as of August 1, 2018.

Data-Competency Restoration-Misdemeanor Restoration Orders

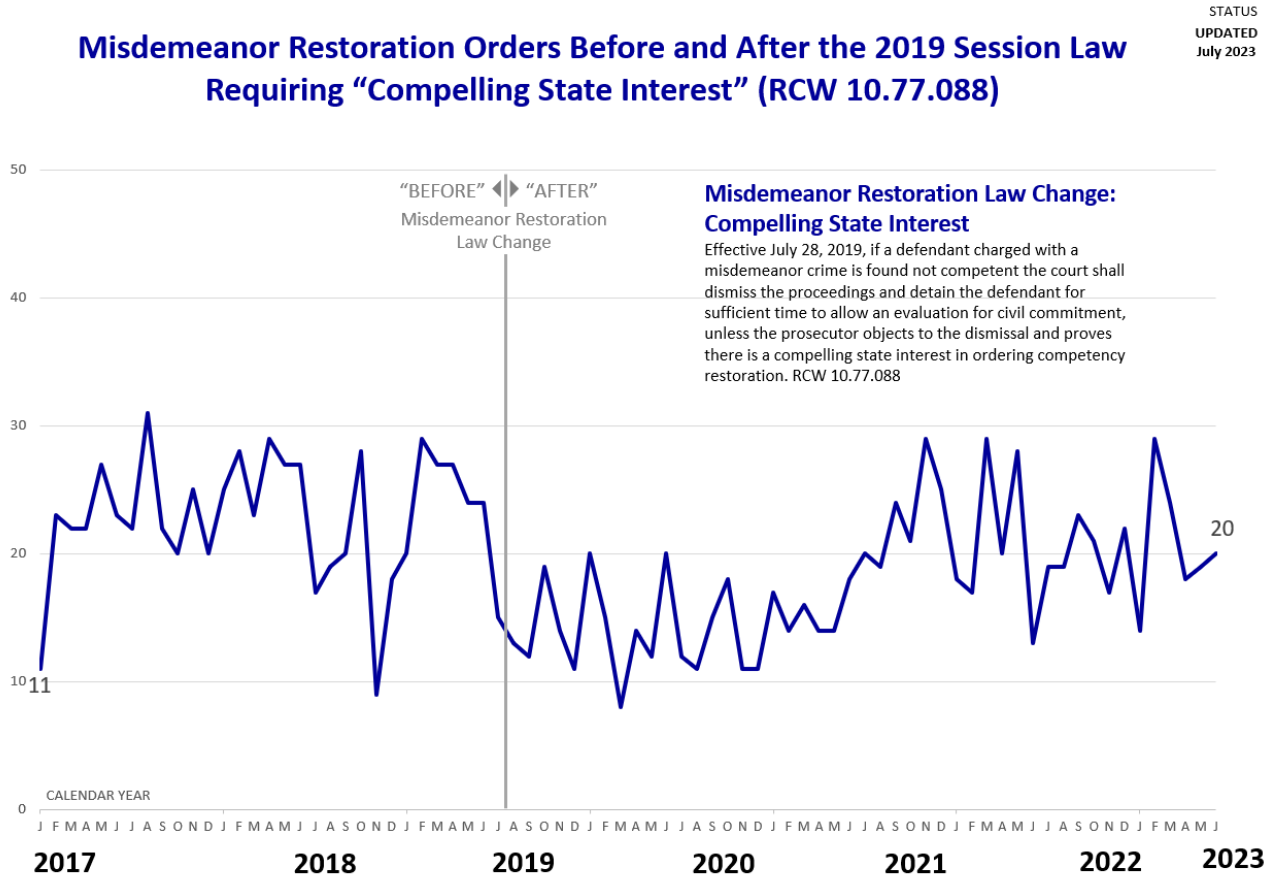
As part of the Settlement Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supports legislation toward this goal. ESSB 5444 was signed into law by the governor on May 9, 2019, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. These changes went into effect July 28, 2019. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. The department continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088). Misdemeanor restoration orders decreased slightly after the 2019 law change, but have recently returned to a level similar to the period before the law change. During the 24-

month period prior to the 2019 law change, courts issued an average of 23 misdemeanor restoration orders per month, which decreased to an average of 15 per month during the 24-month period after the law change. However, in the past six months (January 2023 to June 2023) the average returned to 21 orders per month. In June 2023, 20 misdemeanor restoration orders were issued statewide (Figure 3). The department continues its efforts to conduct outreach to the courts that refer the highest number of misdemeanor restoration orders and remains engaged in ongoing discussions with the Court Monitor and Plaintiff's counsel about how to reduce these referrals.

Note that in 2023, RCW 10.77.088 was amended by E2SSB 5440 (signed into law May 15, 2023, and effective July 23, 2023) to require the court to consider "all available and appropriate alternatives to inpatient competency restoration." This includes developing a diversion program for defendants charged with nonfelony crimes. The department will continue to monitor the impacts of this amendment on misdemeanor restoration orders.

FIGURE 3.

Misdemeanor Restoration Orders Before and After the 2019 Session Law that Required "Compelling state Interest" (RCW 10.77.088)



DATA SOURCE: Forensic Data System.

Competency Restoration-Community Outpatient Services

The Outpatient Competency Restoration Program element of the Settlement Agreement is managed by the Health Care Authority in collaboration with the Department of Social and Health Services. HCA administers OCRP through contracted providers as an option for courts to order community-based restoration services in a less-restrictive environment for defendants with appropriate acuity levels. The intent of OCRP is to provide competency restoration and ancillary community-based services to the individual closer to their home community. OCRP also offers emergent housing interventions in addition to connecting people with housing through Forensic HARPS and connects individuals to other community-based services such as vocational and behavioral health services.

Current Status and Areas of Positive Impact

Phase 2 OCRP services began Oct. 31, 2022, in the King region. OCRP contractors in Phases 1 and 2 are accepting outpatient restoration orders from courts in their regions and working with DSHS to communicate and certify when adequate space is available in each of the separate programs. In spite of workforce hiring challenges and some contractors experiencing vacancies in program staffing, these programs are still meeting the needs of those enrolled in the OCR program. HCA is working with all four contractors on ways to address their program's staff vacancies. As an example, HCA added additional funding for more competitive salaries for existing staff on July 1, 2023, and is continuing to review and revise education and experience requirements where appropriate.

Since inception of the program, the department and HCA have worked closely to identify and initiate program improvements to increase the efficacy of OCRP. These improvements include:

- A transition plan that aids the OCRP, FHARPS, and FPATH teams who may be working with enrolled participants to provide information related to OCRP groups, the element program providers' contact information, and applicable housing plans.
- DSHS and HCA continue to meet to review the findings and identify best practices.
- At a minimum, monthly case staffing events occur between Settlement Agreement elements to ensure communication and program coordination for people enrolled in multiple Trueblood programs.
- OCRP staff complete weekly meetings with forensic navigators and other Settlement Agreement elements, as applicable to review all people enrolled in OCRP services.
- The OCRP administrator, in conjunction with DSHS, has provided examples of how the Breaking Barriers Competency Restoration Program curriculum could be amended to be more culturally aware.

DSHS and HCA have piloted a project that allows residential treatment facility treatment teams to refer people to the Forensic Navigator Program to be re-assessed for suitability for OCRP services as an alternative to completing their entire restoration treatment in an inpatient facility-based program.

OCRP contractors in Phases 1 and 2 have housing units they can use specifically for people enrolled in OCRP. HCA continues working with Phase 1 and 2 OCRP contractors to increase OCRP-specific housing resources and to add master leasing. The Phase 2 OCRP provider plans to open two master-leased properties which will house OCRP participants, provide on-site breaking barriers courses, and include staffing outside of normal business hours.

Areas of Concern

Along with the other programs established through the Trueblood Settlement Agreement, OCRP has been rolled out through a phased approach and currently exists in 11 out of Washington's 39 counties. An article published in Advances in Psychology and Law states that research literature on outpatient competency restoration program efficacy is nascent, with most data being limited to internal evaluations rather than published research (Gowensmith, N. Murrie, D.C. (2022, pp. 215-239)[12]. At the same time, an analysis of outpatient competency restoration services from April 2017 provided some data regarding how many people a new OCR program typically serves. The analysis categorized OCR programs as "new" if they have been operating for fewer than 10 years and showed that new OCR programs serve approximately 50 defendants per year. In calendar year 2022, Washington state OCR programs served more than 50 people, keeping us in line with national trends for new OCR programs. There is great demand for OCR programming to expand and to serve more people than the national average for a new program. HCA has concerns that especially while out-of-custody restoration in Washington in its first 10 years of operations, if courts order more people into OCRP than programs have capacity for, OCR providers may move to terminate OCRP contracts and cease providing out-of-custody restoration in their region(s).

Recommendations to Address Concerns

DSHS and HCA must continue to communicate realistic expectations for an OCR program that has been operating for less than 10 years while working with OCRP providers to expand both within currently phased regions and into new regions.

DSHS and HCA will continue to engage court partners in discussions regarding the utilization of OCRP for clinically appropriate people. Contracted OCRP providers are included in collaboration and engagement activities in all Phase 1 and 2 regions and relationships continue to grow and develop among the programs. HCA and DSHS will continue to reach out to courts in the phased regions to include jurisdictions that may be less familiar with the option of outpatient competency restoration programming. HCA and DSHS will continue to work together so that Washington state's OCRP continues to expand in line with national trends.

HCA has provided additional funding to all Phase 1 and 2 OCRP contractors to increase staff salaries and has reviewed education and experience requirements to broaden hiring potentials.

Data-Competency Restoration-Community Outpatient Services

OCRP services began in Phase 1 regions on July 1, 2020, and Phase 2 King region began on Oct. 31, 2022. A key accomplishment since the last report was the migration of historical data from the program-level Excel data tracker into the Navigator Case Management system. This required

[12] Gowensmith, N., Murrie, D.C. (2022). Competence Restoration Amid a Widespread "Competency Crisis". In: Bornstein, B.H., Miller, M.K., DeMatteo, D. (eds) Advances in Psychology and Law. Advances in Psychology and Law, vol 6. Springer, Cham. https://doi.org/10.1007/978-3-031-13733-4_8

reconciling data discrepancies between data collection modes, file testing, and validation to ensure accurate migration.

Between July 1, 2020, and June 30, 2023, 152 clients were enrolled in OCRP Phase 1 regions: 45 in Pierce, 60 in Southwest, 35 in Spokane, and 12 in King (Appendix B, Table 1). Additional data by region are not reported due to the small number of cases, with the exception of length of stay (more on this below). Across regions, most enrollments were for felony restoration orders (81 percent) and participants were mostly male (74 percent), 30-49 years old (50 percent), non-Hispanic white (66 percent), and unstably housed or homeless (a combined 76 percent).

Of the 120 participants discharged, (Appendix B, Table 2), 41 percent were opined competent, 28 percent had their conditional release revoked, and 13 percent had their charges dismissed. Nearly two-thirds (64 percent) were in the community at the time of discharge, 16 percent were admitted to inpatient services at either a state hospital or a residential treatment facility, and 11 percent were in jail. Among those discharged, the average length of stay in OCRP was 71 days, ranging from 58 days in King region to 84 days in Pierce region. The average length of stay includes misdemeanor and felony orders and all discharge types (e.g., those who completed the program and were opined competent, and those who were returned to jail or whose conditional release was revoked).

Forensic Navigators

DSHS' Forensic Navigator Program seeks to divert criminal defendants out of jails and inpatient restoration settings, and into community-based restoration and treatment settings. Program participants are assigned a forensic navigator at the time the court orders a competency evaluation. For participants deemed not competent to stand trial and determined clinically appropriate for outpatient competency restoration, courts may elect to grant conditional release, so they can receive restoration services in the community.

Navigators work closely with the courts and jails in the pre-hearing phase to include meeting with program participants to interview, observe, and assess their willingness to participate in outpatient restoration services, if found not competent to stand trial. Navigators use client-reported information and gather records from OFMHS, jails, behavioral health agencies, and other agencies, as well as from registries and databases, to assist in fully informing the court in its determination of clinical appropriateness for outpatient restoration. Navigators may also gather substance use disorder information and seek information from family and other sources when the client has signed a release of information.

If the court finds that a person is suitable for outpatient competency restoration and agrees to order the client to outpatient restoration, forensic navigators continue to work with these participants. At this point, forensic navigators assist those clients in maintaining compliance with any conditions of release, assisting clients to attend their outpatient competency restoration classes, and encouraging their adherence to prescribed medications. Forensic navigators also work closely with OCRP, FHARPS, FPATH, and community-based mental health providers to coordinate continuity of care across all providers and programs. If the client is not ordered into outpatient restoration, navigators attempt to complete warm handoffs to inpatient facilities, jail mental health professionals, designated crisis responders, and other forensic services retain as many services as possible for their clients.

Current Status and Areas of Positive Impact

Forensic navigators remain in close contact with attorneys and outpatient competency restoration programs. Navigators have referred program participants in all three Phase 1 regions. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators facilitate eligible clients' connections to housing and recovery programs as well as to forensic peer services and case management supports even when class members are not ordered into outpatient restoration, and after the forensic navigator is no longer actively assigned to the client. As mentioned above, forensic navigators have also connected with both OCRP and RTFs to pilot a program that re-assesses clients on a second 90-day inpatient restoration order, who may be suitable for community restoration.

The Phase 2 navigators became fully staffed as of July of 2023 and continue making every effort to advocate for Trueblood class members in King County. The Phase 2 supervisor, Sejahdah Brimmer, has done an excellent job leading the staff, which has allowed the team to increase

communication with courts and attorneys. It is anticipated that as OCRP continues to increase its capacity, the navigators will be able to transition more clients into diversion options. Due to the large caseload average, the team will be adding five new forensic navigators to increase support for both clients and staff. The program staff has been essential in furthering refinement of program practices.

The navigator team has initiated implementation processes for Phase 3. The program is excited to be on track for getting staff hired, trained, and onboarded. It is anticipated that the team will be comprised of nine navigators, one supervisor and one administrative assistant throughout the Thurston, Mason, and Salish regions.

Additionally, the program will be expanding in its current regions with diversion navigators that will support clients who have had engagement with court and still need additional advocacy. As RCW 10.77.072 notes, the diversion navigator's role will be to divert individuals who have received two competency evaluations in the last 24 months where cases have been dismissed. Since these individuals are in custody for a new charge, the program seeks to engage with these clients before they receive another referral into the forensic competency system. The diversion navigator's goal is to connect with each client to complete the recommended diversion plan and provide the completed plan to all court parties.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one that primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not necessarily extend to a larger group of people for whom competency to stand trial has been raised, particularly those for whom a competency evaluation is ordered at or after their release from jail. Thus far, forensic navigators have also been serving those people. However, as the volume of clients grows, there may come a time when forensic navigators must prioritize their caseloads for class members. While the Forensic Navigator Program has had open communications and contact with stakeholders around this issue, it remains an area of concern voiced in various regions. Additionally, the level of agitation is centered around resources and diversion options. With the additions to our program roles included in House Bill 5440, the attention increases on how both components of the navigators will function within the court system.

Program staff continue to engage and inform prosecution, defense, and judges to develop a shared understanding of this new program. Meetings and discussions continue with prosecutors, defense, and courts in all three Phase 1 regions in partnership with HCA. While the program grows and awareness increases, outreach remains a necessity to enhance the referral process. Phase 2 outreach and engagement have been more consistent after learning from Phase 1 interactions. While courts, jails, and many attorneys have been understanding partners, because the program is in its infancy, defense attorneys have allowed minimal client contact across the county. The lack of access to clients in this region continues to be an issue as OCRP certification

of space continues to increase. The Forensic Navigator Program believes these issues will subside as the phase two region obtains more capacity with staff and housing.

DSHS and its service partners continue to work well together to maintain programmatic alignments. Communication between HCA and DSHS is consistent and efficient. With the addition of more diversion services and the new phase, the conversations will continue to occur frequently with HCA.

Recommendations to Address Concerns

It remains important to focus forensic navigator time and resources primarily on Trueblood class members, who await forensic evaluation or restoration services in jail, while simultaneously serving those who may not meet the definition of class member. In the King, Pierce, and Spokane regions, caseload prioritization requires focus on class members. Navigators will continue to conduct focused outreach to the courts on this topic in each region indicating the program's willingness to continue providing warm handoffs for this population to applicable agencies and entities in all circumstances, even when the forensic navigator is discharged and no longer actively assigned to the client. It is anticipated that the increase of resources and the additional diversion navigator roles will mitigate some of the resource concerns based on more availability of staff. It is the hope that the diversion staff will be able to support clients who face lower-level charges and connect them with resources earlier in the timeline.

Data-Forensic Navigators

A total of 5,124 people were assigned a forensic navigator between July 1, 2020 (program start) and June 30, 2023 (Appendix C, Table 1). This includes 2,224 people in King County, where forensic navigator services began in January 2022. The majority of people assigned a navigator were male (62 percent), over half (56 percent) were between the ages of 30 to 49, and nearly half (46 percent) were non-Hispanic white. Just under half (48 percent) were charged with a felony, and 52 percent were charged with a misdemeanor. This shift from a majority of felony cases to misdemeanors is attributed to the King region ramping up, where 7 in 10 people served by forensic navigators had a misdemeanor offense.

Forensic navigators worked to gather information for the courts for nearly all people assigned a navigator during the reporting period (99 percent, Appendix C, Table 2). Client meetings, interviews, or observations were conducted with 47 percent of people assigned a navigator. A recommended service plan was completed for 72 percent of people. Navigators provided coordination of care for 34 percent of clients overall, with a higher rate in Southwest (70 percent) and Spokane (51 percent), compared to Pierce (37 percent) and King (15 percent). Nearly one in three (29 percent) received a referral to other community services. Forensic navigator services in King County started prior to other Trueblood programs in the region. Navigator services and referrals are expected to increase as OCRP services expand and the program matures.

The most common types of referrals were for other Trueblood partner programs: 18 percent received a referral to the FPATH program and 16 percent received a referral to FHARPS.

A total of 4,743 people were discharged during the reporting period, with an average length of stay in the program of 39 days, ranging from 34 days in King region to 58 days in Southwest region (Appendix C, Table 3). About one-third (30 percent) of those were discharged with a warm handoff to provider or jail staff. Thirty percent of cases were closed because the person was determined competent, and 21 percent of cases were closed because the person was ordered by the court to receive inpatient restoration. Over one-third (33 percent) of the people in the Spokane region and one-quarter in King (24 percent) were discharged after they were released from jail on personal recognizance. Nearly one in four clients in King region (24 percent) had their charges dismissed.

Data for the program is collected through the Navigator Case Management system. The program continues to make improvements to data collection and data quality. The program and data collection continue to evolve. Note that the department has worked to develop a Power BI dashboard to track program data and illustrate trends. The dashboard is currently in the governance review cycle and the department intends to utilize this data dashboard in subsequent semi-annual reports.

Competency Restoration-Ramp Down of Maple Lane RTF

DSHS opened two RTFs to provide additional inpatient competency restoration services in 2016, the Yakima Competency Restoration Program and the Maple Lane's competency restoration program (Cascade Unit). In 2019 they opened a third RTF, Fort Steilacoom Competency Restoration Program. The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order.

Both YCRP and MLCRP were scheduled to close as part of the overall integrated system changes contemplated in the Settlement Agreement. Yakima was scheduled to close by Dec. 31, 2021 but closed on Aug. 14, 2021, due to difficulty recruiting and retaining staff through December 2021. The last patient transferred out on July 26, 2021. Maple Lane's Cascade Unit has a hard closure date of July 1, 2024. The DSHS positions at the Cascade Unit converted to permanent status on Dec. 16, 2021, providing the staff who stay until closure layoff rights. During the 2023 Legislature session, funding was secured to keep the building that houses MLCRP open permanently. Competency restoration services will end on June 30, 2024, along with the contract with WellPath. As of July 1, 2024, the Cascade Unit will be re-purposed for a different population. Cascade Unit's ramp down plan timeline was updated due to this change. As part of the Settlement Agreement, low median wait times for inpatient competency services can trigger an earlier closure. For the Cascade Unit, it is four consecutive months of a median wait time for admission of nine days or fewer.

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup is developing full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for Maple Lane's Cascade Unit. As stated above, the timelines were modified due to the DSHS positions being converted to permanent. The meeting on June 28, 2022, clarified the changes that needed to occur. Additional information on that meeting's outcomes will be reported in the future. Based on the closure of the Yakima restoration program, the current plans may be adjusted to reflect lessons learned from that recent closure. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations with two other RTFs opening on the same campus during the time of the ramp down of the competency program. As of July 2023, staffing has consistently remained around 75 percent of DSHS positions filled. Currently, the director of forensic RTFs is working on reallocating the positions to institutional counselors, to be consistent with the other RTFs on that campus and increase retention.

Recommendations to Address Concerns

DSHS continuously monitors turnover, morale, and other factors, and actively takes steps to neutralize negative affects at Maple Lane's Cascade Unit now that Yakima has closed. Given the potential variability in closure dates due to agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient discharges. Additionally, our contract oversight of the contractor at the Cascade Unit will focus on the contract requirements to ensure sufficient staffing. The residential services manager works closely with the director of residential treatment facilities on staffing challenges for the DSHS side of operations at the Cascade Unit. As of late fall 2022, two changes have been made: recruiters have expanded where open positions are advertised, and all DSHS positions have been made permanent. The director of RTFs is currently working on reallocating the staff to be consistent with the two other DSHS programs opening on the Maple Lane campus starting in December 2022. In January 2023, the Cascade Unit entered a contract with Centralia College to offer a practicum for its students in the college's Behavioral Health program. Staff from the Cascade Unit attended a job fair in early January and received a few applicants from that job fair.

Data-Competency Restoration-Ramp Down of Maple Lane RTF

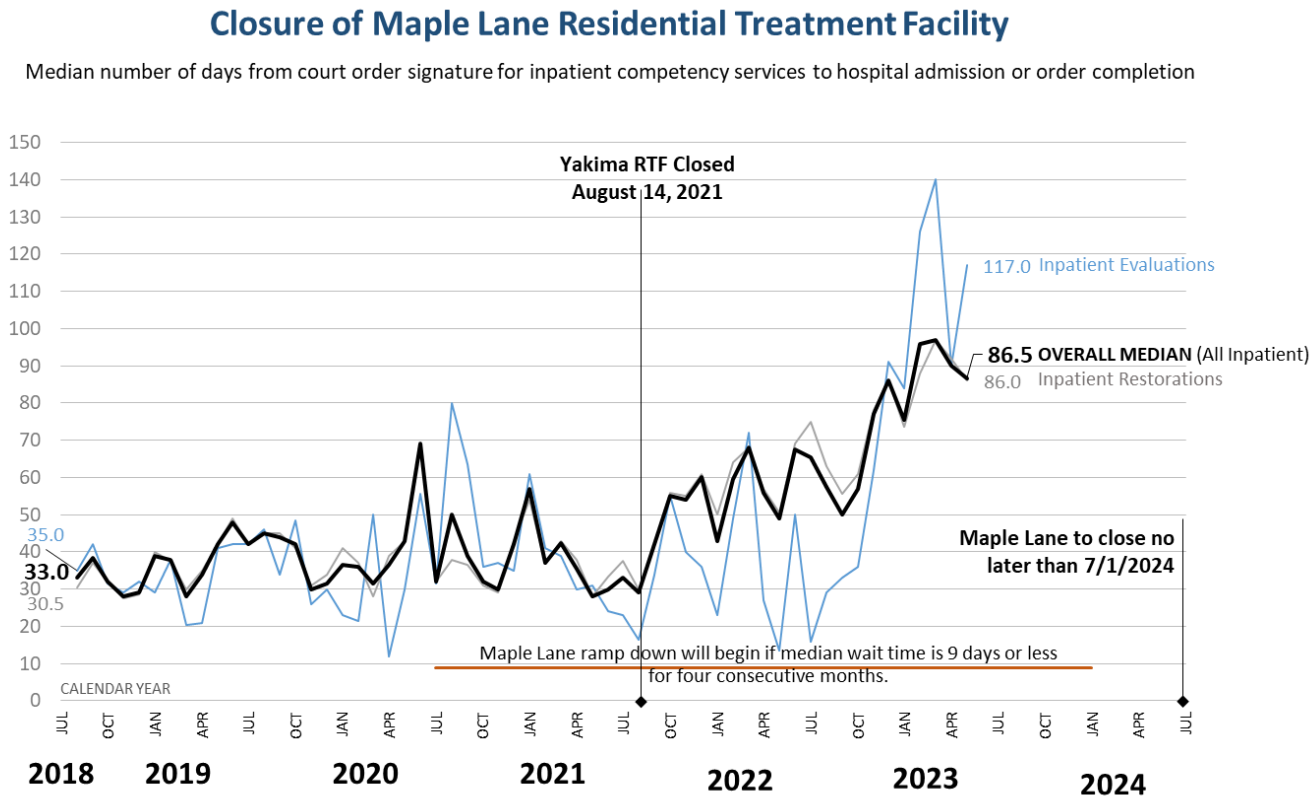
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services monthly (Figure 4). As of July 2023, the median wait time for inpatient competency services in May 2023 was 86.5 days. The ramp down of Maple Lane's Cascade Unit will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 4.

Closure of Maple Lane Residential Treatment Facility

Median number of days from court order signature for inpatient competency services to hospital admission or order completion

JULY 2023



DATA SOURCE: BHA Forensic Data System.

MEASURE DEFINITION: The median wait time represents the number of days from the beginning of a period of waiting in jail for competency services to order completion among orders completed in the specified month. Includes all inpatient competency evaluation or restoration orders for individuals waiting for services in jail. The order is completed when the individual is admitted for inpatient services, or when the order is dismissed, withdrawn or when the individual is physically released from jail (e.g., on personal recognizance or work release). Includes admissions to WSH, ESH, Maple Lane's Cascade Unit, and Yakima Residential Treatment Facilities.

Crisis Triage and Diversion-Additional Beds and Enhancements

Trueblood funds were provided to increase crisis bed capacity in Phase 1 and Phase 2. Crisis stabilization/crisis triage facilities are residential treatment facilities that are licensed through the Department of Health to provide short-term clinical interventions in a safe, structured environment, and to offer support and behavioral health crisis stabilization services to individuals that are experiencing a behavioral health crisis. The services provided in these facilities are short term, usually 23 hours or less, but on an as needed basis; care can be extended for up to two weeks.

In Phase 1, Trueblood enhancement funding was provided to crisis stabilization facilities for the enhancement of services and to ensure usability for individuals experiencing a mental health crisis who are interacting with law enforcement or other first responders.

In Phase 2, enhancements provide support for individuals throughout the region both in a facility and in the community. Trueblood funding was provided to improve and update facility technology at Downtown Emergency Services Center as well as enhance a telehealth system, so that individuals in crisis have additional options to communicate with a behavioral health specialist. Funding was also provided to increase staffing.

Current Status and Areas of Positive Impact

Additional Crisis Beds – Spokane Phase 1

HCA worked with the Department of Commerce to expand bed capacity in the Spokane region by adding 16-crisis stabilization beds and creating the Spokane Regional Stabilization Center. The SRSC was designed to provide alternative options for law enforcement and other first responders when interacting with individuals demonstrating a behavioral health crisis whose behaviors did not meet the threshold of arrest and would benefit from behavioral health support. SRSC reports that during calendar year 2022, they served a total of 1,012 individuals with a patient service satisfaction rate of 4.72 (1 = Very Dissatisfied, 5 = Very Satisfied).

Additional Crisis Beds – King Phase 2

In accordance with the Phase 2 Settlement Agreement, the state requested funding from the legislature to support the creation of two additional 16-bed crisis facilities for the King region.

The Department of Commerce entered into a contract with Recovery Innovations International on June 30, 2022, for one of the two King County crisis stabilization facilities. RII identified a $1.6 million shortfall in their previously estimated budget for this facility in October 2022 and received a direct appropriation of $1.9 million on July 1, 2023. As of August 2, 2023, RII has not begun construction. The Department of Commerce is currently working on amending its contract with RII to incorporate these funds and include updated timelines with deliverables.

ConnectionsWA is now under contract with the Department of Commerce. Negotiations with the landlord for the intended property took longer than expected. ConnectionsWA was able to meet the deadline for construction to begin by June 30, 2023 and construction is underway.

Areas of Concern

The implementation plan required that two crisis stabilization facilities be under contract with the Department of Commerce by June 30, 2022, and that they begin their construction in King County by December 2022. ConnectionsWA began construction but RII has not. RII has been under contract with the Department of Commerce but did not start construction by the deadline of December 2022 due to a gap in funding. RII continues to express concerns about the sustainability of a crisis stabilization facility despite having described in the response to Department of Commerce's RFP how the facility would be sustainable for a minimum of 15 years.

Recommendations to Address Concerns

To address the concerns indicated above, HCA and DSHS will:

- Work with RII to meet the updated timelines and deliverables established by Department of Commerce through amendment.

- HCA is working to update how reimbursement rates affect the sustainability of crisis stabilization facilities in order to better support providers like ConnectionsWA and RII when standing up these kinds of facilities.

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 1

Successes at Lifeline in Southwest region include hiring two full-time MHPs and one part-time MHP to support the unit. The facility reports this has greatly improved their ability to provide more enhanced individual and group sessions. Lifeline reports that since opening in 2020 they have served 2,073 individuals at CTS. They have been able to discharge 68 percent of those served to behavioral health support, voluntary SUD treatment, or other services in the community. Lifeline reports that 56 percent of those discharged have completed treatment, and they report having only 4 percent of people discharged into the community "against medical advice."

The Spokane ASO worked with Pioneer Human Services to implement stabilization services at the Spokane Regional Stabilization Center for people identified as potential Trueblood class members. PHS also reports continued success in providing 24/7 stabilization services that people can access through first responders, with positive feedback from both clients and referents.

Recovery Innovations International in Pierce region reports that both of their facilities have been instrumental in connecting/reconnecting clients with community-based outpatient services for both behavioral health and substance use disorders including through Trueblood Settlement Agreement program contractors at Greater Lake Mental Health and Comprehensive Life Resources. The program supervisors also continue to partner with the Tacoma Rescue Mission, Nativity House "Fresh Start," and "Where Do they Go" programs for coordination of services and comprehensive discharge planning.

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 2

The total number of clients served increased during the last quarter. King County BHASO reports a SUD supervisor has been hired, onboarded, and is currently working alongside the Crisis Diversion Facility Program Manager on hiring the SUD frontline staff positions. Other staffing changes that occurred during this reporting period were mainly due to multiple waves of COVID-19 outbreaks that affected staff members. The Crisis Solutions Center has been working closely

with the designated public health investigator and continues to follow safety precautions, routine symptom screening for staff and clients, conduct frequent sanitation procedures as well as continue to require all staff to wear PPE.

Areas of Concern

Lifeline Connections reported some service gaps in getting people appointments in the community in a timely manner after discharge. They also report hiring for night shift positions has been challenging.

The Spokane region reports continued obstacles in finding and retaining staff, particularly RNs and behavioral health clinicians.

King County BHASO reports there is an identified shortage of applicant responses to advertised job positions and reports only a fourth of their MHP positions are filled. As a result of program evaluation and to improve employee retention, the Crisis Solutions Center has been working on increasing wages during the first quarter. As a result, they report an increase in qualified applicants and will continue to offer premium pay for shift coverage.

King County BHASO reports there is an identified shortage of applicant responses to advertised job positions, which has led to less than 25 percent of their MHP positions being filled. As a result of program evaluation, the Crisis Solutions Center increased wages during the first quarter. As a result, they report an increase in applicants overall but have not seen any change in MHP applicants.

Recommendations to Address Concerns

To address the dynamic nature of the crisis service provider network, HCA staff have engaged in relationship building with crisis provider organizations within the region and through the accountable communities of health as well as the supportive regional partners. HCA staff will continue to provide technical assistance and resources as implementation progresses, including linking these providers with resources and making them aware of related initiatives that will further support strong crisis service systems.

At this time, Lifeline has identified a possible solution to their current workforce challenges. They report working to stop using agency workers and hire more Lifeline Employees.

The SCRBH is working with Pioneer Human Services to address their workforce concerns. Prospects and strategies are reported to include collaborating with universities and dual-licensure staff, pending contract with Eastern Washington University.

The Crisis Solution Center hopes the addition of premium pay will result in an increase of MHP.

Data-Crisis Triage and Diversion-Additional Beds and Enhancements

Additional crisis triage and stabilization beds and enhancement to services (e.g., accepting police drop-offs to serve persons in mental health crisis) may divert some people from arrest and incarceration. HCA will provide information on the date, location, and number of beds added. Data on crisis housing vouchers distributed by crisis triage and stabilization facilities is included in the Crisis Triage and Diversion-Residential Supports section and (Appendix D).

Crisis Triage and Diversion-Residential Supports

Residential supports connect people with shelter-based, transitional, and permanent housing through peer support and housing subsidies, which cover application fees, security deposits, several months of rent and/or rental arrears, as well as necessities. This model also fosters engagement with staff who have lived experience with recovery and who are certified to provide peer supports.

Current Status and Areas of Positive Impact

FHARPS teams receive referrals from forensic navigators, Outpatient Competency Restoration Programs, Forensic PATH, crisis stabilization facilities, outpatient behavioral health agencies, family members, and from self-referrals. Teams work in tandem with clinical and outreach staff to enroll, house, and provide targeted supports and housing voucher subsidies to unstably housed people who have had engagement with the forensic mental health system. Once enrolled, FHARPS teams also refer participants to supported employment programs as well as medical, dental, and other housing and community-based resources in their local communities.

HCA allowed FHARPS providers to request exemptions to policy when participants are clinically unique, are engaged in the program, and might otherwise re-enter the criminal court or forensic systems if no exception is granted. These extensions allow people to access more housing voucher funds and continue to receive housing supports for longer than an initial six-month period. This increases a participant's likelihood of obtaining permanent housing solutions, and during Q4 FY23, an additional 45 requests for exceptions to policy were approved by HCA.

FHARPS providers are engaged in multiple master leasing projects with the majority of dedicated units existing in Pierce County. Pierce County providers have access to over 60 units and the units fill quickly when they become vacant. Most participants move into master leased units from initial shelter-based placements including hotels and motels. However, some people can move directly into these units from time of enrollment, whenever units are available, which may account for a small decrease in the percentage of initial shelter-based housing placements at intake this past quarter.

HCA and Metropolitan Development Council in the Pierce region mutually terminated the FHARPS contract at MDC effective Jan. 31, 2023. The Pierce region's other FHARPS provider, Comprehensive Life Resources, assumed the funding for MDC's team, which allowed two FHARPS teams to continue serving the region. CLR offered to interview any FHARPS staff member from MDC for their new positions and began hiring in March 2023. Although not fully staffed, CLR reports they have hired for most of the new positions and were able to schedule intakes for an increased number of FHARPS participants in April and May 2023.

The Phase 2 FHARPS teams began providing services in the King region on April 12, 2022 and continue to experience staff turnover and workforce shortages. HCA met with the FHARPS provider to discuss staff shortages and worked with the agency to add retention, sign-on, and

referral bonuses for FHARPS staff beginning July 1, 2023. The FHARPS program in Phase 2 receives most of its referrals from forensic navigators, unlike other regions where FHARPS teams have experienced increased referrals from other community partners. HCA believes this practice is more in line with the purpose of the program and has encouraged the team to continue to work closely with the forensic navigators in their region. FHARPS data for Phase 2 will reflect this, showing most referrals to the program have come from FNs, as well as a difference in location of first contact with eligible participants.

Emergency Housing Vouchers

Because there are no licensed crisis stabilization facilities currently located in the King region, HCA and the King County BHASO have made crisis housing vouchers available to programs that provide hourly crisis services. King County BHASO reported the vouchers are now available through Downtown Emergency Services Center's Community Outreach and Advocacy Team program, Navos' Adult Crisis Services, and Valley Cities' Adult Crisis Services and Assisted Outpatient Services teams. DESC, COAT, and Valley Cities Assisted Outpatient Services are currently the only programs that have used the vouchers. King County BHASO held support meetings with each provider to identify more ways to support the teams in utilizing this resource. There has been an increase in utilization of crisis housing vouchers in Q4 FY23; however, outpatient teams continue to report the need to assess for a multitude of dispositions, which may not always include the use of crisis housing vouchers when carrying out hourly crisis work.

In Phase 1 regions, utilization of crisis short-term vouchers increased after Recovery International's Recovery Response Center reopened in the Pierce region's City of Fife. HCA added $77,000 in additional crisis housing vouchers, which may be used at either of RII's Pierce region facilities. Lifeline's crisis stabilization facility utilizes the most crisis housing vouchers in the Phase 1 regions and had completely exhausted funding before FY23 ended. HCA was able to add an additional $10,000 at Lifeline and the crisis stabilization facility continued to issue vouchers up until the fiscal year-end.

In meetings between HCA, FBH in Spokane, and King County BHASO, reasons for lower levels of utilization by hourly crisis teams have included the fact that hourly crisis teams are often assessing people who are currently experiencing behavioral health crises, whereas crisis stabilization facilities use crisis housing vouchers after a period of treatment and stabilization within the stabilization facility. Because of this difference in scopes of work, dispositions of people contacted by crisis hourly service staff is more varied than dispositions of people discharging from facilities, and may include need for civil detainment, emergency department referrals, and other crisis interventions.

Areas of Concern

HCA began directly addressing the impacts of COVID-19 on FHARPS teams in October 2021 and was particularly interested in how increased COVID-19 infections in a region could affect the

level of face-to-face services provided by an FHARPS team. As the number of COVID-19 cases decreased in Phase 1 regions over the last year, HCA saw the number of face-to-face services increase in each of those regions. HCA also added metrics for success in contract deliverables for FHARPS teams in the Phase 1 regions that included corresponding levels of payments, which increased as the number of face-to-face hours increased. Each of the Phase 1 FHARPS teams met the highest possible metric for face-to-face, direct service provision in FY23. As of June 30, 2023, HCA has stopped tracking face-to-face services for FHARPS teams.

Master leasing, as an available housing intervention, has unique challenges as well as unique benefits. FHARPS programs with the most available master leased units, reported increasing difficulty remaining in line with the principles of SAMHSA's permanent supported housing model, particularly in keeping services and housing separate. Teams with increased numbers of master leasing units find themselves operating more and more in the capacity of a landlord and have requested additional support to keep services and housing separate. The decreased ability to keep housing and services separate as well as the decreased community integration of housing in master leasing properties are important considerations when offering master leasing.

HCA has hired a Trueblood Master Leasing program manager and worked with a national technical assistance agency to create a Master Leasing Toolkit. The toolkit includes an environmental scan of current and historical behavioral health agencies and programs which have employed master leasing as a housing option. The completed toolkit, environmental scan, and literature review will help to inform policies and procedures for FHARPS and other HCA housing programs, which will address barriers housing programs have faced while engaged in master leasing.

Recommendations to Address Concerns

Hourly crisis teams assess people who are currently experiencing behavioral health crises and show decreased use of crisis housing vouchers in an outpatient setting, while inpatient facilities use CHVs after a period of treatment and stabilization. As a result, it may be beneficial to widen the scope of facility types that could access crisis housing vouchers.

HCA hired a Trueblood Master Leasing program manager and worked with a national technical assistance agency to create a Master Leasing Toolkit. The toolkit includes an environmental scan of current and historical behavioral health agencies and programs that have employed master leasing as a housing option. The completed toolkit, environmental scan, and literature review included will help to inform policies and procedures for FHARPS and other HCA housing programs, which will address barriers and approaches to address barriers that agencies may face while engaging in master leasing.

Data-Crisis Triage and Diversion-Residential Supports

Residential supports are provided through two mechanisms: (1) crisis housing vouchers provided by crisis triage and stabilization facilities; and (2) the FHARPS program. The collections

continue in Excel tracker workbooks while HCA works to implement the alternative forms-based collection. The FHARPS program was the first to transition to this system in August 2023. Data processes will be updated to report data from both sources in the next semi-annual report.

Vouchers Data

The crisis stabilization and triage facilities and provider teams contracted with HCA to provide housing vouchers distributed 580 vouchers to 443 people between Dec. 1, 2019, and June 30, 2023 (Appendix D, Table 1). Vouchers were available in the Phase 2 King region beginning July 2022, and King region data is included for the first time.

Southwest (accounting for 38 percent of vouchers) replaced Spokane as the lead region in voucher distributions. The Southwest region also served the largest portion of people receiving vouchers (41 percent). The total amount disbursed across Phase 1 regions was $564,772 and the average amount per recipient was $1,275. Due to vouchers now being distributed both by CS/CT facilities and within the community, the 'referral source' can mean either how the individual was referred to the CS/CT facility or to the community entity distributing housing vouchers. Self-referrals and hospitals accounted for nearly two-thirds of the referrals among those receiving vouchers (35 percent and 30 percent, respectively).

Most voucher recipients were male (68 percent), between 30 and 39 years old (56 percent), and non-Hispanic white (66 percent).

Based on matching crisis housing voucher recipients to those within the FHARPS program data, 25 percent of voucher recipients were referred to FHARPS, 23 percent were contacted and enrolled, and 20 percent were housed or sheltered by FHARPS. Most initial housing placements through FHARPS were shelter/emergency placements (85 percent), which included motels.

Not all voucher recipients are eligible for FHARPS, and providers appear to be pre-screening cases to determine program eligibility. The discharge planner toolkit also assists in identifying appropriate community resources, which results in fewer referrals of ineligible people to FHARPS. This process allows FHARPS teams to focus resources on eligible cases and directs individuals to appropriate supports more quickly. Information on subsequent housing information for those receiving crisis housing vouchers is limited to those who transition to FHARPS support.

FHARPS Data

The FHARPS program expanded to Phase 2 King region in April 2022. A total of 1,621 individuals were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to June 30, 2023 (Appendix E, Table 1). Of these referrals, 1,105 (68 percent) were contacted[13] and 980 (60 percent) were enrolled.

Contact and enrollment rates vary in part due to data entry practices. Spokane region enters all referrals in the Excel trackers, while other providers enter referrals that result in a contact or program enrollment. The King region also operates differently because it is focused on Trueblood class members awaiting competency services in jail who are referred by forensic navigators. Given the differences in program processes and data entry practices, comparisons across FHARPS regions are not appropriate.

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 60 percent of recorded referrals. Forensic navigators made the most referrals, 35 percent overall, and comprised 99 percent of referrals in King region. FPATH referred 14 percent and crisis stabilization and triage facilities referred 9 percent.

Most initial contacts were made by phone (38 percent). This method of contact is down substantially from 74 percent in yearend 2020, when outreach methods were limited due to COVID-19 protocols. King region contacted 80 percent of referrals, with 99 percent of these initial contacts occurring in jail.

More than two-thirds of people (69 percent) enrolled in FHARPS were male, 57 percent were between 30 and 49 years old, and 50 percent were non-Hispanic white. One-quarter of participants (25 percent) identified as Black or African American and 10 percent as Hispanic or Latino. Individuals can identify as more than one race or ethnicity. Most people were homeless at the time of enrollment (59 percent).

Of those enrolled, 78 percent were housed or sheltered at least once since their enrollment (Appendix E, Table 2). About 55 percent of first housing types were emergency/shelter placements, which included motels. This is down from 68 percent at year-end 2021. There was simultaneously an increase in transitional housing from 23 percent at year-end 2021 to 36 percent as of June 30, 2023, due in part to an increase in the use of master leasing options and King region utilizing mainly transitional housing placements.

The King region has a lower rate of people housed or sheltered compared to other regions. This is likely due to enrollments in jail and that the King region mostly uses transitional housing rather than emergency placements. Those enrolled could still be incarcerated, may transfer to

[13] Attempted contacts are not counted as contacts in the data. Many persons referred to this program are challenging to contact due to lack of stable housing and lack of phone. Not everyone referred to the program is eligible to receive services.

inpatient treatment, may be released into the community and fail to reconnect with the program, or may be awaiting placement in transitional housing through the program.

Seven in 10 people enrolled between March 2020 and June 2023 were discharged as of June 30, 2023, with an average length of support of 209 days, ranging from 42 days in King region to 228 days in Spokane days (Appendix E, Table 3). The average total subsidy support received by those discharged was $6,493.

Among people discharged, 27 percent of cases were closed due to loss of contact, 16 percent transitioned to other housing support, 14 percent transitioned to self-support, and 14 percent withdrew. Another 9 percent had received the maximum assistance and were discharged without transition to other services. At the time of discharge, about one-third (34 percent) were stably housed, 13 percent were homeless, and 12 percent were in a facility. Housing status at program discharge was unknown for 33 percent of people (similar to the loss of contact rate).

Crisis Triage and Diversion-Mobile Crisis and Co-responders

In Washington, crisis services are provided statewide 24 hours per day, 365 days per year, under HCA's contracts with regional behavioral health administrative service organizations. Mobile crisis response is an integral part of the regional behavioral health crisis system and provides community-based services to people experiencing, or at imminent risk of experiencing, a behavioral health crisis. MCR offers law enforcement and first responders an option for diverting people from the legal system while providing community-based interventions supporting people through least restrictive community-based behavioral health options intended to support and stabilize acute symptoms.

Washington state's mobile crisis model, under the guidance of the HCA, uses SAMHSA's evidence based best practice of working to redirect the current trend of use of DCRs and/or law enforcement and is working to address crises at the lowest-level threshold of care. The importance of mobile crisis services can be seen in the governor's most recent budget, where under his leadership, and for the last two budget biennia, the legislature has passed a variety of provisos and bills related to strengthening the core of client crisis care to include mobile crisis.

According to contract, MCR teams are required to meet a response time of two hours or less. The three Phase 1 regions report that the majority of their MCR teams have response times within a 90-minute mark. During contract negotiations with King County BHASO, it was reported that for emergent calls, their window of response also was of 90 minutes or less.

Current Status and Positive Impacts

Under the Trueblood implementation plan, HCA sought to enhance the regional MCR service provision by working with the BHASOs to identify needed enhancements to support the implementation plan's goals. These enhancements as listed below are designed to support and provide supplemental assistance to traditional MCR services. Additional changes and enactments as provided from the state included funding for:

- Enhancements in the form of administrative support and leadership positions have provided increased capacity for mobile crisis teams to engage in more regular communication with community partners this past quarter. This has allowed for community partners to have a more consistent ability to reach out for case consults, feedback, education/training, and overall avenues of communication and coordination of services.

- The state has also provided additional funding to expand traditional MCR services with the creation of HB1477.

The enhancements in the three Phase 1 regions were funded to provide a timelier response for people in the community who were experiencing a crisis and to work collaboratively with law enforcement, co-responders, and other first responder teams to accept referrals and thereby divert from arrest. Trueblood-funded MCR enhancements during the Phase 1 schedule have included:

- Increased staffing
- Increased service hours
- Expanded MCR service delivery area
- Increased coordination with law enforcement

Spokane Region
The Spokane BHASO holds the regional MCR contracts. Their contracted service agencies are Frontier Behavioral Health and Adams County Integrated Health Care Services.

- Frontier Behavioral Health utilized MCR enhancements to expand MCR services outside of Spokane County to better assist with and address the needs of neighboring rural counties. FBH continues to actively work to provide community outreach and education to promote awareness for the MCR program in Spokane County.

- Adams County Reports that enhanced MCR services have assisted the needs of their rural communities by providing a more efficient way of dealing with crisis and with individuals that meet criteria by meeting them where they are, in community settings. They report that being able to provide this level of services in this way addresses crises with more resources that can aide people in their current situations.

Adams County's MCR is responding to daytime calls and requests from community entities and remains available to address questions and concerns that may arise during these hours. They report that they are hoping to be more mobile next quarter and will work to continue to meet people where they are, to break the barrier of transportation to their facility and the inconveniences of emergency department visits. Adams County has also educated schools on appropriate referrals and joined with them in order to be more present and available when needed.

Pierce Region
Pierce Beacon has changed to Carelon Behavioral Health/Multicare and provides MCR services in the Pierce region with MultiCare Behavioral Health's mobile outreach crisis team to provide crisis outreach services. Their main objectives in enhancing MCR services were the following.

- Reduce response times
- Expand services to increase in-person response to rural areas
- Increase follow up services
- Provide community training and education.

Southwest Region
Three community agencies provide mobile crisis services: Sea Mar Adult Mobile Crisis Intervention in Clark County, Comprehensive HealthCare in Klickitat County, and Skamania County Community Health in Skamania County.

The sheriff's office in Skamania continues to use enhanced MCR services as a resource when they determine they do not need to hold someone themselves for mental health reasons or the person does not need to be transported to the hospital. They also submit referrals for individuals when they or a family member is concerned about safety and it is not appropriate for law enforcement to intervene.

Carelon Behavioral Health continues working to reestablish crisis services with a new contractor in Klickitat County.

In Phase 2, the King County BHASO enhanced its existing mobile crisis response system by adding new positions to the current staffing structure.

Mobile crisis teams in King County continue to provide services to all of King County on a 24/7 basis. King County BHASO reported that senior leadership recently updated North, South, and Central boundary lines within the county to determine which sites will respond to particular locations based on distance, as a way to reduce response times. They also report they have begun piloting and will continue to establish touch point sites as a method to not only engage with law enforcement but also cut down on response times to more rural locations.

<u>Areas of Concern</u>
There are no areas of concern that this time.

Recommendations to Address Concerns

Mobile crisis response has moved from the Trueblood team to Adult Services and Inpatient Treatment division and will be funded under HCA's maintenance budget.

Data-Crisis Triage and Diversion-Mobile Crisis and Co-responders

Spokane Region:

FBH and Adams County IHCS's MCR continue to work diligently on coordinating with co-responders/first responders monthly to provide updates on processes to divert arrest and provide least restrictive alternatives to individuals by connecting them with resources and decreasing the barriers that lead to high utilization rates. MCR staff have developed law enforcement referrals and are contacting these individuals to engage them in services that will aid in reducing and diverting arrests. FBH's MCR has had continued success in utilizing the Mental Health Coordinator at the Spokane Police Department in the downtown precinct when appropriate to coordinate joint efforts with law enforcement teams. Internal program referrals and communication have continued to be effective and the focus this quarter has been on implementation of an MCR Triage phone to expand access for external referrals through local law enforcement by creating a main point of access to the team during working hours that would allow both follow-up as well as coordinating on scene with a client when appropriate.

Pierce Region:

The teams report they have presented to Pacific Lutheran University twice, Tacoma General Hospital twice and South Sound 911 once. They report response by phone call averaged 8.6 minutes over this reporting period beating their goal of 15 minutes. Face-to-face response averaged 60 minutes for the MOCT team beating their goal of responding in less than 120 minutes. Additionally, the DCR face-to-face response averaged 122 minutes, coming close to their goal of responding in less than 120 minutes. Pierce reports they continue to respond to all rural areas within Pierce County, and that they have averaged 291 follow-ups with individuals seen in crisis.

Southwest Region:

Trueblood enhancements funds have helped expand existing MCR services by providing additional funds for staffing. Sea Mar AMCI is currently maintaining a coverage pool of 22 MHPs, 5 CIS's and 5 Seconds for Safety/Non-MHP staff, and 6 CPCs. Sea Mar reports they also have 1 MHP in the hiring process as well as Peer. AMCI has expanded to 24/7 and has been operational without any interruption since going live on Oct. 16, 2022.

AMCI's number of referrals has been consistently around 140 per month indicating that AMCI has made significant strides in increasing public awareness of Enhanced MCR services. Through March, AMCI has continued to meet with police officers to increase awareness and provide training on AMCI services through; CIT trainings, co-outreaches, phone consults, and face-to-face meetings in the community. These meetings will help with education and information for a larger

group of officers. AMCI plans to continue meeting and collaborating with community partners to increase public awareness of Enhanced MCR services within Clark County.

Klickitat funds were not used this quarter as there was not a provider willing to contract for these funds.

In Skamania, the Trueblood enhancement funds continue to allow Skamania County Community Health to provide MCR services. It provides the resources and structure to interact with community at a lower level of intervention. SCCH continues to offer services to the community in these capacities. They would like to work to expand these services from additional referral sources once staffing increases. They have been able to defer individuals from needing to access a higher level of service by offering this outreach.

King Region:
Mobile Crisis Team's partner operations coordinator continues to attend roll calls that first responders host to provide information regarding the services that the MCT provides as a method to divert arrest and provide a least restrictive alternative.

The partner operations coordinator has attended 15 roll calls this quarter and has been in contact with 23 law enforcement agencies. The partner operations coordinator is also the point person for communication with first responders regarding feedback for the MCT, as an opportunity to strengthen rapport with first responders.

Senior leadership has also begun piloting a "touch point" site at the Federal Way Police Department, resulting in positive relationships with law enforcement and an improved and ongoing understanding of services, resulting in further diversion.

Crisis Triage and Diversion-FPATH

FPATH teams provide assertive outreach, in-reach, and engagement, receive referrals from other Trueblood Settlement elements, and provide intensive case management services to those they enroll. On a monthly cadence, RDA identifies people with two or more competency evaluation orders in the last two years who have a higher risk of future intersection with the criminal court system. The FPATH Program Administrator sends the teams a prioritized list so that outreach and engagement efforts are focused on individuals who have the highest barriers, such as people who live in rural counties, have four or more competency evaluation referrals, or experience homelessness.

Current Status and Areas of Positive Impact

FPATH teams across the state are reporting an increased number of referrals coming from forensic navigators and have been adjusting their services to meet the increased need. In March 2023, all FPATH teams across the state met for the second annual FPATH meeting. HCA continues to facilitate learning opportunities for FPATH providers.

HCA added funding in the FY24 amendment for the Phase 2 FPATH provider to master lease a house and provide transitional supportive housing to FPATH-eligible participants. The Phase 2 FPATH provider also reported utilizing other housing providers in the region as they work alongside forensic navigators and other Trueblood element program teams to improve quality of life for FPATH participants.

Areas of Concern

In the King region, FPATH teams struggled with utilization of HMIS for data recording. The primary issue identified was the need to keep FPATH data separated from King County's larger HMIS database, because the FPATH referral list contains Personal Health Information. Other issues included adjusting to a new method of recording data, as well as the need to have people enrolled in the FPATH program sign consent forms for their information to be recorded.

Workforce shortages and retention continue to impact FPATH providers across the state. For some of the teams, the staffing shortage has impacted their ability to outreach to new people. Most teams reported having been down at least one to two staff members throughout the reporting period and the Phase 2 provider was down more than two FPATH positions.

Recommendations to Address Concerns

HCA is discontinuing HMIS use by the FPATH teams this year and will be transitional to a new data acquisition and storage program.

HCA worked with the Phase 2 FPATH provider to add retention, hiring, and referral bonuses for staff in an attempt to decrease some of the workforce shortages on the team. Those bonuses will become available to eligible FPATH staff beginning FY24.

Data-Crisis Triage and Diversion-FPATH

FPATH data in the current report is from the Homeless Management Information System, as well as monthly Excel trackers submitted by FPATH providers in the Phase 1 and 2 regions. Program eligibility is based on a referral list of people with two or more competency evaluation referrals in the past 24 months.

The FPATH program began March 1, 2020 in Phase 1 regions, and April 1, 2022 in the Phase 2 region. Between March 1, 2020 and June 30, 2023, 2,859 people were referred to the program across all regions (Appendix F, Table 1). HCA continues to encourage providers to focus outreach efforts on a subset of these people based on housing status (prioritizing unstably housed and homeless), number of referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 1,243, which was 43 percent of the total referral list.

Of all people on the referral list, FPATH providers attempted to contact 1,173 (41 percent) and successfully contacted 869 (30 percent). As of June 30, 2023, a total of 497 people (17 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Enrollments among the prioritized population were slightly higher (19 percent).

Of the Phase 1 regions, Southwest had the smallest referral list and enrolled the largest proportion (37 percent, Appendix F, Table 1). The Pierce region had the largest referral list and enrolled 16 percent. The Phase 2 King region has had 110 enrollees since the program started in April 2022, which was 12 percent of its referral list. Of these, 40 were from the prioritized population.

Among enrolled people, the majority were male (77 percent overall) and between 30 and 49 years old (62 percent). More than two-thirds of enrollees (69 percent) were homeless at program enrollment, while 21 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among all people discharged from the FPATH program through June 30, 2023, the average length of stay in the program was 270 days. People in the Pierce region had the longest length of stay at 314 days, while the King region had the shortest at 148 days. (Appendix F, Table 1). Loss of contact was the most common reason for FPATH discharge throughout all four regions (46 percent overall).

Services

There have been 10,820 service encounters between FPATH providers and participants over the duration of the program, with an average of 2.7 services per participant, per month (Appendix F, Table 2). Averages ranged from 2.5 services per month in the Southwest region to 3.1 in Spokane. Across all FPATH regions, the most common service encounter was case management

(1.5 per person, per month, on average), followed by outreach services (0.4 per person, per month) (Appendix F, Table 2).

Referrals

Of the 497 FPATH enrollees, 233 (47 percent) had received at least one referral through June 2023 (Appendix F, Table 2). The Spokane region provided the most referrals, with 79 percent of participants having at least one, followed by 50 percent in the Southwest region and 46 percent in the Pierce region. In the Phase 2 King region, 13 percent of enrollees had received at least one referral.

The most common referral throughout all four regions was to FHARPS housing, with 24 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Approximately 17 percent of enrollees received at least one community mental health referral. Due to low enrollment numbers, and to protect participant confidentiality, detailed referral information for Phase 2 FPATH enrollees is not available as of June 30, 2023.

Education and Training – Crisis Intervention Training

For all the phased regions through June 30, 2023, the Criminal Justice Training Commission has completed thirty-three 40-hour courses for certified peace officers. Within these classes, CJTC has trained law enforcement officers, mental health professionals, dispatchers, co-responders, military police, and corrections officers. As of June 30, 2023, 2,469 law enforcement officers have received this training. As of June 30, 2023, every agency in the Phase 2 region had met the 25 percent goal. Phase 1 regions have shifted to a maintenance schedule that includes one or two 40-hour classes annually in each region. The Spokane and Southwest, regions have classes scheduled for the fall.

CJTC has developed and deployed a webinar-style eight-hour course, specifically to meet the needs of correctional agencies. CJTC scheduled 26 of these classes in the first half of 2023. Through the combination of the earlier traditional courses and the addition of Clark County's 40-hour program, 1,142 corrections officers have received at least the minimum eight-hour CIT for corrections training. Lincoln and Skamania counties sheriff's departments cross-train their corrections officers as 911 dispatchers. Those officers took the eight-hour 911 CIT training.

Phase 1 regions remain eligible to receive up to 40 hours of cost coverage for backfill as a result of the Trueblood funding provided by the legislature. As an added incentive, lodging and per diem costs are covered for agencies more than 50 miles from the training site. The CJTC team continues to provide outreach and education, and the team continues to see improvement using these available resources to remove barriers to participation.

CJTC collaborated with the state 911 office for delivery of the eight-hour CIT course for dispatchers. The telecom/911 training was reformatted to a hybrid course comprised of four hours of self-paced online training and a follow-up four-hour instructor-led webinar course. It was also found that several telecom training programs already included the eight-hour CIT materials. Several of these programs applied and were granted equivalency status. To date, 869 dispatchers have received the full eight hours of training.

For Phase 2, the King region has already been running a robust 40-hour CIT program for several years. Because of this, of the 3,137 certified peace officers in the King region, 1,491 have completed the training (48 percent). By June 30, 2023 every police agency in King County (Phase two) had met and or exceeded the mandate of 25 percent of not just officers assigned to patrol but of certified officers assigned to their agency. The King region completed seven of the 40-hour CIT courses in the first half of 2023.

The King region has six correctional agencies encompassing 570 correctional officers. To date, 564 officers (99%) have completed the required eight-hour CIT for corrections training. These courses have been offered exclusively in an interactive webinar format and continue to be offered twice a month.

The King region has 445 Telecom/911 dispatchers. Of these, 421 (95 percent) have completed either the hybrid four-hour static/four-hour webinar or equivalent training. At least two webinar courses are scheduled each month and the static course can be taken at any time as the prerequisite.

Areas of Concern

The current training environment continues to present challenges. The pandemic and resulting vaccine requirements had a significant impact on staffing levels across the board. The CJTC has doubled the number of basic law enforcement academies, and there is an eight-month wait for entry. Every law enforcement, corrections, and telecom agency are working short-staffed. Some are staffed as much as 25 percent below their allotted positions. When an agency cannot cover their own active shifts, it is difficult to encourage them to create a larger deficit by sending an officer to 40 hours of training. This trend has begun to turn around, and we are seeing minor improvements in staffing levels at more and more agencies.

Recommendations to Address Concerns

CJTC continues to increase communication working with agencies individually to find ways to get students into classes. Communication and marketing efforts are continuing to increase. WSCJTC presented training to the 11 newly elected Sheriffs and included information on Trueblood compliance and opportunities. The CIT for Corrections eight-hour course is being offered on swing shift and weekends. CJTC has hired two additional instructors and a dedicated program specialist 3 and is continuing to seek additional quality instructors.

Data-Education and Training-CIT

Phase 1

CJTC monitors law enforcement training completion rates through the Learning Management System. Per the Settlement Agreement, 25 percent of patrol officers in each law enforcement agency within a Trueblood phased region were required to complete 40 hours of enhanced CIT throughout the three Phase 1 regions.

Appendix G, Figure 1 displays training completion rates for each individual law enforcement agency in Phase 1. As of June 30, 2023, 40 (74 percent) law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies continued to achieve higher training completion rates (49 percent, overall) than small agencies (39 percent) in all three regions (Appendix G, Table 1). It should be noted that the CIT program achieved 100 percent compliance for the law enforcement training requirement in June 2022. Training rates will continue to shift, however, as the number of officers in each agency fluctuates over time.

As shown in Appendix G, Table 1, the overall training completion rate for all law enforcement agencies in Phase 1 was 40 percent as of June 30, 2023. In the Pierce region, 26 percent of officers were trained, compared to 58 percent in the Southwest region, and 53 percent in the Spokane region. Washington State Patrol units in the Phase 1 regions have achieved a training rate of 24 percent.

The Settlement Agreement also requires 911 dispatchers and correctional officers in the Trueblood Phase 1 regions to complete an eight-hour CIT course. In June 2022, the CIT program achieved 100 percent compliance with the 911 dispatchers training requirement in the Phase 1 regions. As of June 30, 2023, 96 percent of 911 dispatchers had completed CIT training (Appendix G, Table 3). In addition, 92 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 82 percent in the Southwest region to 97 percent in the Pierce region (Appendix G, Table 2).

Phase 2

Appendix G, Figure 2 displays the training completion rates for the law enforcement agencies in Phase 2, which began July 1, 2021. As of June 30, 2023, all 28 (100 percent) law enforcement agencies were meeting or exceeding the 25 percent benchmark, with an overall training completion rate of 48 percent (Appendix G, Table 1). Washington State Patrol units in Phase 2 had a training completion rate of 26 percent. Unlike Phase 1, large and small law enforcement agencies in King County had similarly high overall training rates of 50 percent, while medium-sized agencies had a slightly lower overall rate of 39 percent.

Nearly all (99 percent) correctional officers in King County had completed the eight-hour CIT course by June 30, 2023 (Appendix G, Table 2), as well as 95 percent of 911 dispatchers (Appendix G, Table 3). Dispatchers and correctional officers in the Phase 2 region had until June 30, 2023 to meet the 100 percent training requirement.

The Settlement Agreement states that the 25 percent training target should prioritize agencies that serve areas with higher population densities. As of June 30, 2023, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (65 percent and 61 percent, respectively) than the Pierce region (25 percent, Appendix G, Table 1). This pattern was not observed in the King region (Phase 2), however, where large agencies with higher population densities had similar training completion rates to small agencies with lower population densities (49 and 50 percent, respectively) (Appendix G, Table 1).

Education and Training – Technical Assistance for Jails

The Settlement of Contempt Agreement has directed the state to develop and provide educational and technical assistance to jails. DSHS' Jail Technical Assistance program provides training and information to jails across the state to support jail staff in working effectively with persons who live with mental illness.

In 2019, the Jail Technical Assistance team worked in collaboration with several entities to create a guidebook of best practices for behavioral health services in a jail setting. The guidebook workgroup included representation from Disability Rights Washington, WASPC, the Washington State Office of the Attorney General, HCA's enhanced peer services program administrator, and representatives from city and county jails both within and outside of Phase 1 regions. The guidebook was completed in 2020 and is now available on the DSHS and has served as a support document for trainings on the topics it covers.

- Also in 2020, JTA staff began to provide online monthly JTA Learning Events, and made those events available to jail staff from all jails statewide. Additionally, JTA began in-person visits to jails to build relationships and to gather information regarding training needs, staffing, and jail practices. These efforts were then interrupted by COVID-19 restrictions.

https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/trainings

- As COVID-19 restrictions eased, JTA resumed the in-person visits. During 2022, JTA staff visited each of the 60 jails in Washington, 15 city, 39 county, and 6 tribal jails.

The jail visits used a structured interview aimed at gathering information about current practices in four components of mental health work:

- Initial Screening
- Assessment and Treatment Planning

- Service Delivery
- Continuity of Care/Release Planning

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plans have been delivered and are available on the JTA website. These webinar-based learning events continue monthly with robust participation. Many of the training topics are the direct result of information gained through jail visits and through input from participants attending prior events and providing feedback on topics of interest to jails. The learning events presented from January 2023 through June 30, 2023 were:

- January: Health Care Authority overview with emphasis on jail transition services.
- February: Developmental Disability Administration. Who are they and what do they do?
- March: Forensic Evaluations via Telehealth: Making it Easier on Jails
- April: Towards Less Restrictive Housing and More Mental Health Treatment: The Yakima County Jail Experience.
- May: No learning event – Washington Sheriffs and Police Chief (WASPC) Conference
- June: JTA goes on the road – 2022 jail site visits summary.

Through outreach and relationship-building efforts, we have extended the reach of JTA training. We have also worked toward improving audience engagement by inviting stakeholders to participate in various presentation events and through increasing opportunities for discussion. We have also standardized communication avenues for all JTA learning events and initiated a regular resource-sharing email. Throughout the year JTA staff disseminate relevant information to its 200-plus network; this includes, articles, free trainings, legislative updates, etc. Additionally, these efforts have helped bring in a broader more diverse audience, such as representatives from jail leadership- chiefs, directors, commanders, superintendents, lieutenants, captains, and sergeants, correction deputies, mental health professionals, nurses, behavioral health navigators, certified peer counselors, county prosecutors, psychiatrists, diversion specialists, community mental health agency representatives, reentry specialists, case managers, transition specialists, social workers, jail mental health liaisons, designated crisis responders, therapists, community care coordinators, police officers, police chiefs, college professors, and representatives from WASPC.

Outreach efforts and a regular presence at the WASPC conference also helped foster relationships which led to three significant workgroup invitations: the Washington Jail

Commander meetings, the Legislative Joint Jail Standards and Accountability Taskforce meetings, and the Washington State University Rural Jail Project meetings. The Jail Standards and Accountability Taskforce was established to determine if there should be statewide standards and oversight of Washington jails. JTA staff attend the task force meeting as an observer but have been added to a task force subgroup responsible for developing recommendations based on jail survey data. The WSU Rural Jail Project is based on a grant from the Vera Institute of Corrections and involves graduate students and professors working with rural jails to identify challenges and assist with making positive changes. JTA staff meet with this group quarterly to discuss progress and share information.

In June 2023 recruitment began for the workforce development administrator position due to the administrator retiring. At the beginning of July, the position was filled. This action resulted in a vacancy in the workforce development team that is currently under recruitment. The administrator oversees both the JTA and WFD elements.

Areas of Concern

Previous areas of concern have been addressed and resolved. This included enhancing awareness of the JTA program, building stakeholder relationships through varied outreach efforts, and developing a resource library of trainings. Through the statewide in-person jail visits, a continued presence at the Washington Association of Sheriffs & Police Chiefs conference, and participation in relevant workgroups, JTA has increased awareness of its program as well as significantly increased its network. With regards to developing a resource library of trainings, JTA staff began recording and posting the JTA Monthly Learning Events to the JTA website so that they can be accessed anytime. On the horizon, an area of focus for JTA is the review of trainings and publications. This includes previous learning events that have been recorded and posted and the *Best Practices for Behavioral Health Services in Jail Settings* manual. The manual was published in 2020 and needs to be reviewed for potential updates.

Recommendations to Address Concerns

To resolve the necessary updates and review of trainings and publications, JTA staff should develop a review and update plan for the trainings posted online and the *Best Practices for Behavioral Health Services in Jail Settings* manual.

Data-Jail Technical Assistance

In July 2021, JTA staff began tracking the number of participants in each JTA Monthly Learning Event. For the six-month period from July 2021-December 2021, average attendance was 5.5 persons per event. During calendar year 2022, JTA conducted 11 JTA Monthly Learning Events. The average number of participants in the 2022 events was 16 people per event not counting the state staff involved. From January 2023 to June 2023 the average number of participants was 13. The number of attendees is trending similarly to those of 2022, and after compiling the data for the second half of 2023 we expect to see similar average participation.

Enhanced Peer Support

The Settlement Agreement has directed the state to create multiple Trueblood-related service teams that will employ certified peer counselors. The certified peer counselors employed on these teams will be working with persons diagnosed with behavioral health conditions who are involved in the legal system.

Current Status and Areas of Positive Impact

HCA, in partnership with OFMHS, developed a continuing education training titled *The Intersection of Behavioral Health and the Law* that provides a foundational overview of the forensic mental health system. This training was developed for certified peer counselors who work on Trueblood-related services as well as other professionals who work within the forensic mental health system. The IBHL curriculum and the complimentary online training are currently available to learners through a learning management system. This training focuses on the components of the legal system and how they intersect with the behavioral health system. Professionals in the legal and forensic mental health systems also learn about the impacts and effectiveness of peer support services.

Enhancing Your Cultural Intelligence is a training that adds content to IBHL, and is centered on topics and considerations around diversity, equity, and inclusion. HCA contracted with a national diversity, equity, and inclusion subject matter expert to create this continuing education offering. Topics covered include cultural intelligence and safety; diversity, identity, and intersectionality; understanding microaggressions; achieving health equity through the lens of social justice; and reducing the effects of systemic inequities on 2SLGBTQIA+ communities. This training is also currently available to learners through a learning management system.

It is important to note that these virtual trainings were designed to maximize learner engagement, provide an interactive learning experience, and comply with Section 508 ensuring accessibility to all learners accessing the trainings through the learning management system. Section 508 of the Rehabilitation Act of 1973 ensures that people who are living with disabilities have equal access to government information contained on information and communications technology, thereby, ensuring access to government employment programs and services to which all citizens are entitled.

There have been two *Enhancing Your Cultural Intelligence* train-the-trainer events for this diversity, equity, and inclusion training. Since these events, the EPS program continues to bring this group of trained trainers together monthly to discuss the content and prepare to present the training. Through these meetings, it was clear that additional written information on diversity, equity, and inclusion would be helpful to CPCs working with Trueblood class members. From this ongoing conversation, the EPS program has initiated the creation of a diversity, equity, and inclusion written curriculum titled, *Cultural Inclusion in Peer Support: Compassion in Action.* This

curriculum will be written to complement the original *Enhancing Your Cultural Intelligence* training.

At the request of the certified peer counselors on Trueblood element program teams and Trueblood court-funded diversion programs, the Trueblood CPC Learning Community is now being offered monthly. CPCs from teams across the state are in attendance. Recent Trueblood CPC Learning Community topics of discussion included but were not limited to, peer support and housing services, connecting with people who are in the state hospitals, the upcoming changes to the peer counselor profession as a result of SB 5555, how to bridge the voluntary nature of receiving peer support services with mandatory program participation, accessing the *Intersection of Behavioral Health and the Law* and *Enhancing Your Cultural Intelligence* trainings through the learning management system, and professional development opportunities offered by the Enhanced Peer Support program and the HCA Peer Support Services team. Additionally, the learning community provided technical assistance, resourcing, and networking for CPCs on Trueblood program teams and court-funded diversion programs throughout Washington state.

Certified peer counselors working on Trueblood element program and court-funded diversion program teams were invited by the Enhanced Peer Support program to participate in both Wellness Recovery Action Plan WRAP® I and WRAP® II trainings. WRAP® I learners developed their own WRAP® as a personalized system to achieve their own wellness goals. WRAP® II prepared learners to facilitate WRAP® classes and equipped them with the skills and materials to facilitate classes in their community and organization. This training prepared learners to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations.

The EPS program continues to participate in The National Justice-Involved Peer Support Council, a group that facilitates networking and mutual learning focused on peer support that is provided within jails, prisons, and post-incarceration. This council meets weekly with the support of Doors to Wellbeing, a SAMHSA-funded national consumer technical assistance center of the Copeland Center for Wellness and Recovery. Additionally, the EPS program has worked collaboratively with HCA's Peer Support program and the Department of Corrections to offer a 40-hour Certified Peer Counselor certification training to people who are currently incarcerated. The first training was offered at Mission Creek Corrections Center in March of 2023. Thirteen people who are serving varied sentences at Mission Creek Correctional Facility were able to take and complete the certified peer counselor training course. This training was a historical, first-of-its-kind to be offered by Washington state. The training was a great success and led to two additional CPC trainings being offered at Walla Walla State Penitentiary in April and June 2023.

Areas of Concern

The unique value of peer support is derived from lived experience. Certified peer counselors draw upon that experience to build connection and rapport with the people they serve. The certified peer counselors who are best suited to work with people involved in our criminal court system are those who have shared that lived experience. This lived experience can come with a criminal history that might impede the certified peer counselor's ability to work with people who are in jail.

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails. The EPS program has connected with jail staff and Department of Corrections administrators to provide education about peer support services and the role of unique role certified peer counselors. Certified peer counselors have continued to find success in entering the jails by working directly with the sergeant on duty. The Enhanced Peer Services program administrator is working to bring together practices that have led to success in entering the jails in an effort to operationalize certified peer counselors entering the jails.

Data-Enhanced Peer Support

Beginning February 2022, data collection around completion of the online trainings offered by the Enhanced Peer Support program has been captured by a learning management system that registers individual users and tracks each user's completion of trainings. Between January and June 2023, 124 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions, have completed *The Intersection of Behavioral Health and the Law* online training. Between January and June 2023, 208 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions have completed *Enhancing Your Cultural Intelligence* online training.

Workforce Development

The department is responsible for providing workforce development for DSHS staff and providing limited training resources to the forensic mental health community. Workforce development, evaluation, and support will be implemented as part of the statewide effort, and central to this initiative, DSHS hired workforce development specialists for the functional areas specified in the Settlement Agreement.

In previous reports, WFD described the development of a series of brochures illustrating the career pathways for key work positions within the forensic mental health system. These are intended as an outreach and education tool for potential members of the workforce, to increase awareness of and stimulate interest in the field and to provide information about the training and qualifications required. These six "Career Pathway" brochures illustrate the educational pathways for forensic behavioral health careers in psychology, social work, peer counseling, mental health counseling, nursing, and psychiatry. In early 2022, the workforce development team worked with Washington state K-12 school districts and skill centers to distribute these career pathway brochures.

Another significant effort during 2022 was the development of an online training series specifically designed to address the need to enhance basic forensic literacy. Workforce development staff worked in partnership with leadership staff at the King County Jail to craft an outline of the topics to be covered in this training series. Based on that consultation, workforce development staff created a five-module online training series that covers:

1. An overview of the Trueblood Contempt Settlement Agreement
2. Competency and competency evaluation
3. Competency restoration
4. Diversion
5. Continuity of care

These online training modules provide learners with a foundational understanding of our state's forensic mental health system, helping to address the strategic goal of enhancing basic forensic literacy. This series has been posted on the OFMHS workforce development website, making it available to a variety of system partners, to include jail staff, prosecutors, defenders, judges, law enforcement, educational partners, behavioral health providers, and any/all partners in implementation of Settlement Agreement endeavors. Additionally, a second online training series on trauma-informed approaches was developed in partnership with HCA. This series was then made available to all interested parties via the OFMHS website.

Also in early 2022, workforce development staff created a survey to learn more about the perspectives of prosecutors, defense counsel, and judges regarding the continuing increase in demand for pretrial competency services. A key finding resulting from this survey identified opportunities for DSHS to help address important training needs for our legal partners.

Current Status and Areas of Positive Impact

Expanding on the information gathered during the survey of legal partners, the workforce development team procured a contract with Groundswell Services Inc. to conduct follow-up focus groups and interviews with attorneys and judges to collect information regarding the forensic mental health system from their perspective, to discover potential strategies, and to disseminate information about current and future OFMHS initiatives to improve the competency system. Groundswell has substantial expertise related to forensic mental health services, particularly forensic evaluation, competency restoration services, forensic mental health systems, workforce development, and training. They have previously served as consultants for Washington's forensic mental health system and were the lead consultants and an expert witness in the Trueblood vs. Washington State Department of Social and Health Services federal class action lawsuit. Groundswell conducted the focus group and interviews in May 2022, collecting robust information about challenges and recommendations to Washington's competency services system. After gathering the input provided by the legal system partners, Groundswell analyzed the information and compiled material pertaining to promising practices and programs throughout the county.

In June 2023 recruitment began for the workforce development administrator position due to the administrator retiring. At the beginning of July, the position was filled. This action resulted in a vacancy in the workforce development team that is currently under recruitment. The administrator oversees both the JTA and WFD elements.

Workforce development staff continue to lead the Behavioral Health Administration's trauma-informed care workforce development subcommittee, in an intensive effort to embed trauma-informed principles into all DSHS forensic mental health facilities, starting with a pilot project at Western State Hospital. In June 2023, this subcommittee was nearing completion of its deliverables, which included identifying TIC core competencies, developing a master list of trainings in support of TIC implementation, building out a training schedule, developing evaluation and coaching tools, audit tools, and developing recommendations for employee wellness and recognition.

Workforce development staff also continue to be centrally involved in providing guidance and technical assistance statewide in a leadership role with the BHA telehealth committee. This committee has three subcommittees, which together focus on expanding the use of telehealth for competency evaluations, ensuring awareness and the use of best practices regarding telehealth, and providing ongoing support for relevant facilities. This committee has been successful in

creating a community of knowledgeable practitioners and subject matter experts to facilitate the use of technology and the inherent benefits for forensic evaluations.

In Q1 2023, the Cisco-based video conferencing technology solution that BHA has used, reached end-of-life and is being decommissioned. In anticipation of this event, IT staff developed a small profile turnkey solution operating in kiosk mode to offer interested jails and BHA facilities. The first unit was installed at Yakima County Jail in spring 2023. While IT staff continued to make refinements to this initial placement, exceptions to policy were sought to mitigate issues in completing telehealth evaluations for the other counties using the Cisco technology. During this time frame, the telehealth committee continued to work with the King and Snohomish County jails to establish a robust telehealth setup. State IT staff continue working with county partners as they troubleshoot various aspects of technology-related issues pertinent to telehealth implementation.

Due to the limitations imposed by COVID-19, videoconferencing became an effective adaptation to counteract severe restrictions on in-person evaluations. The use of this technology for evaluations increased significantly. It has also helped improve the efficiency with which competency evaluations can be completed. DSHS continues to provide support to complete jail-based competency evaluations via videoconferencing. More than 50 locations statewide are now using videoconferencing to regularly complete telehealth evaluations. During the period covered by this semi-annual report, January 1-June 30, 2023, on average, OFMHS evaluators completed 228 telehealth evaluations per month.

Workforce development staff continue to work on strategies to implement the recommendations outlined in the workforce report, *The Washington State Forensic Mental Health Workforce: Assessing the Need and Target Areas for Training, Certification, and Possible Degree Programs*. This report analyzed the need and target areas for additional training, certification, and degree programs; examined the availability of those programs in and outside of Washington; assessed the statewide workforce needs of the Trueblood programs over the next 10 years; and included recommendations for future action.

WFD continues to build on partnerships and opportunities for collaboration. Some examples are WFD staff's active engagement with the Workforce Training and Education Coordinating Board workgroups, the King County Competency Continuum Workgroup, the Washington State Association of Sheriffs and Police Chiefs, the Health Care Authority's Division of Behavioral Health and Recovery, King County workforce development, and King County WorkSource Training & Learning Management Coordinator.

Workforce development team members continue to lead the delivery of training in support of the New Employee Orientation program for OFMHS staff and are now offering NEO on the first and sixteenth of every month. This ensures minimal time between an employee's first day and OFMHS orientation. This effort is designed to aid in staff retention by welcoming and preparing

staff for their new position and orienting new hires statewide to varied aspects of the forensic mental health system, including an overview of the Contempt Settlement Agreement.

Additionally, the workforce development team has updated the *Hiring and Onboarding Manual* and companion checklist to assist hiring managers in implementing a standardized set of protocols following policy and procedure established by DSHS human resources. This manual serves as OFMHS policy for the hiring and onboarding process. OFMHS workforce development staff have developed and provided training to orient managers to this new policy and its procedures.

OFMHS workforce development staff also continue to provide training to contracted behavioral health provider staff regarding an orientation to the Breaking Barriers curriculum used in OCRP. Staff continue to work on completing an online version of this training to be used as new OCRP staff onboard. Additionally, OFMHS workforce development staff are developing a training for external and internal telehealth providers to assist them in establishing and completing a telehealth session. A storyboard for this training has been created and the script has been written. Workforce development staff are also working on training related to a mentorship program and have completed a training on the Forensic Data System for FDS users.

Areas of Concern

The WFD team has completed all required Phase 2 element tasks on time or ahead of schedule. A broad challenge regarding workforce development continues to be the ongoing statewide workforce shortages within the field of mental health.

Recommendations to Address Concerns

Our previous efforts led to a plan to revamp our external facing website to increase engagement with our intended audience. The WFD team also continued to work on an online version of the Breaking Barriers curriculum for use in OCRP, and an online introduction to mentorship in preparation for a staff mentorship program. WFD staff also completed an online training to support FDS users. This training was uploaded to the state learning center. A companion internal website with additional materials and system updates was established.

Data-Workforce Development

Currently, available workforce data from existing sources are insufficiently specific to the forensic mental health field to support reliable analysis of specific workforce needs. Workforce development continues to work with relevant partners to obtain targeted data.

Conclusions

Behavioral health transformation is well underway in Washington state. The two-year designated implementation period for Phase 1 of the Settlement Agreement concluded on June 30, 2021. Successful Phase 1 implementation required completion of 137 tasks[14] from the Phase 1 Final Implementation Plan. Each task item was completed and has contributed to the enhanced level of services that remain available to Trueblood class members and other eligible clients in the 10 counties that comprise the three Phase 1 regions. Additionally, as of June 30, 2023, 92 of 93 Phase 2 task items are complete[15], and most Trueblood programming in the Phase 2 King region is already operational. The Phase 2 implementation period ran from July 1, 2021 through June 30, 2023.

COVID-19's effect on day-to-day operations has transitioned from pandemic to endemic. Transmission continues through BHA facilities with periodic higher levels of infection that can result in temporary admissions/discharge holds and localized masking requirements, which can place significant constraints on daily life and normal operations of the state's behavioral health system. State and local providers continue to contend with a persistent nationwide behavioral health workforce shortage. With many vacancies remaining unfilled, criminal courts continue processing their significant case backlogs built up during the pandemic. In part, these backlogs have fueled ongoing record-high demand for jail-based evaluation services during FY23.

The state remains committed to both implementing the elements of the Settlement Agreement and improving those elements already established in Phases 1 and 2. Phase 1 programs continue to gain experience serving their clients, and the more recently implemented Phase 2 programming continues rapidly gaining experience in the field and benefiting from the knowledge already gained from Phase 1 implementation and operations. Phase 3 implementation is now underway in five counties and two BHASO regions including the Thurston Mason Behavioral Health ASO, which incorporates Thurston and Mason counties and the Salish Behavioral Health Organization, which comprises Kitsap, Clallam, and Jefferson counties. Phase 3 implementation continues through June 30, 2025.

[14] Document 945. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Declaration of Titus Butcher, p. 2. As submitted with Dkt. 943, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023.

[15] Document 945. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Declaration of Titus Butcher, p. 2. As submitted with Dkt. 943, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed January 11, 2023.

Appendix A-Related Resources

The information presented below provides additional resources and information of potential interest to readers of this report.

State Agency Resources:

***Washington State Criminal Justice Training Commission*:** www.cjtc.wa.gov

***Washington State Health Care Authority*:** www.hca.wa.gov

***Washington State Department of Social and Health Services*:** www.dshs.wa.gov

DSHS Behavioral Health Administration: www.dshs.wa.gov/bha

BHA Telehealth Resource Site: https://www.dshs.wa.gov/bha/telehealth-resources

BHA Office of Forensic Mental Health Services: www.dshs.wa.gov/bha/office-forensic-mental-health-services

OFMHS'* Trueblood *Website: *www.dshs.wa.gov/bha/*Trueblood*-et-al-v-washington-state-dshs*

Trueblood *Contempt Settlement Agreement:*
*www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/*Trueblood*/2018*Trueblood*/623_OrderFinalApprovalSettlement.pdf*

Trueblood *Implementation Plan:*
*www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/*Trueblood*/2019*Trueblood*/679_1_ExhibitA_FinalPlan.pdf*

Trueblood *February 2023 Progress Report for the Court Monitor and Appendices A-L:*

February | *Appendix A-G* | *Appendix H* | *Appendix I* | *Appendix J* | *Appendix K* | *Appendix L*

Forensic Navigator Program: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program

Jail Technical Assistance Program: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/jail-technical-assistance-program

Workforce Development Program: https://www.dshs.wa.gov/bha/workforce-development

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

Disability Rights Washington* Trueblood *Website:
https://www.disabilityrightswa.org/cases/Trueblood/

Washington Association of Sheriffs and Police Chiefs: www.waspc.org

Appendix B-OCRP Dashboard

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

The program objective of the Outpatient Competency Restoration Program (OCRP), administered by the Healthcare Authority, is to provide timely and effective outpatient competency restoration services to individuals determined by the court as a) not competent to stand trial and b) appropriate for community-based services to restore competency. The intent of the OCRP is to reduce the number of people waiting to receive inpatient competency restoration, to provide competency services in a safe and cost-effective environment, and to provide the most appropriate level of care to the individual. OCRP services in Phase 1 Regions began July 1, 2020, and became available in the Phase 2 Region (King County) in October 2022.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
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- TABLE 2: OCRP Discharges, Cumulative
- Definitions

TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	152	100.0%	45	100.0%	60	100.0%	35	100.0%	12	100.0%
Among Enrolled Individuals…										
RESTORATION ORDER TYPE (unduplicated)										
Felony	123	80.9%	--	--	--	--	--	--	--	--
Misdemeanor	29	19.1%	--	--	--	--	--	--	--	--
GENDER										
Female	28	18.4%	--	--	--	--	--	--	--	--
Male	112	73.7%	--	--	--	--	--	--	--	--
Other/Unknown	12	7.9%	--	--	--	--	--	--	--	--
AGE GROUP										
18-29 yrs	47	30.9%	--	--	--	--	--	--	--	--
30-49 yrs	76	50.0%	--	--	--	--	--	--	--	--
50+ yrs	29	19.1%	--	--	--	--	--	--	--	--
RACE/ETHNICITY*										
Non-Hispanic White	100	65.8%	--	--	--	--	--	--	--	--
Black, Indigenous, and People of Color	37	24.3%	--	--	--	--	--	--	--	--
Unknown	15	9.9%	--	--	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	35	23.0%	--	--	--	--	--	--	--	--
Unstably Housed	82	53.9%	--	--	--	--	--	--	--	--
Homeless	33	21.7%	--	--	--	--	--	--	--	--
In a Facility	1	0.7%	--	--	--	--	--	--	--	--
Unknown	1	0.7%	--	--	--	--	--	--	--	--

DATA SOURCE: Excel trackers submitted by each contracted OCRP team to the Washington State Health Care Authority (HCA) and the Navigator Case Management system (NCM).

NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

*Race/ethnicity categories will be expanded when there are sufficient numbers to report by region.

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
CLIENT STATUS (on last day of reporting period)										
Enrolled	152	100.0%	45	100.0%	60	100.0%	35	100.0%	12	100.0%
Active	32	21.1%	--	--	--	--	--	--	--	--
Discharged	120	78.9%	--	--	--	--	--	--	--	--
Among Discharged Individuals…										
DISCHARGE REASON										
Charges Dismissed	15	12.5%	--	--	--	--	--	--	--	--
Opined Competent	49	40.8%	--	--	--	--	--	--	--	--
Opined Not Competent	5	4.2%	--	--	--	--	--	--	--	--
Opined Not Restorable	3	2.5%	--	--	--	--	--	--	--	--
Returned to Jail	6	5.0%	--	--	--	--	--	--	--	--
Inpatient Medical Care	1	0.8%	--	--	--	--	--	--	--	--
Inpatient Civil Psychiatric Care	6	5.0%	--	--	--	--	--	--	--	--
Revoked Conditional Release	33	27.5%	--	--	--	--	--	--	--	--
Legal Authority Ended	2	1.7%	--	--	--	--	--	--	--	--
Death	0	0.0%	--	--	--	--	--	--	--	--
DISCHARGE LOCATION										
Community	77	64.2%	--	--	--	--	--	--	--	--
Residential Treatment Facility	3	2.5%	--	--	--	--	--	--	--	--
State Hospital	19	15.8%	--	--	--	--	--	--	--	--
Jail	13	10.8%	--	--	--	--	--	--	--	--
Unknown	8	6.7%	--	--	--	--	--	--	--	--
LENGTH OF STAY										
Average Length of Stay in Program (days)	71	N/A	84	N/A	66	N/A	67	N/A	58	N/A
HOUSING STATUS AT PROGRAM DISCHARGE										
Stably Housed	44	36.7%	--	--	--	--	--	--	--	--
Unstably Housed	36	30.0%	--	--	--	--	--	--	--	--
Homeless	18	15.0%	--	--	--	--	--	--	--	--
In a Facility	14	11.7%	--	--	--	--	--	--	--	--
Unknown/Missing	8	6.7%	--	--	--	--	--	--	--	--

DATA SOURCE: Excel trackers submitted by each contracted OCRP team to the Washington State Health Care Authority (HCA) and the Navigator Case Management system (NCM).

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

OCRP Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase 1 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Individuals assessed and enrolled into OCRP during the reporting period.
Restoration Order Type	Restoration order type, based on most serious charge of first competency period orders (including concurrent orders). An individual with both a misdemeanor and felony competency restoration order is counted as a felony restoration order.
Misdemeanor	Restoration order with one or more misdemeanor charges as specified in RCW 9a.20.
Felony	Restoration order with one or more felony charges as specified in RCW 9a.20.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Black, Indigenous, and People of Color categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was not reported.
Housing Status at Program Enrollment	Self-reported housing status at time of program enrollment.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program enrollment.
DISCHARGE TABLE, Cumulative	

Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and still active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Discharge Reason	Reason the program ended for participant. Providers are limited to one dropdown option. Table reflects this selection.
Charges Dismissed	Participant charges were dismissed by court order; program has no legal authority to retain participant in the program.
Opined Competent	Evaluator opined the participant competent to stand trial.
Opined Not Competent	Evaluator opined the participant not competent to stand trial but possibly restorable.
Opined Not Restorable	Evaluator opined the participant not competent to stand trial and not restorable.
Returned to Jail	Participant returned to jail and there is no expectation that they would return to the program. Used if 'returned to jail' was the only reason for program end.
Inpatient Medical Care	Participant admitted to a medical hospital due to a serious medical condition and there is no expectation the participant will return, or participant did not return from a Leave of Absence for inpatient medical care.
Inpatient Civil Psychiatry Care	Participant admitted voluntarily or involuntarily to an inpatient psychiatric facility (community or state hospital) due to grave disability and/or danger to self or others (e.g., participant is at risk of suicide or homicide) with no expection the participant will return, or participant did not return from a Leave of Absence for inpatient psychiatric care.
Revoked Conditional Release	Court revoked conditional release order.
Death	Participant passed away while in the program.
Missing/Unknown	Discharge reason is sometimes unknown by providers at time of discharge and left blank in excel trackers. Providers are encouraged to update this field when a reason is determined.
Discharge Location	Location of participant at time of program end.
Community	Participant was not in a facility at the time of discharge. Some participants may be pending inpatient treatment.
Residential Treatment Facility	Maple Lane, Yakima, and Fort Steilacoom competency restoration facilities. Yakima RTF closed in August 2021.
State Hospital	Western and Eastern State Hospitals.
Jail	County, city, or tribal jail facility.
Unknown	Discharge location unknown.
Length of Stay	Length of stay at time of program end.
Average Length of Stay in Program (days)	The average (mean) length of stay, in days, from the most recent OCRP enrollment date to OCRP discharge date, among participants discharged. Leaves of absence from the program are excluded.
Housing Status at Discharge	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program end.

Appendix C-Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health Administration Forensic Navigator Program

CUMULATIVE UPDATE

The Forensic Navigator Program is administered by the Behavioral Health Administration, and is designed to support individuals navigating the state's community-based competency evaluation services and outpatient restoration programs. The program began July 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane region (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). The Forensic Navigator Program began in the Phase 2 Region (King County) on January 1, 2022.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
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- TABLE 1: Enrollment and Participant Characteristics, Cumulative
- TABLE 2: Program Services, Cumulative
- TABLE 3: Program Discharges, Cumulative
- Definitions

TABLE 1.

Forensic Navigator Enrollment and Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	5,141	100%	1,323	100%	609	100%	977	100%	2,232	100%
Forensic Navigator Assigned	5,124	100%	1,316	99%	608	100%	976	100%	2,224	100%
Among Clients Assigned a Forensic Navigator…										
CLIENT STATUS (on last day of reporting period)										
Active	381	7%	62	5%	67	11%	48	5%	204	9%
Pre-Competency Hearing	324	6%	48	4%	52	9%	40	4%	184	8%
OCRP Enrolled	33	1%	--	--	--	--	--	--	--	--
Post-OCRP (Coordinated Transition)	3	0%	0	0%	--	--	--	--	0	0%
Reassess for OCRP	9	0%	--	--	0	0	0	0	--	--
In Process of OCRP Removal	12	0%	--	--	--	--	--	--	--	--
Discharged	4,743	93%	1,254	95%	541	89%	928	95%	2,020	91%
GENDER										
Female	1,024	20%	274	21%	118	19%	230	24%	402	18%
Male	3,158	62%	856	65%	423	70%	728	75%	1,151	52%
Other/Unknown	942	18%	186	14%	67	11%	18	2%	671	30%
AGE GROUP										
18-29	1,208	24%	329	25%	171	28%	226	23%	482	22%
30-49	2,888	56%	719	55%	330	54%	541	55%	1,298	58%
50+	1,028	20%	268	20%	107	18%	209	21%	444	20%
RACE/ETHNICITY*										
American Indian or Alaskan Native	69	1%	31	2%	--	--	21	2%	--	--
Asian	137	3%	35	3%	--	--	--	--	80	4%
Black or African American	949	19%	307	23%	74	12%	71	7%	497	22%
Hispanic or Latino	114	2%	17	1%	19	3%	12	1%	66	3%
Native Hawaiian or Pacific Islander	64	1%	38	3%	--	--	--	--	15	1%
White Only, Non-Hispanic	2,372	46%	606	46%	360	59%	715	73%	691	31%
Other Race	73	1%	--	--	--	--	--	--	58	0
Unknown	1,399	27%	279	21%	125	21%	153	16%	842	38%
MOST SERIOUS CURRENT CRIMINAL CHARGE										
Felony	2,443	48%	767	58%	389	64%	629	64%	658	30%
Misdemeanor	2,681	52%	549	42%	219	36%	347	36%	1,566	70%
HOUSING STATUS AT PROGRAM INTAKE										
Stably Housed	732	14%	209	16%	134	22%	168	17%	221	10%
Unstably Housed	414	8%	181	14%	83	14%	--	--	--	--
In a Facility	9	0%	0	0%	0	0%	--	--	--	--
Homeless	1,069	21%	284	22%	247	41%	239	24%	299	13%
Unknown	2,900	57%	642	49%	144	24%	496	51%	1618	73%

DATA SOURCE: Navigator Case Management System (NCM) and Forensic Data System (FDS).

NOTES: See 'Definitions' for more detailed information on each reporting category. All individuals in Phase 1 Regions with a competency evaluation order are referred to the Forensic Navigator program. A small number of individuals referred had not yet been assigned a navigator because their order was received at the end of the reporting period. The program is working to improve data collection for gender, race and ethnicity. The number of individuals with "Unknown" demographic data is expected to improve in future reports. Counts and percentages may not sum due to suppressed data and/or rounding. Cells with '--' are suppressed to protect confidentiality.

*Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. Individuals may report more than one race/ethnicity.

TABLE 2.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
POPULATION										
Active Clients (at any point during the reporting period)	5,124	100%	1,316	100%	608	100%	976	100%	2,224	100%
Avg Daily Navigator Caseload (most recent qtr of reporting period)	21	N/A	13	N/A	31	N/A	19	N/A	22	N/A
Among Active Clients (at any point during the reporting period)…										
FORENSIC NAVIGATOR SERVICES										
Assisting Clients with Attending Classes and Appointments	107	2%	30	2%	41	7%	--	--	--	--
Attending Competency Hearing	1,052	21%	189	14%	390	64%	402	41%	71	3%
Client Meeting, Interview, and/or Observation	2,397	47%	780	59%	457	75%	630	65%	530	24%
Client Support-Network Interactions	386	8%	115	9%	137	23%	97	10%	37	2%
Completed Recommended Services Plan	3,666	72%	1,008	77%	446	73%	814	83%	1,398	63%
OCRP Compliance Monitoring	173	3%	56	4%	66	11%	34	3%	17	1%
Contact with Client's Attorney or Prosecutor	4,367	85%	1,148	87%	441	73%	778	80%	2,000	90%
Coordination of Care	1,735	34%	481	37%	428	70%	494	51%	332	15%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	445	9%	52	4%	236	39%	126	13%	31	1%
Information Gathering	5,071	99%	1,303	99%	600	99%	973	100%	2,195	99%
Medication Monitoring	243	5%	43	3%	139	23%	40	4%	21	1%
Outreach Services - Attempted Contact	843	16%	181	14%	131	22%	401	41%	130	6%
Outreach Services - Client Contact	604	12%	47	4%	210	35%	309	32%	38	2%
Post-OCRP Client Check-in (up to 60 days)	35	1%	--	--	13	0	11	0	--	--
Post-OCRP Coordinated Transitions	25	0%	--	--	--	--	--	--	--	--
Referral to Services	1,496	29%	367	28%	211	35%	488	80%	430	19%

	TOTAL - ALL REGIONS		Started July 1, 2020						Started January 1, 2022	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
REFERRALS										
Adult Protective Services (APS)	2	0%	--	--	0	0	--	--	0	0
Community Outpatient Mental Health Services	435	8%	37	3%	36	6%	326	54%	36	2%
Designated Crisis Responder (DCR) Referral	12	0%	0	0%	--	--	--	--	--	--
EBT/ABD (Food/Cash Benefits)	221	4%	--	--	--	--	212	0	--	--
Educational Services	47	1%	--	--	--	--	44	0	--	--
Employment Assistance	89	2%	--	--	--	--	85	0	--	--
Forensic HARPS Services	835	16%	197	15%	160	26%	140	23%	338	15%
Forensic PATH Services	929	18%	238	18%	110	18%	259	43%	322	14%
Home and Community Services	216	4%	--	--	--	--	209	0	--	--
Housing Services (Non-HARPS)	232	5%	15	1%	--	--	206	34%	--	--
Job Training	29	1%	0	0%	--	--	28	5%	--	--
Medical Insurance Services	171	3%	0	0%	--	--	170	28%	--	--
Other Community Based Resource	341	7%	64	5%	12	2%	249	41%	16	1%
Primary Health Care/Dental Care	152	3%	0	0%	--	--	149	25%	--	--
SSI/SSDI	175	3%	0	0%	0	0%	175	29%	0	0%
Substance Use Disorder Treatment	300	6%	--	--	--	--	276	0	17	0
Supported Employment	21	0%	0	0%	--	--	--	--	0	0%
VA Benefits	8	0%	--	--	0	0	--	--	0	0

DATA SOURCE: Navigator Case Management System (NCM) and Forensic Data System (FDS).

NOTES: See 'Definitions' for more detailed information on each reporting category. Counts and percentages may not sum due to suppressed data and/or rounding. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
CLIENTS DISCHARGED										
Clients discharged during the reporting period	4,743	100%	1,254	100%	541	100%	928	100%	2,020	100%
Clients discharged w/ warm hand-off to provider or jail staff	1,434	30%	462	37%	197	36%	379	41%	396	20%
Among Clients Discharged…										
DISCHARGE REASON										
Charges Dismissed	759	16%	146	12%	49	9%	79	9%	485	24%
Civil Conversion - Removal from OCRP	3	0%	--	--	0	0	--	--	0	0
Client Death	5	0%	0	0%	--	--	--	--	--	--
Client Determined Competent	1,444	30%	469	37%	212	39%	269	29%	494	24%
Dismiss & Refer to Designated Crisis Responder	238	5%	89	7%	40	7%	17	2%	92	5%
Diversion Program(s)	4	0%	0	0%	0	0%	--	--	--	--
Felony (72-Hour) Civil Conversion	56	1%	--	--	--	--	41	0	--	--
Inpatient Restoration	977	21%	389	31%	151	28%	125	13%	312	15%
Not Restorable - Developmental Disability	8	0%	--	--	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	13	0%	--	--	--	--	--	--	--	--
Order Canceled or Withdrawn	152	3%	20	2%	15	3%	11	1%	106	5%
Re-arrest	4	0%	--	--	--	--	0	0	--	--
Refused Forensic Navigator Services	97	2%	--	--	--	--	39	0	34	0
Released from Jail on Personal Recognizance (PR)	914	19%	97	8%	32	6%	309	33%	476	24%
Successful OCRP Completion - Coordinated transition completed	29	1%	--	--	12	0	--	--	--	--
Successful OCRP Completion - Summary of treatment completed	11	0%	--	--	--	--	--	--	0	0
Violation of OCRP Conditions of Participation/Court Ordered CR	28	1%	--	--	13	0	--	--	0	0
LENGTH OF STAY										
Average Length of Stay in Forensic Navigator Program (days)	39.0	N/A	35.4	N/A	58.4	N/A	43.0	N/A	34.3	N/A

DATA SOURCE: Navigator Case Management System (NCM) and Forensic Data System (FDS).

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality.

Forensic Navigator Program Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and Phase 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred or enrolled more than once in Forensic Navigator services during the reporting period, only the most recent information is included.
Referred	All individuals with an outpatient competency evaluation order are referred to the Forensic Navigator Program.
Forensic Navigator Assigned	Individuals assigned to a Forensic Navigator during the reporting period.
Client Status (on last day of reporting period)	Program enrollment status on the last day of the reporting period, among those assigned to a Navigator.
Active	Individuals assigned a navigator, who have not yet been discharged from the program as of the last day of the reporting period.
Pre-Competency Hearing Clients	Individuals in the pre-competency hearing phase of Forensic Navigator services. These individuals have not yet had a competency hearing.
OCRP Enrolled	Individuals in the Outpatient Competency Restoration Program (OCRP) phase of Forensic Navigator services. These individuals have been found not competent to stand trial and ordered by the court to participate in outpatient (community-based) competency restoration treatment.
Post-OCRP (Coordinated Transition)	Individuals who have successfully completed the Outpatient Competency Restoration Program and are in the coordinated transition phase of Forensic Navigator services, meaning the Navigator is attempting to ensure the client is connected to community behavioral health services.
Reassess for OCRP	Individuals for whom a Navigator is re-opening a case when OCRP is being re-considered. This can happen for individuals in jail, in the state hospitals or an RTF, or in the community.
In Process of OCRP Removal	Individuals who have been terminated from OCRP and the Navigator is making attempts to remove them to inpatient restoration, but they have not yet been admitted to an inpatient facility.
Discharged	Clients who were discharged from Forensic Navigator services during the reporting period.
Gender	Client's gender based on either self report or administrative records.
Age Group	Age is based on date of birth and date the navigator was assigned.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Most Serious Criminal Charge	The most serious criminal charge (Felony/Misdemeanor) associated with the competency evaluation order that initiated forensic navigator services.
Housing Status at Program Intake	Self-reported housing status at time of intake; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission. Forensic navigators attempt to capture housing status at the initial meeting with a client. Housing status is reported as "unknown" when the navigator is unable to meet with the client or when the client is not able to report their housing status.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.

Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing status is unknown. Housing situation indeterminate at time of initial meeting between Forensic Navigator and client or from the information gathered at time of FN assignment.
SERVICES TABLE, Cumulative	
Avg Daily Caseload	The average daily caseload per Forensic Navigator during the reporting period's most recent quarter.
Forensic Navigator Services	Forensic Navigator Services provided to active clients at any point during the reporting period. Number represents the number of individuals receiving the service at any point during the reporting period. Percent represents the percentage of active clients who received the service.
Assisting Clients with Attending Classes and Appointments	Forensic Navigator provided assistance including facilitating transportation of a client to attend OCRP classes or appointments in the community. This includes setting up transport assistance, such as Hopelink, coordinating transportation through FHARPS, FPATH, or OCRP, or providing direct transportation.
Attending Competency Hearing	Forensic Navigator attended the client's competency hearing in-person, by phone, or virtually.
Client Meeting, Interview, and/or Observation	Forensic Navigator met with, interviewed, and observed the client.
Client Support-Network Interaction	Forensic Navigator communicated (via phone, email, in-person) with family and/or friends of a client in order to coordinate care.
Completed Recommended Services Plan	Forensic Navigator completed (or updated) and submitted a Recommended Services Plan to the court, or uploaded the service plan to the Navigator Case Management System (NCM).
OCRP Compliance Monitoring	Forensic Navigator engaged in communication (phone, email, in-person) with OCRP providers, probation officer, legal counsel, and/or client to ensure client's compliance with conditions of release.
Contact with Client's Attorney or Prosecutor	Forensic Navigator called, emailed, met with, or in any other way either communicated with OR sent communication to client's defense attorney, the prosecuting attorney, or the defense/prosecution attorney of record for the case.
Coordination of Care	Forensic Navigator synchronized the delivery of a client's care between multiple providers and/or specialists to ensure care from disparate providers is not delivered in silos.
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	Forensic Navigator provided written or oral report on client's progress to the court per the court's request, on a periodic basis, or at the time of hearing. Written reports may be provided by email, and oral reporting by phone.
Information Gathering	Forensic Navigator gathered one or more documents, or other reported information relevant to the client, prior to the competency evaluation hearing. Includes, but not limited to, behavioral health, educational, and/or law enforcement agency records.
Medication Monitoring	Forensic Navigator engaged in any form of communication (phone, email, in person) with OCRP providers, the client, or others to assure the client's adherence to prescribed medication(s). This also include assisting clients with obtaining medication.
Outreach Services - Attempted Contact	Forensic Navigator attempted to locate and engage client in the community, but was unable to make contact with the client.
Outreach Services - Client Contact	Forensic Navigator attempted to locate and engage client in the community, and successfully contacted the client.
Post-OCRP Client Check-in (up to 60 days)	After a client successfully completes OCRP, Forensic Navigator attempted to follow-up with the client and/or community provider (via phone, email, or in person) to determine whether the client is receiving community mental health services.
Post-OCRP Coordinated Transitions	Forensic Navigator engaged in any form of communication (phone, email, in-person) with community providers to establish on-going behavioral health care for a client after OCRP discharge.
Referral to Services	Forensic Navigator referred a client to a specific outpatient service (substance use, mental health treatment, employment, etc.). Active Forensic Navigator support on behalf of or in conjunction with a client to connect them to another provider, agency or organization for services.
Referrals	Referrals made by the Forensic Navigator on behalf of a client. Among active clients (at any point during the reporting period).
Adult Protective Services (APS)	Forensic Navigator referred client to Adult Protective Services.
Community Outpatient Mental Health Services	Forensic Navigator referred client to Community Outpatient Mental Health Services.
Designated Crisis Responder (DCR) Referral	Forensic Navigator referred client to the Designated Crisis Responders (DCRs).
EBT/ABD (Food/Cash Benefits)	Forensic Navigator aided the client in applying for or reestablishing EBT/ABD (Food/Cash Benefits).
Educational Services	Forensic Navigator aided the client in obtaining educational services (e.g. classes, school, technical).
Employment Assistance	Forensic Navigator aided the client in obtaining employment/vocational services.

Forensic HARPS Services	Forensic Navigator referred client to Forensic HARPS Services.
Forensic PATH Services	Forensic Navigator referred client to Forensic PATH Services.
Home and Community Services	Forensic Navigator referred client to Home and Community Services.
Housing Services (Non-HARPS)	Forensic Navigator aided the client in applying for or reestablish Housing Services (Non-HARPS).
Job Training	Forensic Navigator aided the client in obtaining job training (e.g. classes, school, technical).
Medical Insurance Services	Forensic Navigator referred client to Medical Insurance Services.
Other Community Based Resource	Forensic Navigator referred client to Other Community Based Resource.
Primary Health Care/Dental Care	Forensic Navigator aided client in establishing or reestablishing Primary Health Care/Dental Care.
SSI/SSDI	Forensic Navigator aided the client in applying for Supplemental Security Income/Social Security Disability Insurance.
Substance Use Disorder Treatment	Forensic Navigator aided the client in establishing or reestablishing Substance Use Disorder Treatment.
Supported Employment	Forensic Navigator aided the client in obtaining supported employment (e.g. classes, school, technical).
VA Benefits	Forensic Navigator aided the client in obtaining Veterans Services and/or benefits.
DISCHARGE TABLE, Cumulative	
Discharged with Warm Hand-Off to Provider or Jail Staff	When a Forensic Navigator interacts with service providers or correctional staff to move a client from the Forensic Navigator Program to a jail, community mental health agency, hospital, Residential Treatment Facility, or other forensic service. Occurs if client had a Forensic Navigator assigned, a competency hearing took place, and that client is not ordered to the OCRP.
Discharge Reasons	The reason Forensic Navigator services ended and the individual was discharged from the program.
Charges Dismissed	The criminal charges associated with the order for competency services were dismissed.
Civil Conversion - Removal from OCRP	The court ordered a forensic to civil conversion commitment (72 Hour Felony/Misdemeanor Evaluation) after the client had been ordered to OCRP.
Client Death	Client deceased.
Client Determined Competent	Client found competent by the court.
Dismiss and Refer to Designated Crisis Responder	Charges were dismissed and the client was referred by the court to the Designated Crisis Responders for evaluation.
Diversion Program(s)	Client ordered by court into diversion program (e.g. prosecutorial diversion program).
Felony (72-Hour) Civil Conversion	The court ordered a forensic to civil conversion commitment (72 Hour Felony) at the initial competency hearing.
Inpatient Restoration	Client ordered by court into a state psychiatric hospital for inpatient restoration services.
Not Restorable - Developmental Disability	Navigator services ended because the level of the client's disability indicated to the court that the client could not be restored.
Not Restorable - Pre-Hearing/OCRP	Navigator services ended at the pre-hearing stage because prior findings of not restorable indicated to the court that the client could not be restored. Or the client was evaluated for competency to stand trial while in OCRP and was determined by the court to be not restorable.
Order Canceled or Withdrawn	The court order for competency services was canceled or withdrawn.
Re-arrest	Individual re-arrested and unable to continue Forensic Navigator Program services.
Refused Forensic Navigator Services	Individual refused Forensic Navigator Program services prior to the initial competency hearing.
Released from Jail on Personal Recognizance (PR)	Individual released from jail at, before or after the initial competency evaluation order, but prior to the initial competency hearing or finding.
Successful OCRP Completion - Coordinated Transition Completed	Individual ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator completed a coordinated transition for the client from OCRP to community behavioral health services.
Successful OCRP Completion - Summary of Treatment Completed	Individual was ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator did not complete a coordinated transition for the client from OCRP to community behavioral health services, but did complete a summary of treatment.
Violation of OCRP Conditions of Participation/Court Ordered CR	Individual violated OCRP conditions of participation and/or conditions of release, and was removed from OCRP.
Length of Stay	
Average Length of Stay in Program (days)	The average number of days from the date the Forensic Navigator was assigned to the date the individual was discharged from the program.

Appendix D-Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Crisis Housing Voucher Disbursals

CUMULATIVE UPDATE

Beginning December 2019, Washington State Health Care Authority (HCA) contracted funds for select crisis triage and stabilization facilities. The intent of the program was to provide crisis housing vouchers for persons leaving a facility without housing. To better meet community needs, contracts were expanded to allow teams to distribute vouchers outside crisis triage and stabilization facilities. Vouchers were available in the Phase 1 Regions of the Trueblood settlement agreement including Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) regions on December 1, 2019. Vouchers were available in Phase 2 Region (King County) in July 2022.

REPORTING PERIOD

Cumulative: December 1, 2019 to June 30, 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
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- Definitions

TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started December 1, 2019*						PHASE 2 REGION *Started July 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY										
Vouchers Disbursed	580	100%	89	15.3%	222	38.3%	214	36.9%	55	9.5%
Recipients (unduplicated)	443	100%	89	20.1%	181	40.9%	134	30.2%	39	8.8%
Total Amount Disbursed	$564,772	N/A	$107,638	N/A	$241,104	N/A	$176,659	N/A	$39,371	N/A
Average Amount Per Recipient	$1,275	N/A	$1,209	N/A	$1,332	N/A	$1,318	N/A	$1,010	N/A
FACILITY REFERRAL SOURCE										
Crisis Call Center	2	0.5%	0	0.0%	--	--	--	--	0	0%
Family/Friend	5	1.1%	--	--	--	--	0	0.0%	0	0%
Hospital	131	29.6%	34	38.2%	--	--	66	49.3%	--	--
Mobile Crisis Response	21	4.7%	--	--	--	--	20	14.9%	0	0%
Designated Crisis Responder	33	7.4%	0	0.0%	0	0.0%	33	24.6%	0	0%
Tribe or Indian Healthcare Provider	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0%
Emergency Responder	3	0.7%	--	--	--	--	0	0.0%	0	0%
Other Healthcare Provider	28	6.3%	--	--	17	9.4%	--	--	--	--
Law Enforcement (Police, Co-Responders)	36	8.1%	12	13.5%	--	--	--	--	17	44%
Court/Criminal Justice Referred	8	1.8%	0	0.0%	--	--	0	0.0%	--	--
Self	157	35.4%	21	23.6%	131	72.4%	--	--	--	--
Other	19	4.3%	14	15.7%	0	0.0%	--	--	--	--
GENDER										
Female	136	30.7%	20	22.5%	--	--	--	--	15	38%
Male	301	67.9%	69	77.5%	123	68.0%	85	63.4%	24	62%
Other/Unknown	6	1.4%	0	0.0%	--	--	--	--	0	0%
AGE GROUP										
18-29	92	20.8%	--	--	36	19.9%	24	17.9%	--	--
30-49	249	56.2%	45	50.6%	103	56.9%	79	59.0%	22	56%
50+	102	23.0%	--	--	42	23.2%	31	23.1%	--	--
RACE/ETHNICITY										
Non-Hispanic White	292	65.9%	50	56.2%	142	78.5%	86	64.2%	14	36%
Black, Indigenous, and People of Color	141	31.8%	39	43.8%	39	21.5%	--	--	--	--
Unknown	10	2.3%	0	0.0%	0	0.0%	--	--	--	--

	TOTAL - ALL REGIONS		Started December 1, 2019						Started July 1, 2022	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Voucher Recipients…										
FORENSIC HARPS (FHARPS) STATUS**										
Referred to FHARPS	110	24.8%	25	28.1%	--	--	57	42.5%	--	--
Contacted by FHARPS staff	100	22.6%	23	25.8%	--	--	54	40.3%	--	--
Enrolled in FHARPS	100	22.6%	23	25.8%	--	--	54	40.3%	--	--
Housed or sheltered by FHARPS	89	20.1%	20	22.5%	--	--	47	35.1%	--	--
Among Individuals Housed or Sheltered by FHARPS…										
FIRST FHARPS HOUSING TYPE*										
Permanent	2	2.2%	--	--	0	0.0%	--	--	--	--
Transitional	11	12.4%	0	0.0%	--	--	--	--	0	0%
Shelter/emergency	76	85.4%	--	--	--	--	41	87.2%	--	--
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0%

DATA SOURCES: Excel trackers submitted by each contracted provider to the Washington State Health Care Authority (HCA).

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

*Race/ethnicity categories will be expanded when there are sufficient numbers to report by region.

**Not all voucher recipients are eligible for FHARPS, and may be referred to other housing resources not captured in the data.

Crisis Housing Voucher Definitions

Variable name	DESCRIPTION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
VOUCHERS TABLE, Cumulative	
Voucher Summary	Voucher information including counts, recipients, and amounts.
Vouchers Disbursed	Total number of vouchers disbursed during the reporting period. Regional percentages for Voucher Summary section are calculated based on each region count divided by the 'All Regions' total.
Recipients (unduplicated)	Number of unique individuals receiving vouchers during the reporting period. Individuals in receipt of vouchers from more than one region will be counted in the region that distributed the most recent voucher. Regional percentages for Voucher Summary section are calculated based on each region count divided by the 'All Regions' total.
Total Amount Disbursed	Total amount of voucher monies spent during the reporting period.
Average Amount Per Recipient	Average (mean) voucher amount per recipient. Calculated by the total amount disbursed divided by the number of unduplicated recipients during the reporting period. A region that disbursed a vouchers to a recipient who later received a voucher in another region will not include that individual in the calculation, resulting in a slightly higher average per recipient for that region.
Facility Referral Source	Source that referred the individual to the crisis triage and stabilization facility.
Crisis Call Center	Center that provides support from persons trained in crisis intervention.
Family/Friend	Family member or friend.
Hospital	Facility providing medical and surgical treatment and nursing care for sick or injured people.
Mobile Crisis Response	Mobile Crisis Response team providing community services to individuals experiencing, or are at imminent risk of experiencing, a behavioral health crisis.
Designated Crisis Responder	Person or team that determines a person presents a harm to self/others/property, or is gravely disabled and is at imminent risk, or if there is a nonemergent risk due to a substance use disorder or mental disorder, or is in need of assisted outpatient behavioral health treatment.
Tribe or Indian Healthcare Provider	A tribe member or health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.
Emergency Responder	Person authorized to render emergency medical care (e.g. emergency medical technician).
Other Healthcare Provider	A healthcare provider not included in the other category options (e.g., outpatient behavioral health, primary care physician).
Law Enforcement (Police, Co-Responders)	Federal, state, or local law enforcement officers. Includes Co-Responder teams made up of law enforcement and mental health staff to professionally, humanely, and safely respond to crises involving persons with behavioral health issues.

Court/Criminal Justice Referred	Court or other criminal justice related resource (e.g., reentry program, attorney).
Self	Self-referral.
Other	Other referral sources not listed as a referral source option.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Black, Indigenous, and People of Color categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was unreported.
Forensic HARPS (FHARPS) Status	Voucher recipients were matched to FHARPS cases using unique identifiers; some matches may be missed due to data inconsistencies. Not all voucher recipients are eligible for FHARPs and may be referred to other housing resources not captured in the data.
Referred to FHARPS	Individuals referred to FHARPS during the reporting period.
Contacted by FHARPS staff	Individuals contacted to attempt to enroll in the program during the reporting period.
Enrolled in FHARPS	Participants enrolled during the reporting period.
Housed or Sheltered	Participants who accepted at least one housing placement since enrollment. Includes temporary housing in shelters and motels.
First FHARPS Housing Type	First housing type placement after program enrollment. Includes temporary housing in shelters and hotels/motels.
Permanent	Includes the following housing types: Scattered site, Project site, alternative housing (e.g., rental or purchase of mobile home, RV, tiny home, etc.).
Transitional	Includes the following housing types: Transitional, Oxford House, Recovery Residence, Sober Living, Shared Living, Single Site, Tiney Home Villages, Master Leasing.
Shelter/emergency	Includes the following housing types: shelter, hotel/motel.
Other	Other housing types not listed as a housing type option or missing/unknown first housing type(s).

Appendix E-FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

Forensic Housing and Recovery Through Peer Services (FHARPS), administered by the Healthcare Authority, is designed to provide residental support to unstably housed individuals with former or current involvment with the forensic mental health system, or individuals at risk of becoming involved in the system due to mental health needs. The program began March 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) regions. FHARPS services began in the Phase 2 Region (King County) in April 2022.

REPORTING PERIOD
Cumulative: March 1. 2020 to June 30. 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
Olympia, Washington

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TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	1,621	100%	684	100%	322	100%	414	100%	201	100%
Contacted	1,105	68%	466	68%	278	86%	200	48%	161	80%
Enrolled	980	60%	425	62%	249	77%	194	47%	112	56%
Among Referred Individuals…										
REFERRAL SOURCE										
Trueblood partner programs	980	60%	270	38%	211	65%	300	70%	199	99%
Forensic Navigator	*561*	*35%*	*122*	*18%*	*150*	*47%*	*90*	*22%*	*199*	*99%*
Forensic PATH	*232*	*14%*	*89*	*13%*	*24*	*7%*	*119*	*29%*	*0*	*0%*
OCRP	*12*	*1%*	--	--	--	--	--	--	*0*	*0%*
Crisis Stabilization Center	*152*	*9%*	*49*	*7%*	*34*	*11%*	*69*	*17%*	*0*	*0%*
Mobile Crisis Response	*2*	*0%*	--	--	--	--	--	--	--	--
Co-Response Team	*21*	*1%*	--	--	--	--	*11*	*3%*	*0*	*0%*
Behavioral Health Facility - Outpatient	257	16%	127	19%	89	28%	41	10%	0	0%
Inpatient Facility	56	3%	36	5%	--	--	--	--	0	0%
Family/Self	50	3%	33	5%	--	--	--	--	0	0%
Other	278	17%	218	32%	--	--	43	10%	--	--
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT										
Phone	421	38%	235	50%	155	56%	31	16%	0	0%
Court	2	0%	--	--	--	--	0	0%	0	0%
Hotel/Motel	31	3%	25	5%	--	--	--	--	0	0%
Jail	315	29%	24	5%	103	37%	28	14%	160	99%
Crisis Stabilization Center	63	6%	14	3%	0	0%	49	25%	0	0%
Behavioral Health Facility - Outpatient	121	11%	58	12%	--	--	--	--	0	0%
Inpatient Facilty	25	2%	14	3%	0	0%	11	6%	0	0%
Shelter	12	1%	--	--	0	0%	--	--	0	0%
Street/encampment	10	1%	--	--	--	--	--	--	0	0%
Temporary Residence	6	1%	--	--	0	0%	--	--	0	0%
Other	99	9%	71	15%	--	--	22	11%	--	--
Among Enrolled Individuals…										
PARTICIPANT STATUS (on last day of reporting period)										
Active	290	30%	88	21%	55	22%	49	25%	98	88%
Discharged	690	70%	337	79%	194	78%	145	75%	14	13%
GENDER										
Female	287	29%	--	--	--	--	--	--	28	25%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Male	681	69%	272	64%	182	73%	143	74%	84	75%
Other/Unknown	12	1%	--	--	--	--	--	--	0	0%
AGE GROUP										
18-29	245	25%	114	27%	68	27%	34	18%	29	26%
30-49	555	57%	208	49%	150	60%	129	66%	68	61%
50+	180	18%	103	24%	31	12%	31	16%	15	13%
RACE/ETHNICITY*										
American Indian or Alaska Native	66	7%	30	7%	22	9%	--	--	--	--
Asian	20	2%	--	--	--	--	--	--	--	--
Black or African American	246	25%	154	36%	33	13%	30	15%	29	26%
Hispanic or Latino	94	10%	44	10%	29	12%	--	--	--	--
Native Hawaiian or Pacific Islander	13	1%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	488	50%	186	44%	143	57%	137	71%	22	20%
Other Race	64	7%	18	4%	37	15%	--	--	--	--
Unknown	75	8%	20	5%	--	--	--	--	47	42%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Unstably Housed	401	41%	108	25%	148	59%	--	--	--	--
Homeless	579	59%	317	75%	101	41%	--	--	--	--

DATA SOURCE: FHARPS excel trackers submitted by each provider to the Washington State Health Care Authority (HCA).

NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

*Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. Individuals may report more than one race/ethnicity.

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	980	100%	425	100%	249	100%	194	100%	112	100%
Housed or Sheltered	768	78%	384	90%	179	72%	159	82%	46	41%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies only	14	1%	--	--	--	--	--	--	--	--
Support Services and Subsidies	966	99%	--	--	--	--	--	--	--	--
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	68	9%	47	12%	--	--	12	8%	--	--
Transitional	277	36%	152	40%	49	27%	31	19%	45	98%
Shelter/emergency	422	55%	185	48%	121	68%	116	73%	0	0%
Other	1	0%	0	0%	--	--	0	0%	--	--

DATA SOURCE: FHARPS excel trackers submitted by each provider to the Washington State Health Care Authority (HCA).

NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS										
Enrolled	980	100%	425	100%	249	100%	194	100%	112	100%
Active (on last day of reporting period)	290	30%	88	21%	55	22%	49	25%	98	88%
Discharged (during reporting period)	690	70%	337	79%	194	78%	145	75%	14	13%
Among Individuals Discharged…										
SUBSIDY										
Average total subsidy since enrollment	$6,493	N/A	$7,138	N/A	$6,907	N/A	$4,687	N/A	$1,843	N/A
DISCHARGE REASON										
Transitioned to other housing support	111	16%	92	27%	--	--	17	12%	--	--
Received maximum subsidy	*19*	*3%*	--	--	--	--	--	--	--	--
Did not receive maximum subsidy	*92*	*13%*	--	--	--	--	--	--	--	--
Transitioned to self-support	95	14%	48	14%	28	14%	19	13%	0	0%
Admitted to a facility	41	6%	12	4%	--	--	--	--	0	0%
Received maximum assistance (no transition)	62	9%	30	9%	20	10%	12	8%	0	0%
Withdrew	96	14%	32	9%	38	20%	--	--	--	--
Loss of contact	189	27%	68	20%	74	38%	47	32%	0	0%
Served by another FHARPS team	7	1%	--	--	--	--	0	0%	0	0%
Other	89	13%	49	15%	21	11%	--	--	--	--
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	209	N/A	224	N/A	179	N/A	228	N/A	42	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	236	34%	149	44%	48	25%	39	27%	0	0%
Unstably Housed	58	8%	24	7%	27	14%	--	--	--	--
Homeless	89	13%	55	16%	--	--	--	--	--	--
In a Facility	81	12%	21	6%	--	--	40	28%	--	--
Unknown	226	33%	88	26%	80	41%	47	32%	11	79%

DATA SOURCE: FHARPS excel trackers submitted by each provider to the Washington State Health Care Authority (HCA).
NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

FHARPS Definitions

VARIABLE NAMES	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLES, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Referred	Individuals referred to FHARPS during the reporting period.
Contacted	Individuals contacted to attempt to enroll in the program during the reporting period.
Enrolled	Participants enrolled during the reporting period.
Referral source	Source of the referral to FHARPS services. If more than one source referred the participant for FHARPS services, providers are instructed to enter the first referral source.
Trueblood Partner Programs	Programs implemented as part of Trueblood settlement actitivities.
Forensic Navigator	Staff from the Forensic Navigator program, a program that seeks to divert forensically-involved criminal defendants out of jails and inpatient treatment settings, and into community-based treatment settings.
Forensic PATH	Staff from a Forensic Projects for Assistance in Transition from Homelessness (PATH), a program that connects people to treatment and recovery services.
OCRP	Staff from an Outpatient Competency Restoration Program (OCRP), a program that helps defendants achieve the ability to participate in his or her own defense in a community-based setting.
Crisis Stabilization Center	Staff from a Crisis Stabilization Center that provides services to adults who are experiencing a mental health crisis, or who are in need of withdrawal management services, and helps them restore and stabilize their health.
Mobile Crisis Response	Staff from a Mobile Crisis Response team providing community services to individuals experiencing, or are at imminent risk of experiencing, a behavioral health crisis.
Co-Response Team	Staff from a Co-Responder or Co-Deployment team, made up of law enforcement and mental health staff to professionally, humanely, and safely respond to crises involving persons with behavioral health issues.
Behavioral Health Facility - Outpatient	Staff from a Community behavioral health agency that provides outpatient mental health or substance use services (outside of others listed here, e.g., FPATH and OCRP); excludes Crisis Stabilization Center.
Inpatient Facility	Staff from an Inpatient facility providing treatment for mental health, substance use, or medical needs; exclude crisis stabilization centers and outpatient services.
Family/Self	Family member or guardian of participant referral, or participant initiated contact. May include cases in which family or participant contacted FHARPS after receiving referral information from another source.
Other	Other referral sources not listed as a referral source option, including non-government organizations offering support and recovery services.
Location of Initial Contact	Point of initial contact between participant and FHARPS staff.
Phone	Telephone conversation not including voicemail messages.
Court	Superior, District, or Municipal Court within the region.

Hotel/Motel	Establishment for lodging on a short-term basis.
Jail	County, city, or tribal correctional facility.
Crisis Stabilization Center	A short-term residential stabilization service for individuals with mental health and/or substance use disorders.
Behavioral Health Facility - Outpatient	A community behavioral health agency that provides outpatient mental health or substance use services; excludes Crisis Stabilization Center.
Inpatient Facilty	Any inpatient facility providing treatment for mental health, substance use, or medical needs; excludes crisis stabilization centers and outpatient services.
Shelter	Service agency that provides temporary residence for homeless individuals and families.
Street/Encampment	On the street or in a homeless camp/encampment site (an area with multiple homeless individuals).
Temporary Residence	Shelter or other temporary shared quarters (couch surfing, doubled up); excludes hotel/motel.
Other	Other locations not listed as a location option.
Participant Status	Participant program enrollment status.
Active (on last day of reporting period)	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged (during reporting period)	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
HOUSING SUPPORT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Participants enrolled during the reporting period.
Housed or Sheltered	Participants who accepted at least one housing placement since enrollment. Includes temporary housing in shelters and motels.
Services Participant Agreed To	Participants may choose to receive subsidy assistance only, or subsidies with support services.
Subsidies Only	Participant agreed to receive only subsidy support.
Support Services and Subsidies	Participant agreed to support services (e.g., transportation, seeking housing, assisting with lease and landlord relations, referrals to additional services, etc.) from an FHARPS peer or housing specialist and subsidy support.
First Housing Type	First housing type placement after program enrollment. Includes temporary housing in shelters and hotels/motels.
Permanent	Includes the following housing types: Scattered site, Project site, alternative housing (e.g., rental or purchase of mobile home, RV, tiny home, etc.).
Transitional	Includes the following housing types: Transitional, Oxford House, Recovery Residence, Sober Living, Shared Living, Single Site, Tiny Home Villages, Master Leasing.
Shelter/Emergency	Includes the following housing types: shelter, hotel/motel.
Other	Other housing types not listed as a housing type option or missing/unknown first housing type(s).
DISCHARGE TABLE, Cumulative	
Participant Status	Participant program enrollment status.

Enrolled	Participants enrolled during the reporting period.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Subsidy	The average total subsidy amount per person based on the most recent enrollment and discharge. Subsidies may be approved for a variety of uses, including but not limited to credit checks, application fees, rent, and utilities.
Average Total Subsidy Since Enrollment	Based on total subsidies provided for all discharged participants, divided by the number discharged. Only discharged recipients who received subsidies are included in the calculation.
Discharge Reason	Reason participant is no longer receiving FHARPS subsidies.
Transitioned to Other Housing Support	Transitioned to non-FHARPS subsidy support, either prior to or after receiving maximum FHARPS subsidy.
Received Maximum Subsidy	Received maximum FHARPS subsidy and transitioned to non-FHARPS subsidy support.
Did Not Receive Maximum Subsidy	Did not receive maximum FHARPS subsidy and transitioned to non-FHARPS subsidy support.
Transitioned to Self-Support	Transitioned to self-support (non-subsidized housing placement).
Admitted to a Facility	Became ineligible for FHARPS due to extended facility stay.
Received Maximum Assistance (no transition)	Unstably housed or homeless after receiving maximum FHARPS assistance.
Withdrew	Participant decided they no longer wanted FHARPS subsidies or support, ability to support self is unknown; excludes transition to self support and loss of contact.
Loss of Contact	Did not receive maximum FHARPS subsidy and whereabouts are unknown for > 60 days.
Served by Another FHARPS Team	Participant is enrolled with another FHARPS team.
Other	Other reason participant is no longer receiving FHARPS subsidies not listed as a discharge reason option.
Length of Support	FHARPS subsidies and support services provided from the time of enrollment to discharge.
Average Length of Stay in Program (days)	The average (mean) length of stay, in days, from the time of enrollment to discharge, among participants discharged from the program during the reporting period. Calculation is limited to the duration of most recent enrollment.
Housing Status at Discharge	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program end.

Appendix F-FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

Led by the Washington State Health Care Authority (HCA), the Forensic PATH program offers enhanced engagement and connection to services for individuals identified as most at risk of being referred for a competency evaluation within the next six months. Teams within behavioral health agencies will connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The Forensic PATH program began on March 1, 2020 in the Phase 1 regions and April 1, 2022 in the Phase 2 region.

March 1, 2020 to June 30, 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
Olympia, Washington

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- Definitions

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION										
Number on Referral List	2,859	100%	1,055	100%	309	100%	589	100%	906	100%
Attempted Contacts	1,173	41%	530	50%	119	39%	392	67%	132	15%
Contacted	869	30%	212	20%	152	49%	271	46%	234	26%
Enrolled	497	17%	165	16%	115	37%	107	18%	110	12%
PRIORITIZED POPULATION										
Prioritized Referral List	1,243	43%	501	47%	121	39%	309	52%	312	34%
Attempted Contacts	596	48%	296	59%	47	39%	209	68%	44	14%
Contacted	379	30%	103	21%	66	55%	135	44%	75	24%
Enrolled	237	19%	81	16%	53	44%	63	20%	40	13%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	262	53%	85	52%	41	36%	55	51%	81	74%
Discharged*	235	47%	80	48%	74	64%	52	49%	29	26%
Average Length of Stay in Program (days)	269.5	N/A	314.4	N/A	279.4	N/A	254.3	N/A	147.8	N/A
DISCHARGE REASON										
Successful exit	44	19%	18	23%	11	15%	15	29%	0	0%
Loss of contact	108	46%	38	48%	27	36%	20	38%	23	79%
Needs could not be met by program	11	5%	--	--	--	--	0	0%	--	--
Withdrew	14	6%	--	--	--	--	--	--	--	--
Incarceration	27	11%	--	--	14	19%	--	--	--	--
Admitted to hospital	7	3%	--	--	--	--	--	--	0	0%
Transferred to another FPATH program	1	0%	--	--	--	--	0	0%	0	0%
Death	9	4%	--	--	--	--	--	--	0	0%
Other	14	6%	--	--	--	--	--	--	0	0%
GENDER										
Female	100	22%	--	--	--	--	--	--	19	24%
Male	348	77%	126	80%	83	76%	80	75%	59	76%
Other/Unknown	49	10%	--	--	--	--	--	--	32	29%
AGE GROUP										
18-29	121	24%	43	26%	28	24%	--	--	--	--
30-49	308	62%	88	53%	73	63%	72	67%	75	68%
50+	68	14%	34	21%	14	12%	--	--	--	--
RACE/ETHNICITY**										
American Indian or Alaskan Native	18	4%	--	--	--	--	--	--	--	--
Asian	15	3%	--	--	--	--	--	--	--	--
Black or African American	109	22%	41	25%	--	--	--	--	38	35%
Hispanic or Latino	40	8%	13	8%	15	13%	--	--	--	--

Native Hawaiian and Other Pacific Islander	8	2%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	196	39%	43	26%	66	57%	54	50%	33	30%
Other Race	25	5%	--	--	--	--	--	--	--	--
Unknown	114	23%	63	38%	--	--	31	29%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	35	7%	--	--	--	--	11	10%	--	--
Unstably Housed	106	21%	32	19%	27	23%	32	30%	15	14%
Homeless	343	69%	113	68%	77	67%	64	60%	89	81%
Unknown	13	3%	--	--	--	--	0	0%	--	--
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	48	20%	22	28%	12	16%	14	27%	0	0%
Unstably Housed	11	5%	--	--	--	--	--	--	--	--
Homeless	32	14%	13	16%	--	--	--	--	--	--
In a Facility	41	17%	--	--	19	26%	12	23%	--	--
Unknown	103	44%	30	38%	30	41%	21	40%	22	76%

DATA SOURCE: FPATH excel trackers submitted by each provider to the Washington State Health Care Authority (HCA) and FPATH program data from the Washington State Department of Commerce Housing Management Information System.

*The number of discharged participants in the Pierce region has decreased since the September 2022 semi-annual report due to previous provider data entry errors.

**Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. People may be a member of more than one race/ethnicity.

-- Cells less than 11 suppressed to protect confidentiality.

NOTES: See 'Definitions' for more detailed information on each reporting category. Counts and percentages may not sum due to unreported data and/or rounding.

TABLE 2.

Forensic PATH Services

CUMULATIVE: March 1, 2020 - June 30, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS										
Total Forensic PATH Service Encounters	10,820		4,247		1,770		3,162		1,641	
Average Service Encounters (per participant, per month)		2.7		2.7		2.5		3.1		2.7
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services		0.4		0.2		0.3		0.8		0.3
Re-engagement		0.1		0.0		0.1		0.1		0.0
Screening		0.2		0.3		0.0		0.1		0.1
Clinical assessment		0.0		0.0		0.0		0.0		0.0
Habilitation/rehabilitation		0.0		0.0		0.1		0.0		0.0
Community mental health		0.1		0.0		0.4		0.0		0.0
Substance use treatment		0.0		0.0		0.0		0.0		0.0
Case management		1.5		1.9		1.1		1.5		1.3
Residential supportive services		0.1		0.1		0.3		0.0		0.0
Peer services		0.1		0.0		0.0		0.1		0.6
Service coordination		0.2		0.1		0.1		0.3		0.3
Other		0.0		0.0		0.0		0.0		0.0
Among Enrolled Individuals…										
REFERRALS - *Number of participants with at least one referral*										
Any Referral	233	46.9%	76	46.1%	58	50.4%	85	79.4%	14	12.7%
Referral Type										
Community mental health	83	16.7%	35	21.2%	--	--	23	21.5%	--	--
Substance use treatment	41	8.2%	12	7.3%	--	--	21	19.6%	0	0.0%
Primary health/dental care	42	8.5%	--	--	--	--	28	26.2%	--	--
Job training	3	0.6%	--	--	0	0.0%	--	--	0	0.0%
Educational services	3	0.6%	--	--	0	0.0%	--	--	0	0.0%
FHARPS housing	117	23.5%	45	27.3%	--	--	39	36.4%	--	--
Permanent housing (non-FHARPS)	20	4.0%	14	8.5%	--	--	--	--	--	--
Temporary housing (non-FHARPS)	47	9.5%	24	14.5%	--	--	--	--	--	--
Other Housing Services (non-FHARPS)	60	12.1%	23	13.9%	30	26.1%	--	--	0	0.0%
Housing services (pre-August 2021)	40	8.0%	--	--	--	--	30	28.0%	0	0.0%
Income assistance	14	2.8%	--	--	--	--	--	--	0	0.0%
Employment assistance	17	3.4%	--	--	--	--	--	--	0	0.0%
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	36	7.2%	--	--	--	--	25	23.4%	--	--

DATA SOURCE: FPATH excel trackers submitted by each provider to the Washington State Health Care Authority (HCA) and FPATH program data from the Washington State Department of Commerce Housing Management Information System.
-- Cells less than 11 suppressed to protect confidentiality.
NOTES: See 'Definitions' for more detailed information on each reporting category. Counts and percentages may not sum due to unreported data and/or rounding.

FPATH Definitions

Variable Name	DEFINITION
Total - All Regions	**Includes all Phase One Regions: Pierce, Southwest, Spokane.**
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
Phase Two Region	Phase Two Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLES, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated, meaning if a person is referred or enrolled more than once in Forensic PATH during a reporting period, the most recent case information is included.
Number on Referral List	Number of individuals who appeared on the Forensic PATH eligibility list during the reporting period. Eligibility criteria include having two or more competency evaluation referrals in the past 24 months.
Attempted Contacts	Individuals with an attempted (unsuccessful) contact during the reporting period.
Contacted	Individuals successfully contacted by the program during the reporting period.
Enrolled	Individuals who have agreed to formally accept Forensic PATH services and referrals, and were enrolled into the program during the reporting period.
Prioritized Population (Subset of Total Population)	Participant counts are unduplicated, meaning if a person is referred or enrolled more than once in Forensic PATH during a reporting period, the most recent case information is included.
Number on Prioritized Referral List	Number of individuals who appeared on the prioritized Forensic PATH eligibility list during the reporting period. Eligibility is prioritized based on the number of referrals for competency evaluation, county of residence, and housing status.
Attempted Contacts	Individuals on the prioritized referral list with an attempted (unsuccessful) contact during the reporting period.
Contacted	Individuals on the prioritized referral list who were successfully contacted by the program during the reporting period.
Enrolled	Individuals on the prioritized referral list who have agreed to formally accept Forensic PATH services and referrals, and were enrolled into the program during the reporting period.
Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Average Length of Stay in Program (days)	The average number of days that individuals were enrolled in the Forensic PATH program.
Discharge Reason	Reason a participant is no longer enrolled in the Forensic PATH program.
Successful exit	Participant has been successfully transitioned into services (e.g., outpatient mental health, employment, housing, substance use treatment).
Loss of contact	The Forensic PATH worker has not had any contact with the participant for at least 60 days (excludes cases where client transitioned to other outpatient services or self-withdrew).
Needs could not be met by program	Participant's needs were unable to be met by services or referrals from the Forensic PATH program.
Withdrew	Participant decided they no longer wanted Forensic PATH services or support, ability to support self is unknown.

Incarceration	Participant is no longer in the Forensic PATH program due to incarceration.
Admitted to hospital	Participant is no longer in the Forensic PATH program as a result of being admitted to a state psychiatric hospital or residential competency restoration facility.
Transferred to another FPATH program	Participant was transferred from one Forensic PATH program to another.
Death	Participant is no longer in the Forensic PATH program due to death.
Other	Participant was exited for reason(s) not listed above.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.
Race/Ethnicity	Race and Ethnicity information is based on an individual's self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
Housing Status at Program Exit	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program end.
SERVICES TABLES, Cumulative	
Program Totals	Program totals regarding services provided during the reporting period.
Total Forensic PATH Service Encounters	Sum of all Forensic PATH service encounters during the reporting period.
Average Service Encounters (per individual, per month	The average number of service encounters (per individual, per month) experienced by Forensic PATH program participants during the reporting period.
Forensic PATH Services	The primary service provided to the individual during the contact with the Forensic PATH worker/team, including the following options:
Outreach Services	Providing outreach and engagement services to individuals on the Forensic PATH eligibility list.

Re-engagement	Service that involves engaging with a Forensic PATH-enrolled individual who is disconnected from Forensic PATH services.
Screening	An in-person process during which a preliminary evaluation is made to determine a person's needs and how they can be addressed through the Forensic PATH Program.
Clinical assessment	A clinical determination of psychosocial needs and concerns.
Habilitation/rehabilitation	Services that help a Forensic PATH individual learn or improve the skills needed to function in a variety of activities of daily living.
Community mental health	A range of mental health and/or co-occurring services and activities provided in non-institutional settings to facilitate an individual's recovery. Note: This category does not include case management, alcohol or drug treatment, habilitation, or rehabilitation, as they are standalone services with distinct definitions.
Substance use treatment	Preventive, diagnostic, and other services and supports provided for people who have a psychological and/or physical dependence on one or more substances.
Case management	A collaboration between a service recipient and provider in which advocacy, communication, and resource management are used to design and implement a wellness plan specific to a Forensic PATH-enrolled individual's recovery needs.
Residential supportive services	Services that help Forensic PATH-enrolled participants practice the skills necessary to maintain residence in the least restrictive community-based setting possible.
Peer services	Peer counselor support with the individual; in-person or remotely
Service coordination	Services spent assisting individual with their goal without the person present (e.g. phone call to DSHS or Coordinated Entry, email communication)
Other	Other services that are not covered in the above options.
Referrals	Referrals provided by Forensic PATH for services outside of the program.
Any Referral	Sum of all referrals received by Forensic PATH participants during the reporting period.
Referral Type	The primary referral made from the following options: (Note: Number represents the number of individuals referred in the reporting period. Percent represents the percentage of active participants in the reporting period who received the referral.)
Community mental health	A range of mental health and/or co-occurring services and activities provided in non-institutional settings to facilitate an individual's recovery. Note: This category does not include case management, alcohol or drug treatment, habilitation, or rehabilitation, as they are standalone services with distinct definitions.
Substance use treatment	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers preventive, diagnostic, and other services and supports for individuals who have psychological and/or physical problems with use of one or more substances.
Primary health/dental care	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers physical and/or dental health care services.
Job training	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that helps prepare an individual to gain and maintain the skills necessary for paid or volunteer work.
Educational services	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers academic instruction and training.
FHARPS housing	Connecting the Forensic PATH participant to an FHARPS provider that offers assistance with attaining and sustaining living accommodations.

Permanent housing (non-FHARPS)	Connecting the Forensic PATH participant to a non-FHARPS housing agency, organization, or service that offers residence in a stable setting where length of stay is determined by the individual or family without time limitations, as long as they meet the basic requirements of tenancy.
Temporary housing (non-FHARPS)	Connecting the Forensic PATH participant to a non-FHARPS housing agency, organization, or service that offers shelter in a time-limited setting.
Other Housing Services (non-FHARPS)	Connecting the Forensic PATH participant to other non-FHARPS housing services not listed above, that offer assistance with preparing for and attaining living accommodations.
Housing services (pre-August 2021)	Housing service referral categories used prior to the implementation of updated housing referrals in August 2021.
Income assistance	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers benefits that provide financial support.
Employment assistance	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers assistance designed to lead to compensated work.
Medical Insurance	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers coverage that provides payment for wellness or other services needed as a result of sickness, injury, or disability.
Other	Connecting the Forensic PATH participant to any other agencies, organizations, or services not listed above.

Appendix G-Crisis Intervention Training Dashboard

CIT Dashboard

Crisis Intervention Training (CIT)

CUMULATIVE UPDATE

Per the Trueblood settlement agreement, crisis intervention trainings (CIT) are being offered to law enforcement, 911 dispatch, and corrections officers throughout Washington State. At a minimum, 25% of patrol officers in the Phase 1 and 2 regions are required to complete 40 hours of enhanced CIT, while 100% 911 dispatchers and correctional officers are required to complete an eight-hour course. Contempt settlement-mandated crisis intervention trainings began on July 1, 2019 for Phase 1 and July 1, 2021 for Phase 2 - however, trainings prior to this date have been included for some 911 dispatchers.

REPORTING PERIOD

Monthly: June 2023

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
Olympia, Washington

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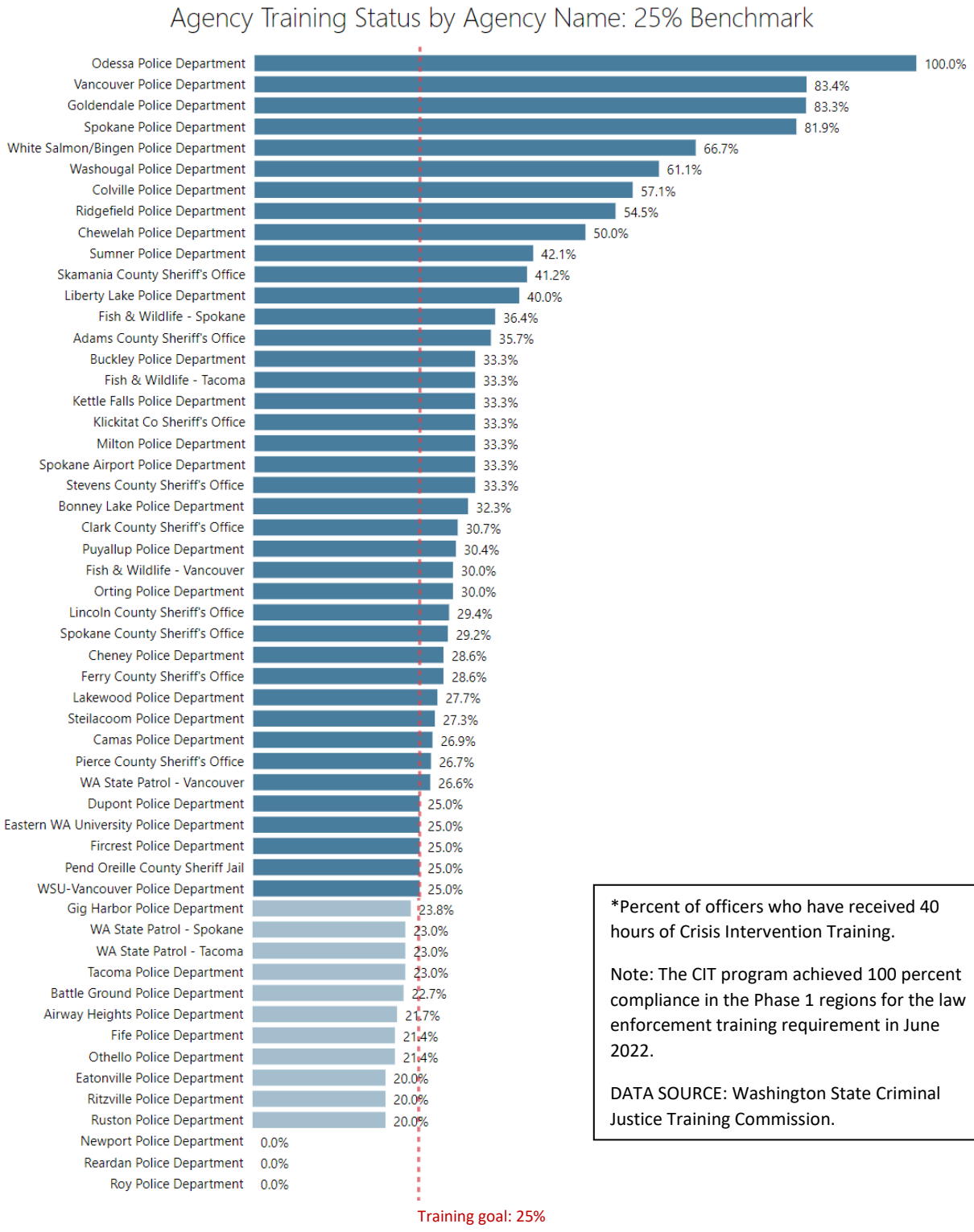
Figure 1.

Crisis Intervention Training Program Measures
Agency Training Status: 25% Benchmark, Phase 1 Region*

JUNE 30, 2023



*Percent of officers who have received 40 hours of Crisis Intervention Training.

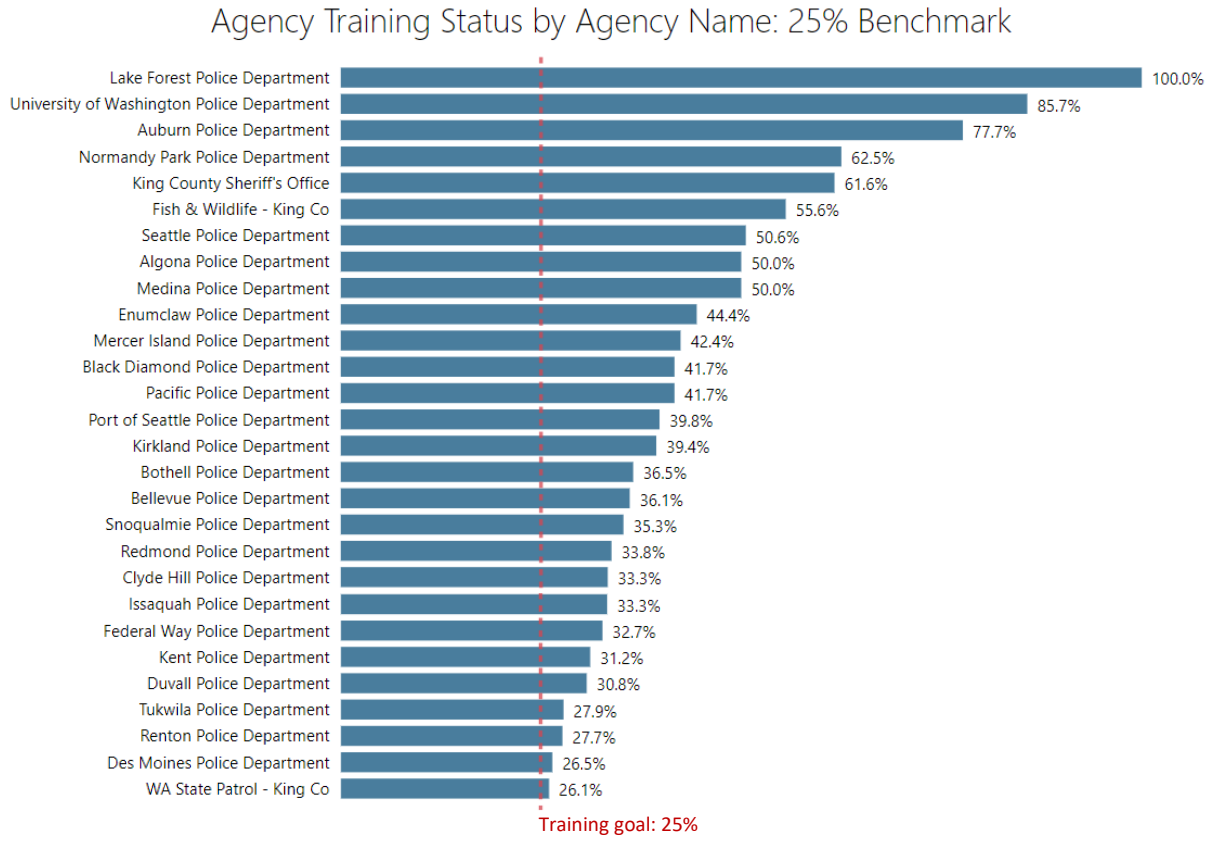
Note: The CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

Crisis Intervention Training Program Measures
Agency Training Status: 25% Benchmark, Phase 2 Region*

JUNE 30, 2023



*Percent of officers who have received 40 hours of Crisis Intervention Training.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 1.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Agency Size, Phase, and Region

JUNE 30, 2023

Number of Law Enforcement Officers Trained by Agency Size, Phase, Region, and Agency

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**1,478**	**695**	**47.0%**	**597**	**156**	**26.1%**	**359**	**127**	**35.4%**	2,434	**978**	**40.2%**
Fish & Wildlife - Phase 1							27	9	33.3%	**27**	**9**	**33.3%**
Pierce Region	603	149	24.7%	243	68	28.0%	103	31	30.1%	**949**	**248**	**26.1%**
Southwest Region	325	211	64.9%	48	12	25.0%	80	40	50.0%	**453**	**263**	**58.1%**
Spokane Region	550	335	60.9%	53	15	28.3%	149	47	31.5%	**752**	**397**	**52.8%**
WA State Patrol - Phase 1				253	61	24.1%				**253**	**61**	**24.1%**
Phase 2	**2,498**	**1,233**	**49.4%**	**510**	**193**	**37.8%**	**129**	**65**	**50.4%**	3,137	1,491	47.5%
Fish & Wildlife - Phase 2							9	5	55.6%	**9**	**5**	**55.6%**
King Region	2,356	1,196	50.8%	510	193	37.8%	120	60	50.0%	**2,986**	**1,449**	**48.5%**
WA State Patrol - Phase 2	142	37	26.1%							**142**	**37**	**26.1%**
Total	**3,976**	**1,928**	**48.5%**	**1,107**	**349**	**31.5%**	**488**	**192**	**39.3%**	5,571	2,469	44.3%

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington State. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1 regions are required to complete 40 hours of enhanced CIT. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers. The CIT program achieved 100 percent compliance for the law enforcement training requirement in June 2022 (Phase 1 regions) and June 2023 (Phase 2 region).

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 2.

Crisis Intervention Training Program Measures
Number of Correction Officers Trained by Agency Size, Phase, and Region

JUNE 30, 2023

Number of Correction Officers Trained by Agency Size, Phase, Region, and Agency

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**558**	**518**	**92.8%**				**80**	**70**	**87.5%**	**638**	**588**	**92.2%**
Pierce Region	243	237	97.5%				11	9	81.8%	**254**	**246**	**96.9%**
Southwest Region	111	87	78.4%				26	25	96.2%	**137**	**112**	**81.8%**
Spokane Region	204	194	95.1%				43	36	83.7%	**247**	**230**	**93.1%**
Phase 2	**512**	**511**	**99.8%**	**24**	**24**	**100.0%**	**34**	**29**	**85.3%**	**570**	**564**	**98.9%**
King Region	512	511	99.8%	24	24	100.0%	34	29	85.3%	**570**	**564**	**98.9%**
Total	**1,070**	**1,029**	**96.2%**	**24**	**24**	**100.0%**	**114**	**99**	**86.8%**	**1,208**	**1,152**	**95.4%**

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington State. All 911 dispatchers and correctional officers are required to complete an eight-hour course. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

Crisis Intervention Training Program Measures
Number of 911 Dispatchers Trained by Agency Size, Phase, and Region

JUNE 30, 2023

Number of 911 Dispatchers Trained by Agency Size, Phase, Region, and Agency

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**247**	**247**	**100.0%**	**109**	**100**	**91.7%**	**113**	**101**	**89.4%**	**469**	**448**	**95.5%**
Spokane Region	101	101	100.0%	28	23	82.1%	57	48	84.2%	**186**	**172**	**92.5%**
Pierce Region	146	146	100.0%							**146**	**146**	**100.0%**
Southwest Region				60	56	93.3%	20	17	85.0%	**80**	**73**	**91.3%**
WA State Patrol - Phase 1				21	21	100.0%	36	36	100.0%	**57**	**57**	**100.0%**
Phase 2	**238**	**230**	**96.6%**	**119**	**104**	**87.4%**	**88**	**87**	**98.9%**	**445**	**421**	**94.6%**
King Region	238	230	96.6%	119	104	87.4%	77	77	100.0%	**434**	**411**	**94.7%**
WA State Patrol - Phase 2							11	10	90.9%	**11**	**10**	**90.9%**
Total	**485**	**477**	**98.4%**	**228**	**204**	**89.5%**	**201**	**188**	**93.5%**	**914**	**869**	**95.1%**

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington State. All 911 dispatchers and correctional officers are required to complete an eight-hour course. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers. The CIT program achieved 100 percent compliance for the 911 Dispatchers training requirement in June 2022 for the Phase 1 regions.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Appendix H-Assistant Secretary Kevin Bovenkamp's Letter – Hospital Admission Triaging

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Behavioral Health Division
P.O. Box 45090, Olympia, Washington 98504-5090

December 14, 2022

TO: Washington State Partners

FROM: Kevin Bovenkamp,
Assistant Secretary

RE: Hospital Admission Triaging

Dear Washington State Partners,

We are informing our system partners that the Department of Social and Health Services' ability to admit new patients to Eastern State Hospital and Western State Hospital has reached a critical point. The short-term impacts of this critical situation, and the efforts to address it, are discussed below.

A New Challenge: Civil Felony Conversion Patients Are Limiting New Admissions to State Hospitals

The population of civil conversion patients at the state hospitals has reached such a critical mass that all admissions to the hospitals are greatly impacted. This is due to several factors: 1) a sharp increase in competency restoration referrals (nearly 40% in just the last fiscal year), 2) COVID-19 impacts to admissions (pausing and starting admissions due to outbreaks which created large backlogs, and a recent increase in cases), and 3) the increase in wait times for inpatient beds which leads to more dismissals and an increase in civil conversion patients. The civil conversion patients court-ordered into the state hospitals then occupy beds that were previously used to provide inpatient competency services, like competency restoration. Because civil conversion patients stay at the hospitals much longer than most competency patients (approximately one year and at times more), each civil conversion patient admitted to the state hospital has resulted in fewer beds available for competency patients, and those beds being unavailable for longer periods of time. When a treatment bed is occupied by a civil conversion patient during a year, it serves only that patient, instead of it being able to serve at least 4-5 competency patients in that bed, during that same time period. Over the last year, this has increased wait times for competency restoration and is severely impacting admissions of all types.

In addition to the ongoing difficulties in admitting patients for competency services, DSHS's ability to admit all forensic patients has become extremely limited, to include not guilty by reason of insanity (NGRI) patients, patients transferred from other DSHS facilities, restoration admissions designated as priority admissions under the triage consultation and expedited admission process, outpatient competency program removals, and other types of admissions.

While timely admissions for competency services have long been delayed, the current situation represents a distinct new phase of limitations on admissions to WSH and ESH. Longer delays in admissions for competency services also results in more dismissals of criminal charges as a result of motions brought in the criminal proceedings, which could then lead to more releases back to the community.

Because the hospitals have now hit the point where not all civil conversion patients can be timely admitted, it is expected that some civil conversion patients referred to DSHS will not be able to be admitted, which could lead to these individuals then being released from jail into the community.

At this time, DSHS is adjusting admitting procedures to evaluate and admit patients who present the highest levels of risk to the community and to themselves. DSHS will triage patients using the information it has and identify those who present the highest levels of risk based on their criminal charges, clinical acuity, and criminal history, and prioritize those patients for admission. As much as possible, admissions will still happen in accordance with existing processes, including the existing prioritization algorithm. When DSHS identifies a felony conversion patient who cannot be admitted to the state hospital, DSHS will attempt to provide timely notice that the admission cannot be completed.

DSHS is Taking Numerous Steps to Address Admission Limitations

DSHS is taking numerous steps to admit as many patients as possible to the state hospitals and the residential treatment facilities, and to complete current projects that will expand bed capacity. This includes a blend of near-term efforts, and long-term projects.

Although we are making every effort to treat and discharge patients back to the community from our civil programs, most of these patients have involvement in the criminal justice system. The state hospitals are now serving populations with increasingly complex clinical and serious criminal histories, and for these reasons finding safe and effective discharges for these patients has become increasingly difficult.

DSHS has a number of projects that have been in development for years. In the coming months and years, DSHS will open new inpatient psychiatric beds, including: two new forensic wards opening in early 2023 at WSH (58 beds total); a new NGRI unit opening at the Maple Lane campus in fall 2023 (30 beds total); and a new forensic hospital opening on the WSH campus in 2027 (350 beds total). In addition, DSHS is opening a new civil residential treatment facility at the Maple Lane campus in February 2023 (16 beds total) and is projecting to open new civil residential treatment facilities in Clark County in late 2024 (48 beds total). These new civil beds will allow DSHS to open up additional forensic beds at WSH by moving and treating civil conversion patients outside of the state hospitals.

DSHS is also in the process of identifying other treatment opportunities in community hospitals for civil conversion patients. This work could result in the identification of additional beds in existing psychiatric facilities that can be used to provide treatment to the civil conversion population. Currently, competency admissions to the residential treatment facilities are continuing, and are not directly impacted by this current situation.

Inside of the state hospitals, DSHS is remodeling existing space to create more treatment beds and identifying any opportunity to safely increase treatment beds and efficiencies. These efforts are critical in the context of the necessary closure of old treatment wards to make space for the new 350-bed forensic facility.

Opportunities to help

The increase in behavioral health needs impacts people and systems throughout Washington state. We recognize that as the system has been inundated with demand, other facilities and systems are also facing increasing challenges.

For those counties where prosecutorial diversion or other diversion programs exist, we strongly encourage prosecutors to use their counties' prosecutorial diversion programs to offer people in need wraparound services, especially for any misdemeanor cases. Additionally, for the eleven counties with outpatient competency restoration, we encourage continued and on-going use of this program whenever possible.

We encourage all of our partners, including law enforcement and other first responders to partner with diversion programs in their communities to provide people with needed behavioral health resources before they encounter the criminal court system.

In addition, we would like to remind jail partners of the new 21-day competency check program; more information can be found here. Any patient who can have competency resolved before being admitted to an inpatient bed will help the system, and any patient who is stabilized before arriving at a state hospital helps to shorten the lengths of stay and admit more patients.

Please contact Behavioral Health Administration Assistant Secretary, Kevin Bovenkamp, at kevin.bovenkamp@dshs.wa.gov, with any questions.

KB:tk:so

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