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

Semi-Annual Report

March 31, 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 July through December 2022. 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 continues to implement Phase 2 of the Settlement Agreement in the King region.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes, where possible. For this SAR, FPATH reporting includes service and referral data, and several programs (Forensic Navigator, FHARPS, and FPATH) have expanded race/ethnicity reporting. Phase 2 (King region) data has been expanded for FHARPS. Additional Phase 2 data will be added for other programs as it becomes available.

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 Dec. 31, 2022. Program data will typically be included in the SAR following at least two calendar quarters of operation, assuming sufficient counts to preserve confidentiality. Crisis housing vouchers and OCRP began in the King region in August 2022 and late-October 2022, respectively, and more individuals must be served before data can be reported.

Impacts of the COVID-19 Pandemic

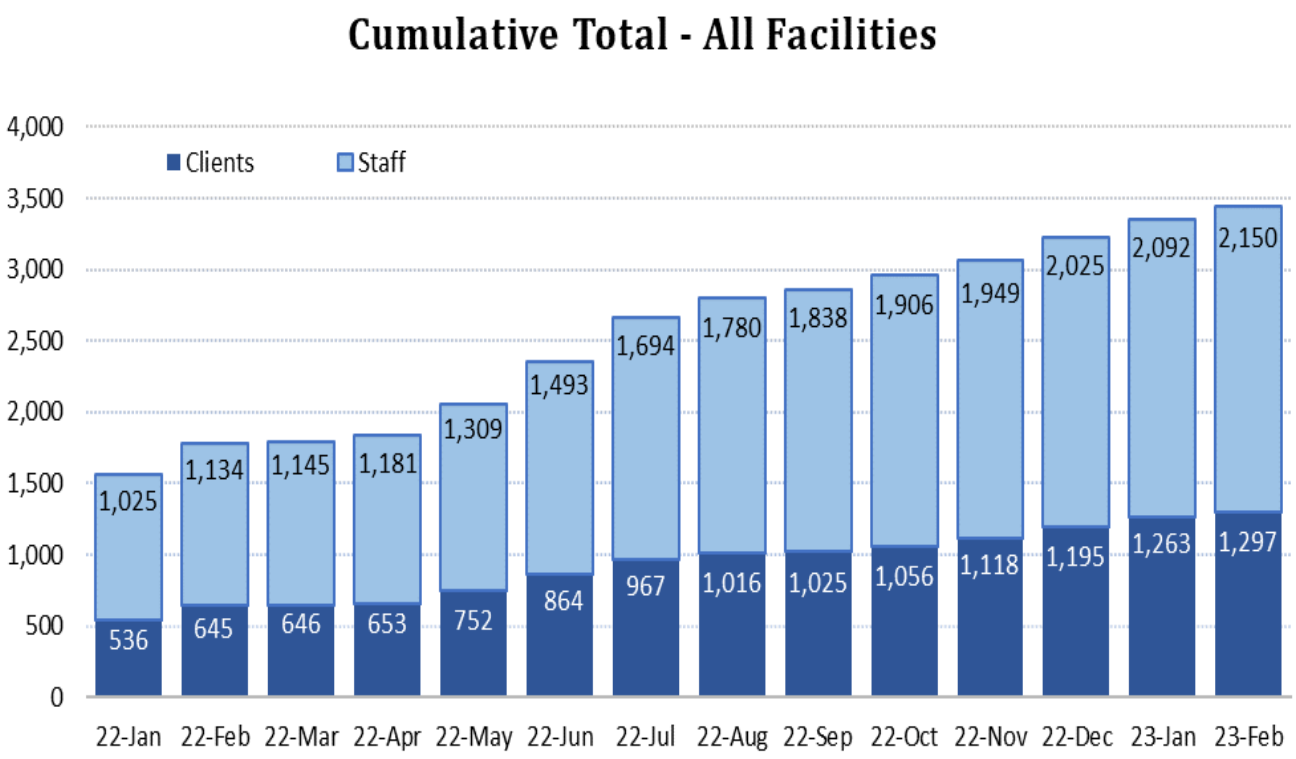
In March 2020, the COVID-19 pandemic began impacting Trueblood implementation efforts. The state of Washington has experienced an ongoing state of emergency since mid-March 2020, and this has affected aspects of operations and preparations for service enhancements. Initial effects included supply procurement challenges, impacts on construction, and delays to competency evaluation interviews when there was no safe way to interview a defendant. Rapid changes in the early spring and summer of 2020 required significant adaptations, and responding to COVID-19 outbreaks in many of our facilities has required additional changes since the pandemic started.

As permitted by evolving employee, client, and contractor safety considerations, the state is continuously undertaking efforts to minimize impacts to settlement activities, but impacts remain. More recently, in summer and fall 2021, the COVID-19 Delta variant intensified the pandemic's impacts, and the governor mandated that most state employees become vaccinated. Before the Delta variant could even wane, a new, more infectious but less deadly variant, Omicron, emerged placing even greater stress on our state's medical systems. Primary implementation impacts due to the Delta and Omicron variants and other COVID-19-specific systemic impacts, as well as the state's efforts to overcome those impacts, are discussed throughout this report. Additionally, Figure 1 below is illustrative of the impact of the recent variants on BHA facilities. During calendar year 2022, cumulative BHA COVID-19 cases increased more than 106 percent due to the newly dominant Omicron variant. Omicron infections finally slowed down heading into Q3, although it and its subvariants remained the dominant strain of COVID-19 throughout most of 2022.

The governor's state of emergency proclamations were gradually allowed to expire and the formal emergency declaration ended on Oct. 31, 2022. Facilities-specific precautions continued through the fall and winter, however, as COVID-19 has continued to circulate along with significant cases of seasonal influenza, norovirus, and RSV. Gradually, healthcare response to COVID-19 is moving from that of an emergency pandemic response to that of an endemic, seasonal outbreak type of response as it is expected that COVID-19 will adopt circulatory patterns similar to those of other seasonal viruses.

FIGURE 1.

COVID-19 Cases All BHA Facilities
Client and Staff
FEBRUARY 28, 2023



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 Feb. 28, 2023, more than 87 percent of all COVID-19 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 including Trueblood class members have specified statutory time limits delimiting 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 the 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 treatments centers. 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.

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

One mitigating factor in this admissions crisis is that 74-104 new beds are expected to open in 2023. A detailed list of facilities and currently projected opening dates follows:

- The new 16-bed Civil Center for Behavioral Health at Maple Lane is projected to open to patients in April 2023

- Two new 29-bed forensic competency restoration wards at WSH, planned opening Q1 2023
- Columbia Cottage at Maple Lane, as a newly remodeled 30-bed facility for NGRI patients from WSH. The current estimated opening is late 2023 to early 2024.

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[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.

Gaining 104 new beds from approximately April 2023-March 2024 does not solve the admissions crisis outright, 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 requests:

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

- 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 have been cancelled and will be re-scheduled for a later date.

Workforce Challenges-Recruitment and Retention

Competing for staff talent with the private sector in the context of the ongoing pandemic leaves many positions, especially at our treatment facilities, chronically unfilled. BHA identifies and implements creative solutions within our existing authority and partners with executive leadership, state human resources, labor, and other partners to develop and implement innovative approaches to recruiting and retaining critical staff positions. During spring and summer 2022, DSHS has taken several steps to alleviate staffing challenges. Steps taken included hiring more contractors and travel nurses, adding 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 postdoctoral fellows this year, and engaging a successful demand to bargain with labor partners to allow for contract evaluations to take place until vacancies can be filled. For the contracted evaluators, OFMHS executed three contracts during this time and cases are being assigned to these individuals. During the second half of 2022, an additional five contracts were started to bring up the total number of contractors to eight. Regarding the postdoctoral fellowship program, five of the fellows submitted job applications for permanent positions and were hired as forensic evaluators in OFMHS. The program will begin recruitment for six more fellows in the next reporting period. Working toward implementing new policies and practices to attract and retain passionate, talented staff remains critical to success, and BHA has continued this critical focus through fall 2022 and into winter 2023.

National Staffing Crisis and Pandemic Staff Burnout

A new challenge has emerged in the department's efforts to operate restoration beds, and to open new restoration capacity as it nears completion of construction. The nation faces an acute staffing crisis in healthcare. On May 23, 2022, the U.S. Surgeon General issued a press release summarizing a recent Surgeon General Advisory on the healthcare worker crisis:

> *Today, United States Surgeon General Dr. Vivek Murthy issued a new Surgeon General's Advisory highlighting the urgent need to address the health worker burnout crisis across the country. Health workers, including physicians, nurses, community and public health workers, nurse aides, among others, have long faced systemic challenges in the health care system even before the COVID-19 pandemic, leading to crisis levels of burnout. The pandemic further exacerbated burnout for health workers, with many risking and sacrificing their own lives in the service of others while responding to a public health crisis[6].*

[6] https://www.hhs.gov/about/news/2022/05/23/new-surgeon-general-advisory-sounds-alarm-on-health-worker-burnout-and-resignation.html

Washington state, and the facilities run by the department, are not immune to these challenges. The facilities providing restoration services continue to face acute staffing shortages. As of Dec. 31, 2022, vacancies in several critical BHA patient-centered job classes ranged from 30-40 percent. The ability to maintain current restoration capacity is at risk, and staffing new physical capacity has been extremely challenging. To address this, the department is engaging several approaches:

1. Implemented hiring and retention incentives to keep current staff and attract new staff. The incentives are now being offered. While this is an important tool in addressing this crisis, other organizations in the private and public sphere are also using similar tactics, leading to an "arms race" in competing for the extremely limited pool of available people to hire. Additional pay raises that were previously funded became effective on July 1, 2022.

2. The department is using contract staff to fill critical vacancies and keep current capacity operating. While this is a short-term solution, the extreme cost of the contracted staff means that contract staff are not a sustainable long-term solution.

3. The department is also pursuing contract staff for vacant forensic evaluator positions. This has increased capacity for in-jail evaluations as well as assisted with completion of inpatient competency evaluations. The department requested increased evaluation staff in the 2023 legislative session and 17 positions were funded over the next biennium in the governor's budget. Three contractors began seeing cases during this reporting period, which is helping the department to improve on jail-based evaluations timeframes.

4. The department has diversified staffing for certain functions, to use different types of credentials and staff to complete necessary work. For example, at WSH PhDs who are not licensed in Washington are working under a Washington regulatory scheme that allows them to work under supervision as an "agency affiliated counselor" to complete work within the civil center (not for class members). However, even with these efforts in place, there are simply not enough people in the nationwide employment pool. With healthcare providers across the industry facing critical shortages, those providers are engaged in similar mitigations and attempts to recruit from a limited pool of staff. Attracting new staff to department facilities often means that these staff are moving from other important mental health programs, which results in a "rob Peter to pay Paul" situation that leaves programs across the mental health system understaffed. This potentially includes and affects staffing for other Contempt Settlement Agreement programs. The department will continue with these efforts with the goal of ensuring that existing restoration capacity can operate, and that new capacity can open. However, the gravity of

the current situation cannot be overstated: If the available staffing does not improve, the department will not be able to keep existing beds open[7].

[7] Document 907-1. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Trueblood Quarterly Implementation Status Report, June 2022, Filed June 16, 2022, pp. 4-6.

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 is complete as of June 30, 2021, and Phase 2 is the current active settlement phase:

- Phase 2: July 1, 2021 to June 30, 2023 King region
- Phase 3: July 1, 2023 to June 30, 2025 Thurston/Mason and Salish[8] (Clallam, Jefferson, and Kitsap counties) regions recommended for implementation; subject to legislative approval.

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

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

[8] There are 10 regional BHASO's in Washington state. Phase 1 implemented the Settlement Agreement in three BHASO's and Phase 2 added an additional BHASO. Phase 3 proposes to add two additional BHASO's consisting of five counties. If implemented as proposed, 16 of Washington state's 39 counties would have full implementation of Trueblood programming.

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.

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[9]. 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 quarterly 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 data changes.

Data collections continue to evolve. The Navigator Case Management managed by DSHS was updated to include data collected from the HCA Outpatient Competency Restoration programs. Staff are working to migrate the historic data from Excel trackers to achieve a centralized data system. RDA is testing the Forensic Navigator quarterly report dashboard for programmatic use.

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

A publicly available version, which requires additional work to ensure data protections and confidentiality requirements, is planned for mid-2023.

The availability of other dashboards will be impacted by the schedule of HCA's plans to transition program data from Excel trackers to a centralized collection platform. RDA will continue work on quarterly dashboards strategically in the interim.

Client-level data is aggregated and suppressed when necessary to protect individual confidentiality. Data tables in this report reflect what was possible to produce from existing data received by the report deadline. 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. Findings from both methods are included in this report. RDA is in the process of updating the interrupted time series analysis. The difference-in-difference analysis was previously reported and will be updated when resources allow. Figure 2 shows the reference periods for the analysis previously reported, and the following sections outline the method and findings from each approach.

FIGURE 2.

Trueblood Evaluation Reference Periods

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

Interrupted Time Series Analysis

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

The first such analysis was presented for the first nine months of implementation (July 2020 to March 2021) in the September 2021 semi-annual report. For that period, 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).

The analysis was updated in 2022 to include data for the first 18-months of full implementation (July 2020 to December 2021). Findings include:

- Competency Evaluations – 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 $p<.05$.[10]

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

- Competency Restorations – 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.

This analysis indicates Trueblood Implementation programs are having the intended impact on evaluation orders, but not restoration orders in Phase 1 regions. This analysis is being updated again to add 2022, when competency orders continued to grow. Results will be available in spring 2023. An update will be included in the September 2023 SAR.

Difference-in-Difference Analysis

Difference-in-difference testing detects significant differences in the rate of change between groups on specific metrics. Medicaid-enrolled individuals 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 of a series of outcomes measures between Fiscal Year 2020 and 2021. Findings include:

- Mental Health Treatment: A significant increase in the rate of mental health treatment among individuals with at least one competency evaluation order in Phase 1 regions compared to the balance of the state at p<.0001.[11]
- Substance Use Disorder Treatment: 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 balance of the state. This was approaching significance at p<.0553. When analysis was restricted to Trueblood class members (those in jail while awaiting competency services), the difference was significant at p<.05.
- No difference 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 individuals 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) of factors that contribute to these

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

rates, many of which are outside the influence of Trueblood initiatives. This analysis will be updated periodically as data and resources allow.

Forthcoming: Individual Program Evaluation(s)

In the research plan drafted in January 2020, RDA estimated the first Settlement Agreement program evaluation utilizing propensity-score matching methods would be available no earlier than March 2022. This assumed sufficient study populations, with a minimum six-month 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. There are now sufficient data to move forward with the evaluation. This effort will take several months, as it requires identifying appropriate matched comparison groups and utilizing multiple data sources with different lag times. Results will be included in the September 2023 semi-annual report.

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 Dec. 31, 2022, 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, civil petitions, 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 Dec. 31, 2022, 66 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 July-December 2022 reporting period, 63 FRAs were completed. 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 39 FRAs during the 2022 calendar year; however, due to staffing challenges, the department is currently recruiting contractors to help in meeting the June 2023 time frame to have the new system in place. 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 2022, Washington state had its highest number of referrals for all competency evaluations (6,491[12]) to date. Even with continued pandemic-related disruptions in services,

[12] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2022.

referral levels increased dramatically by 39 percent from FY21. The previous record for competency evaluation referrals occurred in FY20 and was 4,712 referrals[13]. This growth came despite the 12 fine-funded[14] 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 as the criminal court system has re-opened, COVID-19 infections continue to result in decreased in-person access to clients and fewer beds to serve our clients, especially with the Delta and Omicron variants.

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 risks for all those involved during this pandemic. As part of this work, 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.

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), Sunnyside, and Yakima City jails. and county jails in Clallam, Clark, Cowlitz, Jefferson, King (King County Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and SCORE in Des Moines for county-level inmates), Kitsap, Mason, 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, Kittitas, Klickitat, Okanogan, Spokane, Stevens, Walla Walla, and Whitman counties, and Yakima city jail. In addition, Airway Heights Corrections and the Colville Tribal Jail now have VTC capabilities.

Additionally, a meeting was held at the end of July 2021 with defense counsel in King County to discuss timelines for jail-based evaluations and the use of telehealth. A second meeting in late

[13] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2022.

[14] 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 for FY23 while receiving a bridge appropriation for one-year, from the state legislature.

summer 2022 was held to share data on telehealth evaluations and its efficacy. Meetings will continue with King County to help improve and streamline telehealth evaluations and receive feedback on the evaluation/report process. A meeting with King County prosecutors was scheduled in early January 2023 to discuss competency evaluations. Ongoing ad hoc meetings with Pierce County defense counsel to maximize scheduling using a block scheduling format has allowed for evaluations to be completed in an expeditious manner.

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 3. Overall, compliance rates for jail-based evaluations remains high. In December 2022, 78 percent of evaluation orders were completed within court-ordered time limits, and Eighty-two percent of orders in the WSH catchment area were completed within court-ordered time limits. 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 highs for 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 the 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 the issues discussed above have resulted in substantial improvement in ESH's evaluation timeliness rate during fall 2022. ESH improved from 25 percent completed within court-order time limits in September to 65 percent in December.

The department examined the number of orders filed by the courts between January 2017 and June 2022 and projected the number of evaluation orders through June 2025 using an exponential smoothing forecast model[15]. 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.

Projections indicate that the number of Trueblood evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 77.0 FTE in the FY2022 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 evaluator calculations do not

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

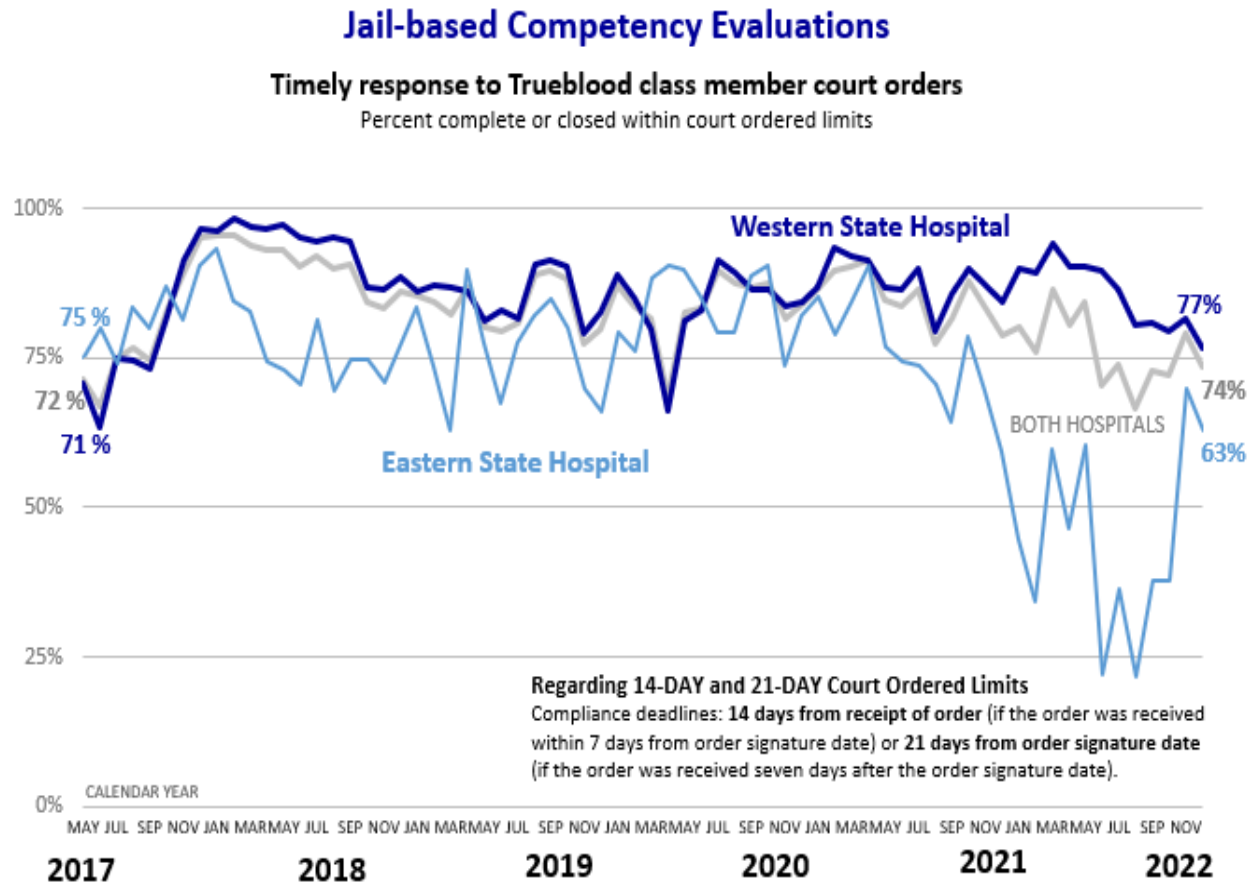
account for evaluations for forensic risk assessments (both initial evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks.

FIGURE 3.

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

Percent complete or closed within court ordered limits

NOVEMBER 2022



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

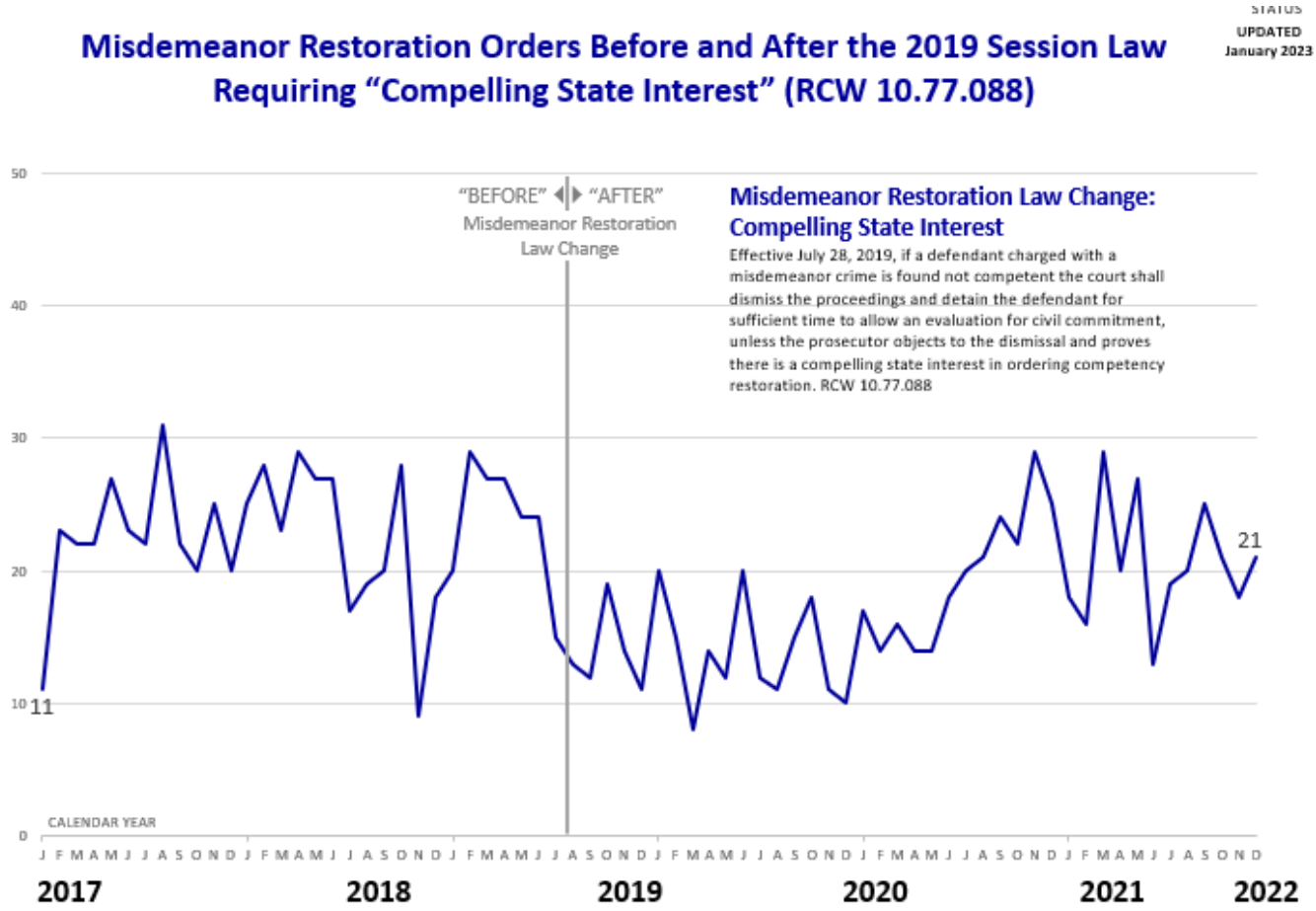
Data-Competency Restoration-Misdemeanor Restoration Orders

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. 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 the average returned to 21 orders per month. In December 2022, 21 misdemeanor restoration orders were issued statewide (Figure 4). 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.

FIGURE 4.

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. The department will continue providing court-ordered inpatient competency restoration services; however, HCA administers OCRP through contracted providers, 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 the most appropriate level of care to the individual, ideally closer to their home community. It is hoped that providing restoration services in a safe and cost-effective environment, while using the newly available community treatment program, will reduce the number of people wait-listed to receive competency restoration in an inpatient setting. OCRP also offers connections for individuals to receive other community-based services such as housing, vocational, and behavioral health services and supports.

Current Status and Areas of Positive Impact

Phase 2 OCRP services began Oct. 31, 2022, in the King region. As of Dec. 31, 2022, OCRP continues operations in all four Phase 1 and 2 regions. All Phase 1 region contractors are accepting outpatient restoration orders from courts in their regions; however, capacity is temporarily limited in the Phase 2 region due to provider-reported staffing shortages. This limited capacity is regularly reviewed by HCA and the contractor. Due to impacts from COVID-19 and workforce hiring challenges, some contractors are experiencing vacancies in their program staff, but are still meeting the needs of those enrolled in the program. HCA is working with all four contractors on ways to address their program's staff vacancies. As an example, HCA is working with the contractors to provide additional funding for more competitive salaries for existing staff, along with reviewing and revising education and experience requirements when 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:

- Publications for use with people enrolled in OCRP and stakeholder groups to ensure accurate messaging is happening regarding OCRP.

- Forensic navigators use of the OCRP transition plan with the support of other elements to provide people enrolled in OCRP with necessary information related to OCRP groups and provider's contact information.

- Quality assurance reviews are completed in all instances where a person is terminated from the OCR program and removed to an inpatient restoration facility or jail to ensure policy and contract deliverables are being followed and to identify service gaps to inform program development and future success. 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, will be working to develop best practices for OCRP providers to restructure the Breaking Barriers Competency Restoration Program curriculum to better align with the outpatient competency restoration model. This has been done by meeting with each OCRP provider and discussing the specific resources and reviewing the population demographic information in their region. 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 when current restoration services clients are likely to receive a second competency restoration order. Forensic navigators re-assess those persons for suitability for OCRP services as an alternative to completing their entire restoration treatment in an inpatient facility-based program. This provides people with the opportunity to use community-based resources. A flowchart and referral form were created for the RTF treatment teams to follow when referring a person for re-assessment by a forensic navigator. This new project went live on July 5, 2022, and referrals from both RTFs have been received.

OCRP contractors use support funds to acquire additional housing units to support people enrolled in OCRP, specifically for Trueblood class members. As of December 2022, all OCRP contractors 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. HCA and DSHS are working together to determine the appropriate methods of tracking and collecting this data.

On June 22, 2022, HCA contracted with Community House, a King County behavioral health agency, for OCRP services in the Phase 2 region. Community House has dedicated housing units for people enrolled in OCRP and continues to work with HCA to develop additional housing resources. OCRP services are operational and began accepting outpatient restoration orders from the courts in the King region on Oct. 31, 2022. HCA continues to meet biweekly with Community House to discuss recruitment, training, and other OCRP-related topics.

Areas of Concern

Consistent support for this program by system partners remains a continued concern for HCA and DSHS. With legislative changes that define clinical appropriateness, active participation, increasing the length of competency restoration treatment for people ordered into OCRP, the ability for forensic navigators to use law enforcement for removals, and outreach by DSHS and HCA to the courts; these concerns could hopefully be mitigated. As a result, HCA will be updating the structure of the monthly OCRP workgroup. This will create longitudinal outreach meaning information that will be shared with all Phase 1 and 2 court partners via meetings and email, so information is not dependent on a specific court partner's attendance. HCA has DSHS continue working together to update forms and documentation related to the OCR and forensic navigator programs to provide clear expectations and information to people enrolled in OCRP and associated stakeholders.

Due to legislative changes, DSHS and HCA have begun to restructure case consultations by creating case staffing, to discuss barriers and develop a plan with the hope that termination and possibly removal will not be necessary. This case staffing takes place prior to a removal consultation occurring, which focuses on terminating the person from OCRP and potentially removing them to an appropriate inpatient competency restoration facility if applicable. Although program removals occur, DSHS and HCA continue to participate in case staffing and removal consultations in conjunction with the OCRP contractors, to ensure that every effort is made to support a person's success in OCRP.

Recommendations to Address Concerns

While the goal for providers is to serve people enrolled in OCRP in an in-person setting, the contractors continue to offer remote and virtual services as needed, particularly in rural communities. The OCRP contractors in each region have not identified any challenges in providing services regionwide. Appropriate referrals to community-based services and supports continues to be a focus of all OCRP teams.

DSHS and HCA will continue to engage court partners in discussions regarding the utilization of OCRP for clinically appropriate persons. Currently, contracted agencies are included in collaboration and engagement activities in all Phase 1 and 2 regions and relationships continue to grow and develop among the programs. Ongoing efforts are being made to increase court personnel in the OCRP workgroup. Court personnel in Phase 1 and 2 regions have been identified and HCA in conjunction with DSHS is hopeful, that having the support and voices from the various jurisdictions in the Phase 1 and 2 regions, will increase the number of referrals to OCRP.

The HCA OCRP administrator is working with DSHS Workforce Development to create a training plan and is discussing an online training format option for new OCRP staff to ensure all staff are trained in the necessary Breaking Barriers Competency Program curriculum. HCA OCRP administrator will continue meeting with all Phase 1 and 2 region contractors to provide technical assistance and necessary support as the program continues.

HCA has also worked with current OCRP providers to address workforce challenges. HCA has allowed one provider to use an "in-training" mechanism to hire a master's-level clinician who is working toward licensure. As previously mentioned, HCA has also 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 potential. As of July 22, 2022, the Phase 2 OCRP contractor has posted all OCRP staff positions and although recruitment is ongoing, the Phase 2 contractor has hired multiple staff. If appropriate, the use of an "in-training" mechanism can be used by this contractor, with HCA OCRP administrator approval, to assist with the workforce challenges.

Forensic navigators continue to communicate with court staff regarding the people ordered into OCRP. This allows the forensic navigators to assist with all referrals and transportation as well as release timing and program needs to ensure people can adequately connect to programs once released.

The OCRP administrator conducts removal reviews in collaboration with the assigned providers and forensic navigators. HCA and DSHS leadership meet to review the removal review findings and make recommendations for best practices in the prevention of removals or identification of commonalities among those removed. These factors may include increased experience of the programs, coordination among all the program elements, courts working with the assigned forensic navigator to order clinically appropriate people to the program, and increased case staffing prior to removal consultation for at-risk persons. HCA and DSHS leadership continue to review commonalities of people removed from OCRP and shares that information with court staff to inform the decision to order future people into OCRP. Commonalities noted thus far include history of non-compliance with community-based services, program refusal upon order, medication refusal, and substance use.

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. As noted above, the King region program will build capacity as it becomes fully staffed. Data will be reported when a minimum of 11 individuals are served.

Between July 1, 2020 and Dec. 31, 2022, 99 clients were enrolled in OCRP Phase 1 regions: 32 in Pierce, 40 in Southwest, and 27 in Spokane (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 (77 percent) and participants were mostly male (82 percent), 30-49 years old (44 percent), non-Hispanic white (67 percent), and unstably housed or homeless (a combined 76 percent).

Of the 80 people discharged, (Appendix B, Table 2), 43 percent were opined competent, 28 percent had their conditional release revoked, and 14 percent had their charges dismissed. More than two-thirds (70 percent) were in the community at the time of discharge, 12 percent were in

jail, and 11 percent were admitted to inpatient services at either a state hospital or a residential treatment facility. Among those discharged, the average length of stay in OCRP was 70 days, ranging from 63 days in the Southwest region to 89 days in the 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).

Data collection transition from individual program Excel trackers to the centralized Navigator Case Management system was largely complete by the end of 2022. Staff are working to migrate historical tracker data into the NCM system and update data processes to streamline reporting. The data in this report are from the Excel trackers.

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 and have referred program participants to outpatient forensic service providers in the 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 restoration order, who may be suitable for community restoration. This process began in July 2022 and has re-assessed numerous clients. As of Dec. 31, 2022, we have not been able to get individuals placed into OCRP as all referred clients have been found competent. RTF staff, HCA, and the navigator team have collaborated and refined the process to allow navigators to

intercept more clients that may be suitable. This newly updated process was initiated in January 2023.

The Phase 2 navigators are fully staffed again and are making every effort to provide resources to clients. 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. Phase 2 navigators were hired in the second half of 2021. After being trained in the Pierce region, Phase 2 navigators began taking King region cases in January 2022 to shorten the communication gap before additional Trueblood services were set to begin in spring 2022. The program staff has been essential in recruitment and further refinement of program practices.

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.

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 bench 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 has 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 not allowed navigators to have client contact. As stated before, the hope is that as resources become more available to clients, that defense attorneys will enable Phase 2 staff to engage clients and provide advocacy.

DSHS and its service partners continue to work well together to maintain programmatic alignments. Extensive process mapping, with the use of a responsibility assignment matrix, has been completed. The value stream mapping has aided communication between the Forensic Navigator Program and partner programs OCRP, FHARPS, and FPATH. The value stream mapping process further resulted in decreased gaps within participant programs for more streamlined processes and operational efficiencies. Communication between HCA and DSHS is consistent and efficient.

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.

Data-Forensic Navigators

A total of 4,036 people were assigned a forensic navigator between July 1, 2020 (program start) and Dec. 31, 2022 (Appendix C, Table 1). This includes 1,596 people in King County, where forensic navigator services began in January 2022. The majority of people assigned a navigator were male (64 percent), over half (57 percent) were between the ages of 30 to 49, and nearly half (48 percent) were non-Hispanic white. Just under half (49 percent) were charged with a felony, and 51 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 nearly 7 in 10 individuals 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 (98 percent, Appendix C, Table 2). Client meetings, interviews, or observations were conducted with 48 percent of people assigned a navigator. A recommended service plan was completed for 65 percent of people. Navigators provided coordination of care for 30 percent of clients overall, with a higher rate in Southwest (70 percent) and Spokane (50 percent), compared to Pierce (33 percent) and King (6 percent). One in four (27 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: 17 percent received a referral to the FPATH program and 15 percent received a referral to FHARPS.

A total of 3,654 people were discharged during the reporting period, with an average length of stay in the program of 38 days, ranging from 33 days in King region to 51 days in Southwest region (Appendix C, Table 3). About one-third (31 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 22 percent of cases were closed because the person was ordered by the court to receive inpatient restoration. Over one-third (34 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. More than one in five clients in King region (23 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. A notable recent change is the collection of data from the Navigator Recommended Services Plan.

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 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 facilities 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 has a hard closure date of July 1, 2024. The DSHS positions at Maple Lane converted to permanent status on Dec. 16, 2021, providing the staff who stay until closure layoff rights. Maple Lane's ramp down plan timeline was updated due to this change. The director of the residential treatment facilities met June 28, 2022, with the DSHS layoff specialist and the labor relations specialist to discuss and update the timeline now that all staff, except probationary staff, have permanent status. Minor changes were made to notify staff sooner and to provide education on the layoff process as soon as notifications are sent out. The timeline for notifications is still being finalized. As part of the Settlement Agreement, low median wait times for inpatient competency services can trigger an earlier closure. For Maple Lane, 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. 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 during ramp down after the official closure notification is given. As of January 2023, staffing has consistently remained around 70 percent of DSHS positions filled. Currently, the director of forensic RTFs is working with her chain of command to come up with both recruiting and retention strategies for the Maple Lane Competency Restoration Program.

Recommendations to Address Concerns

DSHS continuously monitors turnover, morale, and other factors, and actively takes steps to neutralize negative affects at Maple Lane 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 Maple Lane 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 Maple Lane. 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 how to retain staff with two other DSHS programs opening on the Maple Lane campus starting in December 2022. In January 2023, the Maple Lane Competency Restoration Program entered a contract with Centralia College to offer a practicum for their students in the college's Behavioral Health program. Staff from the Maple Lane Competency Restoration Program 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

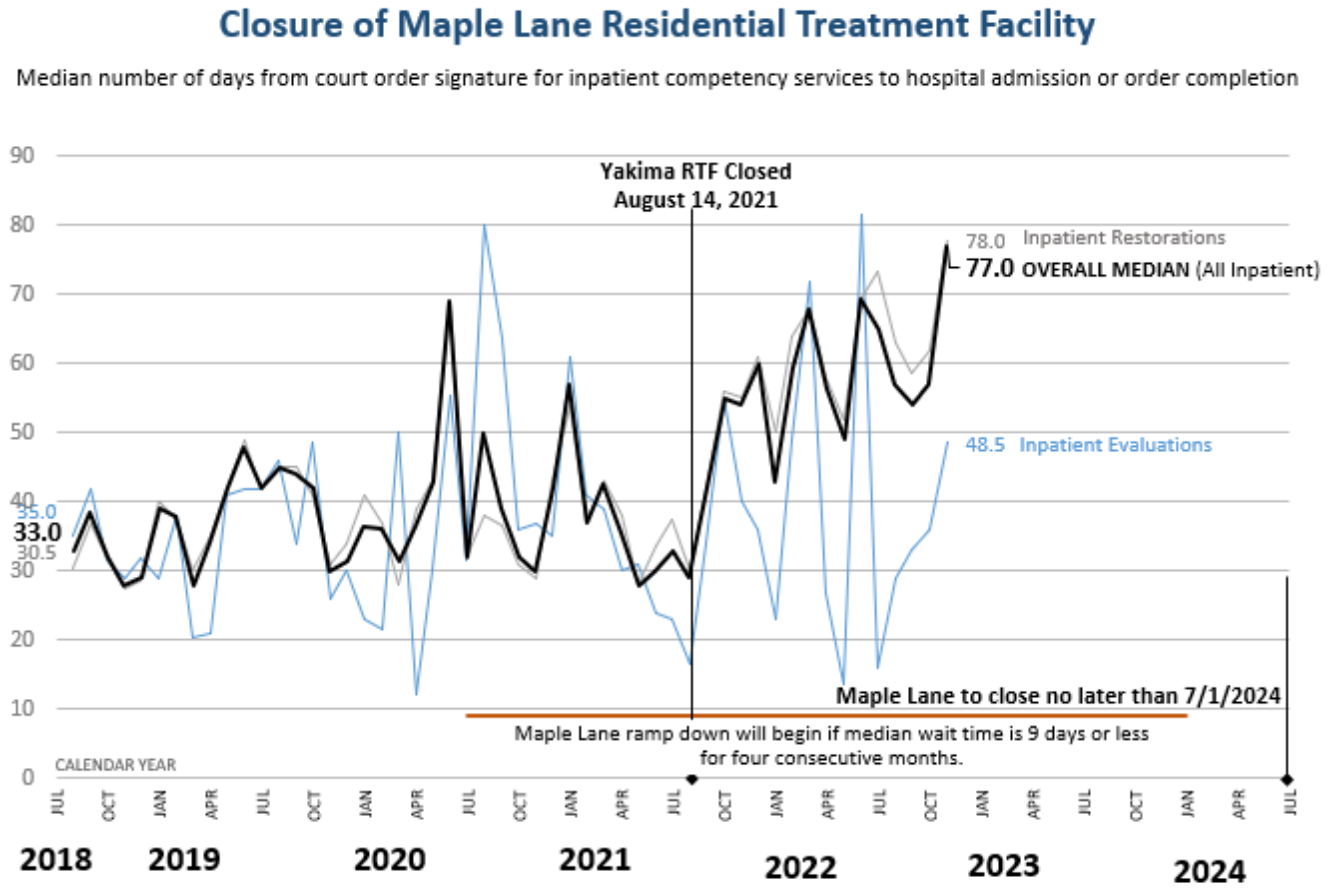
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services monthly (Figure 5). In Nov. 2022, the median wait time for inpatient competency services was 77 days. The ramp down of Maple Lane will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 5.

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

NOVEMBER 2022



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 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. Clinical treatment in the crisis stabilization/crisis triage facility is provided by a multi-disciplinary team of behavioral health specialists trained to provide interventions. The overall goal of care of the facility is to stabilize active symptomology and to assist in the return of the person back to their community of origin with skills or tools needed to address additional stressors. These tools can often be in the form of referrals to other skilled community providers and could entail continued outpatient services to further reduce future crisis.

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 are to 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 create 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. HCA, the Department of Commerce, DSHS project managers, and King County BHASO have been meeting weekly with Recovery Innovations to ensure that they are on track with their pre-construction

timeline. Recovery Innovations identified a $1.6 million shortfall in their previously estimated budget for this facility in October 2022. HCA and DSHS immediately met with Department of Commerce to see whether additional funding could be routed to RII to cover this funding gap. Commerce stated that there may be other competitive funding available; however, the amount available would cover about one-eighth of the identified gap.

HCA asked RII whether construction of the facility could begin prior to the acquisition of any further funding. RII stated they were not willing to begin construction until the gap in funding was resolved. RII reported they have been seeking other funding opportunities through loans and/or grants and HCA continues to request information about these possibilities on a weekly basis. At the same time, HCA continues to request an updated budget from RII to explain where the funding gap originated, whether the gap resulted from new variables, or if it stemmed from an initial error in calculations.

RII states if they secure funding through loans and/or grants, they would be able to begin construction of the project within two weeks. If RII is unable to secure funding to cover the remaining gap, the project most likely would not begin until July 2023. Commerce put forth a re-appropriation request to ensure that the funding remains available at the beginning of Fiscal Year 2024 and has taken the additional step of putting forth a decision package to address funding gaps they have identified for multiple projects that are stuck across the state of Washington. This action by Commerce, should it become law, would ensure that extra funding for this project could be accessible beginning in July. RII reached out to legislators in Washington state and scheduled meetings to discuss the possibility of acquiring additional funding for this project. It is possible additional funding for this project will be added in the state's budget due largely to these efforts.

ConnectionsWA was not under contract with the Department of Commerce by the end of December 2022. Negotiations with the landlord for the property they intend to acquire are taking longer than expected. HCA, DSHS, and Department of Commerce continued working with ConnectionsWA to meet the deadline as soon as possible and ConnectionsWA signed the contract on March 8, 2023.

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 is now under contract. 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.

Recommendations to Address Concerns

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

- Continue providing technical assistance and oversight to aid the contractors in meeting timelines for both crisis stabilization facility projects.

- HCA and DSHS will jointly work to provide technical assistance to ConnectionsWA to assist with meeting the projected June 2023 construction start.

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 1

In the Phase 1 regions, the crisis stabilization facilities continue to provide crisis intervention and symptom reduction (treatment/services). The facilities have improved their discharge planning services by making referrals to community mental health agencies, FHARPS, and to substance use disorder treatment when appropriate. Lifeline Connections was able to almost double their staff while hiring more night shift team members. At the same time, Lifeline has experienced workforce shortages for night shift mental health professionals, which left them unable to take admissions overnight from July-October 2022. The program supervisor at Recovery Innovations International in the Pierce region reported they are always considering whether a person is a good fit for FHARPS and have fostered a working relationship partnering with other local transitional housing programs as well. HCA is working with the Spokane BHASO to determine how best to reallocate the funding previously dedicated to the crisis stabilization facility that closed.

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 2

For Phase 2, HCA worked collaboratively with the King County BHASO on the development of an agreeable proposal that Trueblood funding would be used to provide enhanced crisis services in the Phase 2 region through the Downtown Emergency Service Center location as well as for the whole of the King region communities. King County BHASO continues to receive this funding to make improvements to their facilities and to increase necessary staffing.

Areas of Concern

Lifeline Connections reported they are experiencing challenges working with people who have developmental disabilities and are trying to identify different supportive housing for individuals once they do not meet medical necessity any longer and need to discharge.

RII has also identified that despite multiple efforts to increase their client population of Trueblood class members, they report they have not seen an increase in referrals from law enforcement or emergency services.

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 the same time, crisis stabilization facility service providers have reported that additional staffing has allowed for staff to attend, schedule, and facilitate more meetings in the community with stakeholders including law enforcement and court partners in their regions. Although this may have been an unintended consequence of additional funding needed, these activities should continue as they aid providers in providing increased community education and outreach on the availability of important local crisis services.

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 has 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 in FY23 Q4, an additional 35 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 have agreed to mutually terminate the FHARPS contract at MDC effective Jan. 31, 2023. The Pierce region's other FHARPS provider agreed to assume funding for MDC's team, which allows two FHARPS teams to continue serving the region as soon as March 1.

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 is working to see if adding retention and/or sign-on bonuses would be possible through additional funding.

The FHARPS Phase 2 provider has been successful in forging relationships with established recovery and sober housing providers in the region but has had less success identifying or gaining access to immediate housing interventions that provide participants access to lower-barrier housing. HCA continues encouraging the Phase 2 FHARPS provider to consider master leasing as an option and the provider has reported they may wish to begin master leasing after their staff positions have been filled and have remained filled for longer periods of time.

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 will hold support meetings with each provider to identify more ways to support the teams in utilizing this resource beginning in 2023.

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. HCA continues to monitor utilization for any possible additional funding need in 2023.

Frontier Behavioral Health's crisis stabilization facility closed at the beginning of July 2022 and HCA worked quickly with FBH to allow their mobile crisis response and co-responder teams to access crisis housing vouchers. Utilization of crisis housing vouchers by hourly crisis staff presents a different set of barriers and appears to result in a lower utilization of CHVs within those regions that do not have crisis stabilization facilities.

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 quarter, HCA saw the number of face-to-face services increase in each of those regions. At the same time, an increase in COVID-19 cases in jails in Phase 2 has increased barriers to accessing eligible participants while in-custody.

HCA will continue to monitor the temporary closures of crisis stabilization facilities throughout the phased regions. HCA has also been able to act swiftly and work creatively with agencies to allow crisis housing vouchers to be distributed by other outpatient crisis-related 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. Most master leasing opportunities are not integrated throughout the community and exist instead within one large property. Because of this lack of integration, a housefire in December 2022 displaced ten FHARPS participants in a single day. The provider was able to find temporary housing for each person on that same day and no one was hurt in the fire. However, 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.

Recommendations to Address Concerns

HCA continues to communicate with FHARPS providers to address how COVID-19 infections have or could impact the level of face-to-face services provided to FHARPS participants. HCA encourages all FHARPS teams to follow their local public health jurisdiction's guidance. HCA added performance-based deliverables to Phase 1 contracts beginning July 1, 2022, which included a tiered payment table for face-to-face service provision, and each team met the highest possible goal in face-to-face service provision as of December 2022.

Hourly crisis teams assess people who are currently experiencing behavioral health crises and show decreased use of CHVs in an outpatient setting, while inpatient facilities use crisis housing vouchers 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 has contracted with a national technical assistance entity to create a master leasing toolkit. The toolkit should be completed by June 30, 2023 and will include historically successful models, practices, and policies in master leasing projects with an emphasis on housing people with behavioral health needs. The toolkit is intended to aid in the expansion of master leasing projects in Washington, incentivize landlords to engage in master leasing, and identify best practices in master leasing projects.

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. A data tracker was created for each program as an interim data collection tool until a long-term solution is identified and implemented by HCA. Facilities and FHARPS providers submit the data as required by their HCA provider contracts.

Vouchers Data

The crisis stabilization and triage facilities and provider teams contracted with HCA to provide housing vouchers distributed 451 vouchers to 346 people between Dec. 1, 2019, and Dec. 31, 2022 (Appendix D, Table 1). Since some teams now distribute vouchers outside crisis facilities, the table name was updated to "Crisis Housing Voucher Disbursals." Vouchers were available in the Phase 2 King region beginning June 2022. King region data will be included in the table when there are a minimum of 11 people served.

Spokane remained the lead region in voucher distributions (accounting for 44 percent of distributions), and the Southwest region served a larger portion of individuals (45 percent of those receiving vouchers.). The total amount disbursed across Phase 1 regions was $442,614, and the average amount per recipient was $1,279. 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 alternative community entity distributing housing vouchers. Self-referrals and hospitals accounted for more than 7 in 10 of the referrals for the housing vouchers issued (36 percent and 35 percent, respectively)

Overall, most voucher recipients were male (67 percent), between 30 and 39 years old (55 percent), and non-Hispanic white (69 percent).

Based on matching crisis housing voucher recipients to the FHARPS program data, 30 percent were referred to FHARPS, 28 percent were contacted and enrolled, and 24 percent were housed or sheltered by FHARPS.

The majority of initial housing placements through FHARPS were shelter/emergency placements (87 percent), which includes 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. Data measures that met the requirement of more than 11 cases were included. A total of 1,464 individuals were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to Dec. 31, 2022 (Appendix E, Table 1). Of these referrals, 955 (65 percent) were contacted[16] and 834 (57 percent) were enrolled.

Contact and enrollment rates appear to vary in part due to data entry practices. Spokane enters all referrals in the Excel trackers, while other providers may only enter referrals that result in a contact or program enrollment. The King program data also differs because, as previously mentioned, it is focused on Trueblood class members awaiting competency services in jail and referred by forensic navigators. The program differs in enrollment rates, housing placement type, and period of support, which is discussed in more detail below. 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 59 percent of referrals. Forensic navigators made the most referrals, 32 percent overall, and comprised 98 percent of referrals in King region (as mentioned previously, King region focused on serving clients referred by forensic navigators). FPATH referred 14 percent and crisis stabilization and triage facilities referred 11 percent.

Most initial contacts were made by phone (44 percent). This method of contact is down substantially from the peak of 74 percent on Dec. 31, 2020, when outreach methods were limited due to COVID-19 protocols. King region contacted 73 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, 56 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 (63 percent).

Of those enrolled, 76 percent were housed or sheltered at least once since their enrollment (Appendix E, Table 2). About 58 percent of first housing types were emergency/shelter placements, which includes 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 33 percent by Dec. 31, 2022, 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 individuals housed or sheltered compared to other regions. This is likely due to enrollments in jail and that the King region mostly uses transitional housing

[16] 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.

rather than emergency placements. Those enrolled could still be incarcerated, may transfer to inpatient treatment, may release into the community and fail to reconnect with the program, or may be awaiting placement in transitional housing through the program.

About two-thirds (65 percent) of individuals enrolled between March 1, 2020 and Dec. 31, 2022 were discharged as of the end of that timeframe, with an average length of support of 202 days, ranging from 43 days in King region to 226 days in Spokane days (Appendix E, Table 3). The average total subsidy support received by those discharged was $6,035.

Among individuals discharged, 32 percent of cases were closed due to loss of contact, 15 percent transitioned to self-support and 12 percent transitioned to other housing support. Another 11 percent had received the maximum assistance and discharged without transition to other services. One-third (32 percent) were stably housed, 14 percent were homeless, and 13 percent were in a facility. Housing status at program discharge was unknown for 33 percent of people (consistent with 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 individuals 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 has expanded its MCR services outside of Spokane County to assist with and to address the needs of neighboring rural counties and is actively working to provide community outreach and education to promote awareness for the MCR program in Spokane County.
- Adams County has developed a referral process to enable law enforcement agencies to send the names of individuals in the community they encounter who could use their services. The MCR and client care coordinator collaboratively make efforts to contact these individuals and provide enhanced MCR services. Adams County Integrated Health Care Services is creating a linkage to requested/necessary resources in the community for families and individuals while shoring up its frontline assessment services.

Adams County, recognizing its multicultural needs, enrichened its staffing by hiring a Spanish-speaking mental health professional to meet the needs of its Spanish-speaking residents. The goal of Adams County IHCS's MCR team is to provide services to all individuals to increase MCR services and public awareness to the community.

Pierce Region
Pierce Beacon contracts for MCR services in the Pierce region with MultiCare Behavioral Health's mobile outreach crisis team to provide crisis outreach services.

- MOCT continued response to crisis calls in rural areas of Pierce County, with recent responses to calls from Buckley, Eatonville, and Bonney Lake.

- MOCT reports most of their recent training efforts have been with law enforcement via the crisis intervention training and meetings with East Pierce and Central Pierce fire departments.

- MOCT reports the team continues to remain available to support tribal health partners and be available to them via direct cell number for consults, bypassing the crisis line.

Southwest Region
Beacon contracts for MCR services in the southwest region. Three community agencies providing 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.

- Sea Mar's Adult Mobile Crisis Unit (AMCI) in Clark County continues to accept referrals directly from first responder and crisis teams, including 911, law enforcement, DCRs, and Crisis Connections to divert the need for more restrictive levels of intervention. AMCI reports they are collaborating with Fire and Rescue to begin a pilot co-response program to increase access to services in more rural areas of the county. AMCI states that in many cases, these and other previously established connections continue to lead to less restrictive outcomes through safety planning and engaging with local supports instead of arrest or detainment.

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

Mobile crisis teams in King County are also restarting attending roll calls and team meetings with community partners to provide clarity on crisis services, operations, scope of work, and referral process. As COVID-19 restrictions have eased for law enforcement and other community partners in the region, teams have also reported the goal of getting crisis team leaders to these meetings with community partners to re-infuse accurate information to the community. Mobile crisis teams in King County are also restarting their involvement in CIT training and Mock City to help train officers in crisis intervention.

Another helpful enhancement is the addition of a learning and development specialist, who takes lead on onboarding new staff members and organizing trainings for current staff members that align with DESC's mission & values as well as help emphasize outreach and clinical skills that are important to the work.

<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:

Spokane County Regional Behavioral Health (SCRBH) reported that for this reporting period, MCR received 189 referrals within Spokane County.

Pierce Region:

Pierce Region Beacon Health reported the total number of services provided by MCR during the reporting period was 705. Total number of unduplicated clients' services was reported to be 595 and total number of crisis events was reported at 98.

Southwest Region:

Sea Mar AMCI reported that their average number of referrals has remained around 150 per month during this reporting period.

King Region:

The King County BHASO enhanced their existing mobile crisis response system by adding new positions to their current staffing structure. There are not currently data on number(s) of people served.

Crisis Triage and Diversion-FPATH

As part of the Trueblood Contempt Settlement Agreement, the state created a new program modeled after the federally funded traditional PATH program. FPATH teams provide assertive outreach and engagement to a by-name list, 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 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.

FPATH teams, within community behavioral health agencies, include enhanced certified peer counselors who have experience working with people experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years. FPATH teams use assertive outreach to connect with, engage, and assist people in getting connected to community supports including housing, transportation, health care, and behavioral health services. Eligible people who are assigned to a forensic navigator and court-ordered to outpatient competency restoration may also receive intensive case management services through FPATH.

Current Status and Areas of Positive Impact

FPATH teams continue their efforts to outreach and engage eligible people. Teams across the state are reporting an increased number of referrals coming from the forensic navigators and have been adjusting their services to meet the increased need.

In March 2022, all FPATH teams across the state met for the first annual FPATH meeting. HCA is in the process of planning another annual meeting for the teams in the spring of 2023. This meeting will be the first statewide meeting for FPATH held in-person. The focus of the meeting will be to allow space to reflect on program successes, as well as provide another opportunity for people to connect and learn from one another.

HCA continues to facilitate learning opportunities for FPATH providers. Each month there are two FPATH learning collaboratives, one for direct service staff and another for program supervisors and leads. These semi-structured meetings have led to two in-person site visits for the providers. In August 2022, HCA facilitated a site visit for supervisors at Frontier Behavioral Health in Spokane, which focused on program management, data collection, and staffing. A site visit was offered in November 2022 at SeaMar/CSNW in Vancouver and was geared towards direct service team members. The site visit was tailored to the needs of those attending and included time to shadow the host agency in the community.

In September 2022, HCA amended the contract with Community House Mental Health Agency to provide funding for two respite beds dedicated to people enrolled in the FPATH program. These

beds have been instrumental in helping people who are released from incarceration stabilize before moving into other housing options.

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 report being down at least one to two staff members throughout this reporting period. That said, Greater Lakes Mental Health agency was able to fill all the positions that came with their newly expanded team by December 2022.

Recommendations to Address Concerns

HCA and Department of Commerce worked with both FPATH providers and King County to come up with solutions for the differences in data collection. The primary solution was for FPATH providers to create separate logins for FPATH information being recorded into HMIS, and for housing assessments done for King County's Regional Homelessness Authority. The Department of Commerce continues to provide ongoing technical assistance on how to use the HMIS platform. HCA continues to work with the providers on how to talk to someone about the HMIS consent form.

To address the workforce shortage impacting FPATH, HCA continues to encourage providers to reassess their recruiting practices and look for new ways to advertise positions. With HCA approval, some teams have revisited their staffing model and made adjustments that allowed them to open their positions to a broader range of applicants. Some of the changes made included adjusting requirements for education or work experience. Funding was also allocated to each team to pay for continuing education and state credentials.

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 Dec. 31, 2022, 2,593 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 1,150.

Of all people on the referral list, FPATH providers attempted to contact 1,075 (41 percent), and successfully contacted 699 (27 percent). As of Dec. 31, 2022, a total of 397 people (15 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Enrollments among the prioritized population were slightly higher (18 percent).

Of the Phase 1 regions, Southwest had the smallest referral list and enrolled the largest proportion (39 percent). The Pierce region had the largest referral list and enrolled 14 percent. The Phase 2 region has had 57 enrollees since the program started in April 2022, which was seven percent of its referral list. Of these, 24 were from the prioritized population.

Among enrolled individuals, the majority were male (77 percent) and between 30 and 49 years old (61 percent). Two-thirds of enrollees (68 percent) were homeless, while 20 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among all individuals discharged from the FPATH program through Dec. 31, 2022, the average length of stay in the program was 258 days. People in the Southwest region had the longest length of stay at 296 days, while the King region had the shortest at 75 days. (Appendix F, Table 1). Loss of contact was the most common reason for FPATH discharge throughout the Phase 1 region.

Services

There have been 8,053 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 2.3 services per month in the King 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 (0.5 per person, per month) (Appendix F, Table 2).

Referrals

Of the 397 FPATH enrollees, 215 (54 percent) had received at least one referral through Dec. 31, 2022 (Appendix F, Table 2). The Spokane region provided the most referrals, with 80 percent of participants having at least one referral, followed by 55 percent in the Southwest region and 51 percent in the Pierce region.

The most common referral throughout all four regions was to FHARPS housing, with 27 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Approximately 19 percent of enrollees received at least one community mental health referral. Due to low enrollment

numbers, and to protect participant confidentiality, referral information for Phase 2 FPATH enrollees is not available as of Dec. 31, 2022.

Education and Training – Crisis Intervention Training

For Phase 1 regions through Dec. 31, 2022, the Criminal Justice Training Commission has completed twenty-four 40-hour courses for law enforcement and 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 the end of December 2022, 987 law enforcement officers have received this training. As of June 30, 2022, every agency in the Phase 1 region had met the 25 percent goal. Phase 1 regions have shifted to a maintenance schedule that includes two-to-three 40-hour classes annually in each region. The Spokane, Southwest, and Pierce regions have scheduled maintenance classes for spring 2023.

CJTC also developed and deployed a webinar-style eight-hour course, specifically to meet the needs of correctional agencies. CJTC conducted 19 of these classes in the second half of 2022. Through the combination of the earlier traditional courses and the addition of Clark County's 40-hour program, 1,071 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 compromised 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, 443 dispatchers have received the full eight-hour training, and 100 percent of dispatchers in the Phase 1 regions have completed the 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 3,167 certified peace officers in the King region, 1,419 have completed the training (45 percent). However, not every agency has 25 percent of their officers trained. Thirty-eight officers remain to be trained to bring every King region agency up to the minimum requirement. The King region completed seven of the 40-hour CIT courses in the second half of 2022, training 128 students, and has six of the 40-hour CIT courses scheduled for the first half of 2023.

The King region has six correctional agencies encompassing 746 correctional officers. To date, 456 officers (61%) have completed the required eight-hour CIT for corrections training. These

courses have been offered exclusively in an interactive webinar format and 24 courses are scheduled in the next six months.

The King region has 424 Telecom/911 dispatchers. Of these, 383 (90 percent) have completed either the hybrid four-hour static/four-hour webinar or an 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 significant 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 is 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. In addition to the student issues, CJTC is also experiencing instructor shortages.

Recommendations to Address Concerns

CJTC continues to increase communication working with agencies individually to find ways to get students into classes. For example, two agencies sent their academy graduates directly to a 40-hour training before they were placed on their agency's schedules to begin field officer training. The CIT for Corrections eight-hour course is being offered on swing shift and on weekends. CJTC has hired two additional instructors 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 Dec. 31, 2022, 45 (83 percent) law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies continued to achieve higher training completion rates (48 percent, overall) than small agencies (37 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, 27 percent of officers were trained in the Pierce region, compared to 57 percent in the Southwest region, and 55 percent in the Spokane region. Washington State Patrol units in the Phase 1 regions have achieved a training rate of 26 percent.

The Settlement Agreement also requires 911 dispatchers and correctional officers in the Trueblood Phase 1 regions to complete an eight-hour CIT course by June 30, 2021. As of Dec. 31, 2022, all 911 dispatchers had completed CIT training, with completion rates of 100 percent (Appendix G, Table 3). In addition, 91 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 81 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 Dec. 31, 2022, 17 of the 28 (61 percent) law enforcement agencies were meeting or exceeding the 25 percent benchmark, with an overall training completion rate of 45 percent (Appendix G, Table 1). These training rates remain stable as compared to June 2022 rates (see September 2022 semi-annual report). Washington State Patrol units in Phase 2 had a training completion rate of 18 percent. Similar to Phase 1, large law enforcement agencies had higher training completion rates than small and medium sized agencies.

Approximately 90 percent of 911 dispatchers and 61 percent of correctional officers in King County had competed the eight-hour CIT course by Dec. 31, 2022 (Appendix G, Tables 2 and 3). Dispatchers and correctional officers in the Phase 2 region have 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 Dec. 31, 2022, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (65 percent in both regions) than the Pierce region (26 percent, Appendix G, Table 1). In the King region (Phase 2), large agencies with higher population densities had higher training completion rates (48 percent) than medium and small agencies (37 percent, Appendix G, Table 1).

Education and Training – Technical Assistance for 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.

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 initial workgroup convened on May 24, 2019, and included representation from Disability Rights Washington, WASPC, and the Washington State Office of the Attorney General. The workgroup met monthly and as needed to progress toward the guidebook's completion. Numerous revisions were made in collaboration with the workgroup. The membership grew to include HCA's enhanced peer services program administrator and representatives from city and county jails both within and outside of Phase 1 regions.

The guidebook addresses the topics of pre- and post-booking diversion, identification of need and access to treatment, administration of involuntary medication, transition planning and continuity of care, and use of segregation as well as additional subject matter. The guidebook's completion occurred on May 14, 2020, prior to the June 1, 2020 deadline. It is now available on the DSHS website[17] and has served as a support document for trainings on the topics it covers.

Since 2020, JTA staff have provided online monthly JTA Learning Events, which are available to jail staff from all jails statewide. Previous JTA Monthly Learning Events had been principally didactic presentations. Presenters were typically DSHS staff who used PowerPoint to share information on topics that included:

- The Triage Consultation and Expedited Admission process
- Crisis De-escalation
- Suicide Awareness and Prevention
- Overview of the Trueblood Case and Contempt Settlement Agreement

These valuable events were responsive to jail's training requests. During 2022, JTA repeated some of those previous topics (e.g., TCEA). However, JTA also worked to create events that featured panels of guest presenters who shared promising practices that JTA discovered during the in-person visits to jails, with plenty of time set aside during each event for questions and answers and dialogue. Such panels included:

[17] The *Best Practices for Behavioral Health Services in Jail Settings* guidebook is available on OFMHS' Jail Technical Assistance web site at the following address: www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/OFMHS-MAN-009-Jail-Technical-Assistance-Guidebook-Rev0-14MAY2020.pdf

- The Clark County Jail's four-person Release Planning team describing the structure of their program and its community partnerships.

- The King County Jail describing exactly how they have successfully gotten court orders that provide authority, when necessary and appropriate, for jails to administer involuntary psychiatric medications for patients returning from inpatient restoration.

Other presentations included:

- Three certified peer counselors describing the work that each of them does in different jails, and how CPCs can be valuable allies for jail staff;

- A presentation by an experienced designated crisis responder that explained the role of DCRs, and how they can be helpful to jail staff.

Participation increased in 2022 with several events having over 20 participants. For a more complete list of previous JTA events and all 2022 Learning Events, please visit the JTA trainings webpage.

In order to provide meaningful technical assistance, JTA wanted to learn more about the current state of mental health work being done in jails across the state. Due to COVID-19 restrictions, in-person visits to jails had been greatly limited. But as COVID-19 restrictions eased during 2022, we were able to resume in-person visits. During 2022, JTA staff member Tracy Grunenfelder visited each of the 60 jails in Washington. The number and types of jails visited are listed below:

- 15 city jails

- 39 county jails

- 6 tribal jails

    - **Note:** JTA did not visit the two federal facilities, as they are outside of our scope. Those are an ICE facility in the Tacoma tide flats and the Federal Detention facility located in King County.

Jail visits in 2022 began quite informally, but evolved to include a structured interview aimed to gather information about current practices in four components of mental health work:

- Initial Screening

- Assessment and Treatment Planning

- Service Delivery; and
- Continuity of Care/Release Planning

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plan have been delivered. Webinar-based trainings continue monthly. Many of the training topics have been identified through input from participants attending prior events and providing feedback on additional trainings that would be useful. Jail site visits provide an additional source to identify other topics of interest to jail personnel and their stakeholders. Efforts during 2022 resulted in extending the reach of JTA trainings and improving audience engagement. Additionally, the team collaborates with a BHA communications consultant to improve content and user interface of our public-facing website.

There has been a significant increase in the use of videoconferencing software to conduct forensic evaluations remotely. The use of videoconferencing has been an effective adaptation to the limitations imposed by COVID-19 on in-person evaluations. It has also helped improve the efficiency with which competency evaluations can be completed. Members of the JTA team have been centrally involved in providing guidance and technical assistance statewide in support of this transition to increased online forensic evaluations at jails throughout the state. 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, July 1-Dec. 31, 2022, on average, OFMHS evaluators completed 219 telehealth evaluations per month.

Areas of Concern

Previous areas of concern have been addressed and resolved. This included enhancing regional awareness of the JTA program. As mentioned above, during 2022, JTA staff personally visited each of the 60 jails in our state. These in-person visits greatly increased awareness of, and connection with, the JTA program. Another previous area of concern was determining how to effectively deliver training to jail staff. During 2022, in addition to engaging jails staff in the delivery of training, JTA staff also began recording and posting the JTA Monthly Learning Events so that jail staff can access the trainings online at a time that is convenient for them. Having resolved those concerns and making the improvements to engagement, outreach, and training, there are not currently any glaring areas of concern for the JTA program.

Recommendations to Address Concerns

JTA staff have accelerated an awareness campaign through increased jail site visits and taking part in opportunities such as the WASPC conferences, which JTA staff regularly attend and where JTA staff have also provided presentations. These interactions provide additional avenues to solicit information regarding JTA needs. The information gathered through the visits mentioned

above will help JTA staff design and coordinate future trainings that are strategically targeted to meet the needs of jails statewide, and promote sharing of promising practices across jails.

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. Staff track telehealth data as part of the telehealth committee, and those numbers are provided above.

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 LGBTQ+ 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.

The subject matter expert who co-created the *Enhancing Your Cultural Intelligence* training also facilitated a train-the-trainer event for this diversity, equity, and inclusion training in February 2022. This two-day train-the-trainer event had a strong focus on how to present the content most effectively and how to manage learning environments with learners who have varying levels of experience and understanding of topics related to diversity, equity, and inclusion. Since this event, the EPS program continues to bring this group of trained trainers together monthly to discuss the content and prepare to present the training to learners in-person, when it is deemed safe to do so.

Certified peer counselors on Trueblood program teams and court-funded diversion programs continue to come together quarterly for the Trueblood CPC Learning Community. CPCs from teams across the state are in attendance, including CPCs working in the King region. Recent Trueblood CPC Learning Community topics of discussion included, but were not limited to, connecting with people who are in the state hospitals, 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 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 program and court-funded diversion program teams were invited by the EPS program to participate on formal panels to inform others of the work that CPCs are doing and to speak to the power of peer support services. In March 2022, a panel of CPCs on Trueblood program and court-funded diversion program teams work was featured in the jail technical assistance program's monthly webinar, highlighting the support that they offer to people who are incarcerated and near release for the jail staff and jail leadership that were in attendance. Another panel of CPCs was invited by the EPS program to speak to members of the Trueblood General Advisory Committee about the work that they are doing to connect with people who are in jail and to bridge supports and services in the community.

Traditionally, people with criminal court involvement have been reluctant to move forward to become certified peer counselors because of the possibility that they would not be employable. However, changes to RCW 43.43.842 decreased restrictions for certified peer counselors to access the Agency Affiliated Counselor Credential through the Department of Health. As these changes are being realized, workforce opportunities are slowly expanding for individuals with criminal court and behavioral health experiences. Furthermore, the EPS program lead applied for and was invited to join 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.

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 February and December 2022, 195 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 March 2022 and December 2022, 232 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 total of 279 respondents returned completed surveys. 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 with interested 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.

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. Workforce development staff also co-lead the newly formed 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.

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 Settlement Agreement.

Additionally, the workforce development team has developed a 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 will serve 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 have also begun to provide training to contracted behavioral health provider staff regarding an orientation to the Breaking Barriers curriculum used in the Outpatient Competency Restoration Program. An online version of this training is also being developed to be used as new OCRP staff come onboard. Additionally, OFMHS workforce development staff continue to work on developing new trainings and resources to assist programs.

Areas of Concern

The WFD team is on track to complete all required Phase 2 element tasks on time or ahead of schedule. COVID-19 impacts remain an area of concern. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. However, the use of videoconferencing for online interaction and other available means allows us to engage our partners and continue working to provide education and training to prepare people to enter and successfully work in this field. In addition, a broad challenge regarding workforce development is ongoing statewide workforce shortages within the field of mental health.

Recommendations to Address Concerns

The primary focus to address the identified concerns is to expand the reach and improve the effectiveness of online methods to reach the necessary audiences. Improvement of existing websites, enhancement of online and distance learning offerings, and presentations at virtual conferences and online classes are being pursued as potential ways to reach our audiences more effectively. The WFD team continues to use Articulate software to create online trainings to supplement limited in-person offerings.

Data-Workforce Development

In preparing the Forensic Workforce Report, the OFMHS workforce development team surveyed state staff to learn the numbers and types of staff identified in each contract that is related to operationalizing Phase 1 of the Settlement Agreement. WFD then used population data to make estimates of how many staff, of which types, would be required to implement the Settlement Agreement statewide. This methodology informed some estimates of forensic workforce needs. Thus far, available workforce data from existing sources are not sufficiently specific to the forensic mental health field to support reliable analysis of specific workforce needs. Consultation with RDA and members of state workforce development organizations has been initiated and will continue.

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[18] 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 mid-January 2023, 73 of 91 Phase 2 task items are complete[19], and most Trueblood programming in the Phase 2 King region is already operational. The Phase 2 implementation period began July 1, 2021 and continues through June 30, 2023.

Persistent challenges presented by the COVID-19 pandemic, including workforce challenges and supply chain disruption, slow the overall pace and somewhat temper the impact of Phase 1's successful implementation and 18 months of substantial progress toward the completion of Phase 2 implementation. In late fall 2021, just as it seemed the most severe Delta variant wave of the pandemic was concluding, the Omicron variant emerged as the most rapidly infectious variant of the pandemic, but also as an overall less deadly form of COVID-19. Omicron severely impacted operations in Q1 2022, but its significant impacts, although waning over time, continued to be felt in Trueblood implementation throughout Q2 and into Q3 2022.

Even as the department and its partners prepare for the eventual transition from pandemic COVID-19 to endemic COVID-19, continued high levels of COVID-19 transmission as well as high transmission levels of seasonal flu continue to 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 as well as a behavioral health workforce that has been stretched thin and burnt out by the demands of the pandemic, with many vacancies still left to fill. COVID-19-related impacts to Trueblood initiatives are ongoing, and additional impacts could emerge, efforts to mitigate the effects notwithstanding. Criminal courts continue processing their significant case backlogs built up during the pandemic. In part, these backlogs have fueled record high demand for evaluation services during FY22.

The state remains committed to both implementing the elements of the Settlement Agreement and improving those elements already established in Phase 1. Phase 1 programs continue to gain experience serving their clients, and the recently implemented Phase 2 programming continues rapidly gaining experience in the field and benefiting from the knowledge gained during Phase 1

[18] 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.

[19] 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.

implementation. When the next semi-annual report is published in late September 2023, HCA and the department will have completed the two years of Phase 2 Trueblood program implementation in the King region and will be several months into Phase 3 implementation, assuming legislative approval and funding is granted during spring 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) 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 treatment. The intent of the OCRP is to reduce the number of people waiting to receive competency restoration, to provide the 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. OCRP services were available in the Phase 2 Region (King County) in October 2022. Reporting will begin when there are sufficient cases to protect confidentiality.

REPORTING PERIOD

Cumulative: July 1, 2020 to December 31, 2022

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

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- TABLE 2: OCRP Discharges, Cumulative
- Definitions

TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	99	100.0%	32	100.0%	40	100.0%	27	100.0%
Among Enrolled Individuals…								
RESTORATION ORDER TYPE (unduplicated)								
Felony	76	76.8%	--	--	--	--	--	--
Misdemeanor	23	23.2%	--	--	--	--	--	--
GENDER								
Female	18	18.2%	--	--	--	--	--	--
Male	81	81.8%	--	--	--	--	--	--
AGE GROUP								
18-29 yrs	37	37.4%	--	--	--	--	--	--
30-49 yrs	44	44.4%	--	--	--	--	--	--
50+ yrs	17	17.2%	--	--	--	--	--	--
Unknown	1	1.0%	--	--	--	--	--	--
RACE/ETHNICITY*								
Non-Hispanic White	66	66.7%	--	--	--	--	--	--
Black, Indigenous, and People of Color	33	33.3%	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT								
Stably Housed	23	23.2%	--	--	--	--	--	--
Unstably Housed	58	58.6%	--	--	--	--	--	--
Homeless	17	17.2%	--	--	--	--	--	--
Unknown	1	1.0%	--	--	--	--	--	--

DATA SOURCE: Excel trackers submitted by each contracted OCRP team to the Washington State Health Care Authority (HCA).

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

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

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - December 31, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)								
Enrolled	99	100.0%	32	100.0%	40	100.0%	27	100.0%
Active	19	19.2%	--	--	--	--	--	--
Discharged	80	80.8%	--	--	--	--	--	--
Among Discharged Individuals…								
DISCHARGE REASON								
Charges Dismissed	11	13.8%	--	--	--	--	--	--
Opined Competent	34	42.5%	--	--	--	--	--	--
Opined Not Competent	4	5.0%	--	--	--	--	--	--
Opined Not Restorable	1	1.3%	--	--	--	--	--	--
Returned to Jail	6	7.5%	--	--	--	--	--	--
Inpatient Medical Care	0	0.0%	--	--	--	--	--	--
Inpatient Civil Psychiatric Care	2	2.5%	--	--	--	--	--	--
Revoked Conditional Release	22	27.5%	--	--	--	--	--	--
Death	0	0.0%	--	--	--	--	--	--
Missing/Unknown	0	0.0%	--	--	--	--	--	--
DISCHARGE LOCATION								
Community	56	70.0%	--	--	--	--	--	--
Residential Treatment Facility	1	1.3%	--	--	--	--	--	--
State Hospital	8	10.0%	--	--	--	--	--	--
Jail	10	12.5%	--	--	--	--	--	--
Unknown	5	6.3%	--	--	--	--	--	--
LENGTH OF STAY								
Average Length of Stay in Program (days)	70	N/A	89	N/A	63	N/A	57	N/A
HOUSING STATUS AT PROGRAM DISCHARGE								
Stably Housed	26	32.5%	--	--	--	--	--	--
Unstably Housed	29	36.3%	--	--	--	--	--	--
Homeless	6	7.5%	--	--	--	--	--	--
In a Facility	9	11.3%	--	--	--	--	--	--
Unknown/Missing	10	12.5%	--	--	--	--	--	--

DATA SOURCE: Excel trackers submitted by each contracted OCRP 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.

OCRP Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase 1 Regions: Pierce, Southwest, Spokane.
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.
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 unreported.
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.
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 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 (e.g., liver transplant) 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.
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

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 December 31, 2022

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

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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 - December 31, 2022

	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	4,039	100%	1,125	100%	505	100%	813	100%	1,596	100%
Forensic Navigator Assigned	4,036	100%	1,125	100%	502	99%	813	100%	1,596	100%
Among Clients Assigned a Forensic Navigator…										
CLIENT STATUS (on last day of reporting period)										
Active	382	9%	47	4%	60	12%	62	8%	213	13%
Pre-Competency Hearing	339	8%	39	3%	40	8%	52	6%	208	13%
OCRP Enrolled	29	1%	--	--	13	3%	--	--	--	--
Post-OCRP (Coordinated Transition)	6	0%	--	--	--	--	--	--	0	0%
Reassess for OCRP	8	0%	--	--	--	--	--	--	--	--
Discharged	3,654	91%	1078	96%	442	88%	751	92%	1,383	87%
GENDER										
Female	830	21%	242	22%	97	19%	199	24%	292	18%
Male	2,581	64%	770	68%	363	72%	599	74%	849	53%
Other/Unknown	625	15%	113	10%	42	8%	15	2%	455	29%
AGE GROUP										
18-29	964	24%	285	25%	151	30%	186	23%	342	21%
30-49	2,282	57%	623	55%	262	52%	455	56%	942	59%
50+	790	20%	217	19%	89	18%	172	21%	312	20%
RACE/ETHNICITY*										
American Indian or Alaskan Native	55	1%	29	3%	--	--	15	2%	--	--
Asian	106	3%	34	3%	--	--	--	0%	51	3%
Black or African American	764	19%	278	25%	64	13%	57	7%	365	23%
Hispanic or Latino	80	2%	14	1%	14	3%	11	1%	41	3%
Native Hawaiian or Pacific Islander	47	1%	34	3%	--	--	--	--	--	--
White Only, Non-Hispanic	1,929	48%	534	47%	301	60%	596	73%	498	31%
Other Race	58	1%	--	--	--	--	0	0%	45	3%

	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
Unknown	1,032	26%	199	18%	96	19%	131	16%	606	38%
MOST SERIOUS CURRENT CRIMINAL CHARGE										
Felony	1,994	49%	650	58%	309	62%	540	66%	495	31%
Misdemeanor	2,042	51%	475	42%	193	38%	273	34%	1,101	69%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%
HOUSING STATUS AT PROGRAM INTAKE										
Stably Housed	583	14%	181	16%	111	22%	149	18%	142	9%
Unstably Housed	329	8%	--	--	--	--	--	--	--	--
In a Facility	4	0%	--	--	--	--	--	--	--	--
Homeless	837	21%	229	20%	205	41%	214	26%	189	12%
Unknown	2,283	57%	563	50%	125	25%	385	47%	1,210	76%

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 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.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - December 31, 2022

	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 reporting period)	4,036	100%	1,125	100%	502	100%	813	100%	1,596	100%
Avg Daily Navigator Caseload (most recent quarter of reporting period)	21	N/A	14	N/A	30	N/A	18	N/A	24	N/A
Among Active Clients (at any point during the reporting period)…										
FORENSIC NAVIGATOR SERVICES										
Assisting Clients with Attending Classes and Appointments	68	2%	22	2%	23	5%	--	--	--	--
Attending Competency Hearing	852	21%	193	17%	341	68%	314	39%	--	--
Client Meeting, Interview, and/or Observation	1,918	48%	656	58%	376	75%	523	64%	363	23%
Client Support-Network Interactions	280	7%	93	8%	94	19%	--	--	--	--
Completed Recommended Services Plan	2,622	65%	825	73%	351	70%	647	80%	799	50%
OCRP Compliance Monitoring	102	3%	27	2%	46	9%	--	--	--	--
Contact with Client's Attorney or Prosecutor	3,398	84%	980	87%	377	75%	648	80%	1,393	87%
Coordination of Care	1,230	30%	372	33%	353	70%	410	50%	95	6%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	350	9%	--	--	194	39%	114	14%	--	--
Information Gathering	3,972	98%	1,114	99%	500	100%	809	100%	1,549	97%
Medication Monitoring	143	4%	--	--	106	21%	25	3%	--	--
Outreach Services - Attempted Contact	705	17%	186	17%	114	23%	340	42%	65	4%
Outreach Services - Client Contact	475	12%	39	3%	162	32%	258	32%	16	1%
Post-OCRP Client Check-in (up to 60 days)	26	1%	--	--	--	--	--	--	--	--
Post-OCRP Coordinated Transitions	18	0%	--	--	--	--	--	--	0	0%
Referral to Services	1,079	27%	281	25%	164	33%	387	77%	247	15%
REFERRALS										
Adult Protective Services (APS)	2	0%	0	0%	0	0%	--	--	--	--
Community Outpatient Mental Health Services	275	7%	27	2%	30	6%	218	43%	0	0%
Designated Crisis Responder (DCR) Referral	6	0%	0	0%	--	--	--	--	0	0%
EBT/ABD (Food/Cash Benefits)	126	3%	--	--	--	--	122	24%	0	0%

Educational Services	25	1%	0	0%	--	--	24	5%	--	--
Employment Assistance	53	1%	0	0%	--	--	51	10%	--	--
Forensic HARPS Services	591	15%	164	15%	120	24%	109	22%	198	12%
Forensic PATH Services	694	17%	201	18%	95	19%	217	43%	181	11%
Home and Community Services	132	3%	--	--	--	--	129	26%	0	0%
Housing Services (Non-HARPS)	144	4%	--	--	--	--	134	27%	0	0%
Job Training	15	0%	0	0%	0	0%	15	3%	0	0%
Medical Insurance Services	87	2%	0	0%	0	0%	87	17%	0	0%
Other Community Based Resource	211	5%	43	4%	--	--	152	30%	--	--
Primary Health Care/Dental Care	62	2%	0	0%	--	--	61	12%	--	--
SSI/SSDI	100	2%	0	0%	0	0%	100	20%	0	0%
Substance Use Disorder Treatment	192	5%	--	--	--	--	184	37%	0	0%
Supported Employment	13	0%	0	0%	--	--	12	2%	--	--
VA Benefits	6	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. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - December 31, 2022

	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	3,654	100%	1,078	100%	442	100%	751	100%	1,383	100%
Clients Discharged with Warm Hand-Off to Provider or Jail Staff	1,135	31%	387	36%	163	37%	331	44%	254	18%
Among Clients Discharged…										
DISCHARGE REASON										
Charges Dismissed	556	15%	140	13%	34	8%	67	9%	315	23%
Civil Conversion - Removal from OCRP	4	0%	--	--	0	0%	--	--	0	0%
Client Death	5	0%	0	0%	--	--	--	--	--	--
Client Determined Competent	1,078	30%	391	36%	166	38%	207	28%	314	23%
Dismiss & Refer (to DCR)	194	5%	77	7%	34	8%	12	2%	71	5%
Diversion Program(s)	3	0%	0	0%	0	0%	--	--	--	--
Felony (72-Hour) Civil Conversion	46	1%	--	--	--	--	33	4%	--	--
Inpatient Restoration	821	22%	339	31%	140	32%	103	14%	239	17%
Not Restorable - Developmental Disability	6	0%	--	--	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	13	0%	--	--	--	--	--	--	--	--
Order Canceled or Withdrawn	106	3%	16	1%	10	2%	12	2%	68	5%
Re-arrest	4	0%	--	--	--	--	0	0%	--	--
Refused Forensic Navigator Services	82	2%	--	--	--	--	34	5%	28	2%
Released from Jail on Personal Recognizance (PR)	695	19%	76	7%	33	7%	254	34%	332	24%
Successful OCRP Completion - Coordinated transition completed	18	0%	--	--	--	--	--	--	0	0%
Successful OCRP Completion - Summary of treatment completed	6	0%	--	--	--	--	--	--	0	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	17	0%	--	--	--	--	--	--	0	0%
LENGTH OF STAY										

	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
Average Length of Stay in Forensic Navigator Program (days)	38.0	N/A	36.4	N/A	50.7	N/A	42.6	N/A	32.8	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, 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.
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 Forensic Navigator 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.
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.
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.

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.
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 SSI/SSDI.
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.
Client Death	Client deceased.
Client Determined Competent	Client found competent by the court.
Dismiss and Refer (to DCR)	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.
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.
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. 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. Vouchers were available in Phase 2 Region (King County) in June 2022. Reporting will begin when there are sufficient cases to protect confidentiality.

REPORTING PERIOD
Cumulative: December 1, 2019 to December 31, 2022

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

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- TABLE 1: Housing Vouchers, Cumulative
- Definitions

TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to December 31, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Vouchers Disbursed	451	100%	71	15.7%	183	40.6%	197	43.7%
Recipients (unduplicated)	346	100%	71	20.5%	155	44.8%	120	34.7%
Total Amount Disbursed	$442,614	N/A	$80,637	N/A	$199,765	N/A	$162,212	N/A
Average Amount Per Recipient	$1,279	N/A	$1,136	N/A	$1,289	N/A	$1,352	N/A
REFERRAL SOURCE								
Crisis Call Center	2	0.6%	0	0.0%	--	--	--	--
Family/Friend	4	1.2%	--	--	--	--	0	0.0%
Hospital	120	34.7%	26	36.6%	28	18.1%	66	55.0%
Mobile Crisis Response	14	4.0%	--	--	--	--	13	10.8%
Designated Crisis Responder	26	7.5%	0	0.0%	0	0.0%	26	21.7%
Tribe or Indian Healthcare Provider	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Emergency Responder	2	0.6%	--	--	--	--	0	0.0%
Other Healthcare Provider	22	6.4%	--	--	15	9.7%	--	--
Law Enforcement (Police, Co-Responders)	18	5.2%	11	15.5%	--	--	--	--
Court/Criminal Justice Referred	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Self	126	36.4%	--	--	109	70.3%	--	--
Other	12	3.5%	11	15.5%	--	--	--	--
GENDER								
Female	109	31.5%	17	23.9%	52	33.5%	40	33.3%
Male	231	66.8%	54	76.1%	102	65.8%	75	62.5%
Other/Unknown	6	1.7%	0	0.0%	--	--	--	--
AGE GROUP								
18-29	73	21.1%	18	25.4%	31	20.0%	24	20.0%
30-49	191	55.2%	32	45.1%	88	56.8%	71	59.2%
50+	82	23.7%	21	29.6%	36	23.2%	25	20.8%
RACE/ETHNICITY*								
Non-Hispanic White	239	69.1%	38	53.5%	124	80.0%	77	64.2%
Black, Indigenous, and People of Color	98	28.3%	33	46.5%	31	20.0%	34	28.3%
Unknown	9	2.6%	0	0.0%	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Voucher Recipients…								
FORENSIC HARPS (FHARPS) STATUS**								
Referred to FHARPS	103	29.8%	24	33.8%	26	16.8%	53	44.2%
Contacted by FHARPS Staff	95	27.5%	23	32.4%	21	13.5%	51	42.5%
Enrolled in FHARPS	95	27.5%	23	32.4%	21	13.5%	51	42.5%
Housed or Sheltered by FHARPS	84	24.3%	20	28.2%	20	12.9%	44	36.7%
Among Individuals Housed or Sheltered by FHARPS…								
FIRST FHARPS HOUSING TYPE**								
Permanent	2	2.4%	--	--	--	--	--	--
Transitional	9	10.7%	--	--	--	--	--	--
Shelter/Emergency	73	86.9%	19	95.0%	15	75.0%	39	88.6%
Other	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.

*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 Regions: Pierce, Southwest, Spokane.
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
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.
Referral Source	Source that referred individual to the crisis triage and stabilization facility or other community entity disbursing vouchers.
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, 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).

Appendix E-FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

Forensic Housing and Recovery Through Peer Services (FHARPS), 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 December 31, 2022

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division (RDA)
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TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2022

	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	1,464	100%	637	100%	284	100%	384	100%	159	100%
Contacted	955	65%	408	64%	243	86%	188	49%	116	73%
Enrolled	834	57%	362	57%	214	75%	180	47%	78	49%
Among Referred Individuals…										
REFERRAL SOURCE*										
Trueblood Partner Programs	859	59%	262	41%	172	61%	269	70%	156	98%
Forensic Navigator	*464*	*32%*	*119*	*19%*	*111*	*39%*	*78*	*20%*	*156*	*98%*
Forensic PATH	*209*	*14%*	*84*	*13%*	*22*	*8%*	*103*	*27%*	*0*	*0%*
OCRP	*9*	*1%*	--	--	--	--	--	--	*0*	*0%*
Crisis Stabilization Center	*156*	*11%*	*49*	*8%*	*36*	*13%*	*71*	*18%*	*0*	*0%*
Mobile Crisis Response	*1*	*0%*	--	--	*0*	*0%*	--	--	*0*	*0%*
Co-Response Team	*20*	*1%*	--	--	--	--	--	--	*0*	*0%*
Behavioral Health Facility - Outpatient	254	17%	124	19%	90	32%	40	10%	0	0%
Inpatient Facility	54	4%	33	5%	--	--	--	--	--	--
Family/Self	50	3%	33	5%	--	--	16	4%	--	--
Other	247	17%	185	29%	--	--	44	11%	--	--
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT*										
Phone	420	44%	232	57%	155	64%	33	18%	0	0%
Court	2	0%	--	--	--	--	0	0%	0	0%
Hotel/Motel	25	3%	20	5%	--	--	--	--	--	--
Jail	238	25%	19	5%	76	31%	28	15%	115	99%
Crisis Stabilization Center	65	7%	14	3%	0	0%	51	27%	0	0%
Behavioral Health Facility - Outpatient	102	11%	56	14%	--	--	42	22%	--	--
Inpatient Facilty	16	2%	--	--	0	0%	--	--	0	0%
Shelter	7	1%	--	--	0	0%	--	--	--	--
Street/Encampment	3	0%	--	--	0	0%	--	--	--	--
Temporary Residence	5	1%	--	--	0	0%	--	--	0	0%
Other	72	8%	47	12%	--	--	20	11%	--	--

	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
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	296	35%	123	34%	62	29%	46	26%	65	83%
Discharged (during reporting period)	538	65%	239	66%	152	71%	134	74%	13	17%
GENDER										
Female	244	29%	--	--	--	--	--	--	--	--
Male	579	69%	237	65%	155	72%	131	73%	56	72%
Other/Unknown	11	1%	--	--	--	--	--	--	--	--
AGE GROUP										
18-29	206	25%	91	25%	60	28%	--	--	--	--
30-49	467	56%	179	49%	124	58%	119	66%	45	58%
50+	161	19%	92	25%	30	14%	--	--	--	--
RACE/ETHNICITY**										
American Indian or Alaska Native	0	0%	0	0%	0	0%	0	0%	0	0%
Asian	16	2%	--	--	--	--	--	--	--	--
Black or African American	211	25%	134	37%	32	15%	26	14%	19	24%
Hispanic or Latino	81	10%	36	10%	25	12%	--	--	--	--
Native Hawaiian or Pacific Islander	0	0%	0	0%	0	0%	0	0%	0	0%
White Only, Non-Hispanic	417	50%	160	44%	119	56%	125	69%	13	17%
Other Race	57	7%	14	4%	35	16%	--	--	--	--
Unknown	56	7%	--	--	--	--	--	--	36	46%
HOUSING STATUS AT PROGRAM ENROLLMENT*										
Unstably Housed	310	37%	83	23%	117	55%	--	--	--	--
Homeless	524	63%	279	77%	97	45%	--	--	--	--

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. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality.

*Sum of breakouts by type exceeds the number of referrals and/or enrollments due to provider data entry errors. Corrections will be reflected in future data.

**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 - December 31, 2022

	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	834	100%	362	100%	214	100%	180	100%	78	100%
Housed or Sheltered	633	76%	321	89%	148	69%	139	77%	25	32%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies Only	11	1%	--	--	--	--	--	--	--	--
Support Services and Subsidies	823	99%	--	--	--	--	--	--	--	--
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	50	8%	--	--	--	--	11	8%	--	--
Transitional	212	33%	124	39%	40	27%	--	--	24	96%
Shelter/Emergency	370	58%	167	52%	99	67%	104	75%	--	--
Other	1	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. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - December 31, 2022

	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	834	100%	362	100%	214	100%	180	100%	78	100%
Active (on last day of reporting period)	296	35%	123	34%	62	29%	46	26%	65	83%
Discharged (during reporting period)	538	65%	239	66%	152	71%	134	74%	13	17%
Among Individuals Discharged…										
SUBSIDY										
Average Total Subsidy Since Enrollment	$6,035	N/A	$6,689	N/A	$6,554	N/A	$4,605	N/A	$1,608	N/A
DISCHARGE REASON										
Transitioned to Other Housing Support	67	12%	49	21%	--	--	--	--	--	--
Received Maximum Subsidy	*18*	*3%*	--	--	--	--	--	--	--	--
Did Not Receive Maximum Subsidy	*49*	*9%*	*42*	*18%*	--	--	--	--	--	--
Transitioned to Self-Support	81	15%	42	18%	24	16%	15	11%	0	0%
Admitted to a Facility	33	6%	--	--	--	--	14	10%	--	--
Received Maximum Assistance (no transition)	58	11%	30	13%	16	11%	12	9%	0	0%
Withdrew	72	13%	21	9%	25	16%	--	--	--	--
Loss of Contact	171	32%	64	27%	61	40%	46	34%	0	0%
Served by Another FHARPS Team	1	0%	--	--	--	--	--	--	--	--
Other	55	10%	23	10%	15	10%	--	--	--	--
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	202	N/A	203	N/A	194	N/A	226	N/A	43	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	174	32%	102	43%	37	24%	35	26%	0	0%
Unstably Housed	37	7%	17	7%	--	--	--	--	--	--
Homeless	78	14%	45	19%	19	13%	--	--	--	--
In a Facility	71	13%	18	8%	--	--	35	26%	--	--
Unknown	178	33%	57	24%	65	43%	--	--	--	--

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. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality.

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

Formerly referred to as Intensive Case Management, 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.

March 1, 2020 to December 31, 2022

Prepared by Washington State Department of Social and Health Services
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- Definitions

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2022

	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	2,593	100%	961	100%	274	100%	518	100%	840	100%
Attempted Contacts	1,075	41%	477	50%	122	45%	393	76%	83	10%
Contacted	699	27%	181	19%	141	51%	262	51%	115	14%
Enrolled	397	15%	133	14%	107	39%	100	19%	57	7%
PRIORITIZED POPULATION										
Prioritized Referral List	1,150	44%	467	49%	105	38%	267	52%	311	37%
Attempted Contacts	555	48%	270	58%	48	46%	203	76%	34	11%
Contacted	329	29%	95	20%	60	57%	130	49%	44	14%
Enrolled	208	18%	72	15%	50	48%	62	23%	24	8%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	232	58%	77	58%	48	45%	52	52%	55	96%
Discharged*	165	42%	56	42%	59	55%	48	48%	--	--
Average Length of Stay in Program (days)	258.2	N/A	224.1	N/A	295.6	N/A	259.8	N/A	74.5	N/A
DISCHARGE REASON										
Successful exit	32	19%	--	--	--	--	14	29%	0	0%
Loss of contact	72	44%	31	55%	20	34%	21	44%	0	0%
Needs could not be met by program	6	4%	--	--	--	--	0	0%	0	0%
Withdrew	13	8%	--	--	--	--	--	--	--	--
Incarceration	19	12%	--	--	11	19%	--	--	0	0%
Admitted to hospital	4	2%	--	--	--	--	--	--	0	0%
Death	6	4%	--	--	--	--	0	0%	0	0%
Other	13	8%	--	--	--	--	--	--	0	0%
Missing	0	0%	0	0%	0	0%	0	0%	0	0%
GENDER										
Female	85	23%	--	--	--	--	24	24%	14	34%
Male	286	77%	105	81%	78	76%	76	76%	27	66%
Other/Unknown	26	7%	--	--	--	--	0	0%	16	28%
AGE GROUP										
18-29	98	25%	36	27%	28	26%	--	--	--	--
30-49	243	61%	68	51%	66	62%	67	67%	42	74%
50+	56	14%	29	22%	13	12%	--	--	--	--
RACE/ETHNICITY*										
American Indian or Alaskan Native	17	4%	--	--	--	--	--	--	--	--
Asian	8	2%	--	--	--	--	0	0%	--	--
Black or African American	82	21%	33	25%	22	21%	--	--	19	33%
Hispanic or Latino	32	8%	--	--	13	12%	--	--	--	--

Native Hawaiian and Other Pacific Islander	4	1%	--	--	--	--	0	0%	--	--
White Only, Non-Hispanic	162	41%	35	26%	58	54%	50	50%	19	33%
Other Race	19	5%	--	--	--	--	--	--	--	--
Unknown	97	24%	52	39%	--	--	30	30%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	34	9%	--	--	--	--	11	11%	--	--
Unstably Housed	81	20%	25	19%	--	--	28	28%	--	--
Homeless	269	68%	89	67%	71	66%	61	61%	48	84%
Unknown	13	3%	--	--	--	--	0	0%	--	--
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	37	22%	16	29%	--	--	12	25%	0	0%
Unstably Housed	7	4%	--	--	--	--	--	--	0	0%
Homeless	21	13%	13	23%	--	--	--	--	--	--
In a Facility	29	18%	--	--	14	24%	11	23%	0	0%
Unknown	71	43%	--	--	29	49%	21	44%	--	--

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 - December 31, 2022

	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	8,053		3,290		1,606		2,605		552	
Average Service Encounters (per participant, per month)		2.7		2.9		2.5		3.1		2.3
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services		0.5		0.3		0.4		0.8		0.4
Re-engagement		0.1		0.0		0.1		0.2		0.0
Screening		0.2		0.4		0.0		0.1		0.1
Clinical assessment		0.0		0.0		0.0		0.0		0.1
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		1.2
Residential supportive services		0.1		0.1		0.3		0.0		0.0
Peer services		0.1		0.0		0.0		0.2		0.3
Service coordination		0.1		0.1		0.0		0.2		0.2
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	215	54.2%	68	51.1%	59	55.1%	80	80.0%	--	--
Referral Type										
Community mental health	75	18.9%	34	25.6%	21	19.6%	20	20.0%	0	0.0%
Substance use treatment	40	10.1%	12	9.0%	--	--	19	19.0%	0	0.0%
Primary health/dental care	38	9.6%	--	--	--	--	26	26.0%	0	0.0%
Job training	3	0.8%	--	--	--	--	--	--	0	0.0%
Educational services	3	0.8%	--	--	--	--	--	--	--	--
FHARPS housing	108	27.2%	38	28.6%	--	--	39	39.0%	--	--
Permanent housing (non-FHARPS)	17	4.3%	14	10.5%	--	--	--	--	0	0.0%
Temporary housing (non-FHARPS)	42	10.6%	24	18.0%	--	--	--	--	--	--
Other Housing Services (non-FHARPS)	58	14.6%	22	16.5%	31	29.0%	--	--	--	--
Housing services (pre-August 2021)	39	9.8%	--	--	--	--	30	30.0%	0	0.0%
Income assistance	13	3.3%	--	--	--	--	--	--	0	0.0%
Employment assistance	17	4.3%	--	--	--	--	--	--	--	--
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	32	8.1%	--	--	--	--	23	23.0%	0	0.0%

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.
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 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.
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.
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.
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 , Quarter and 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 mon	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.
Total number of referrals	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.
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

Cumulative: July 1, 2020 to December 31, 2022

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

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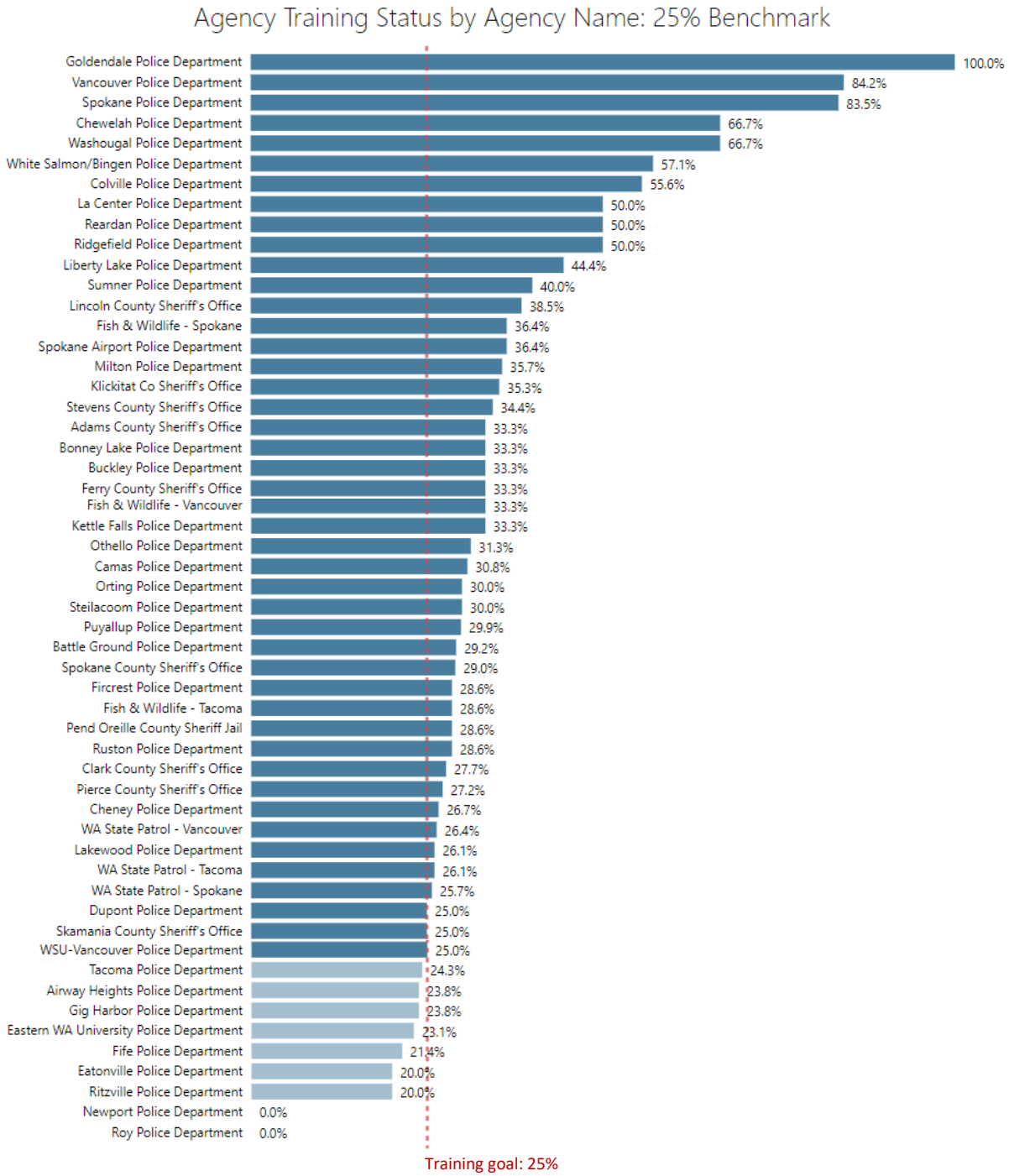
Figure 1.

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

DECEMBER 31, 2022



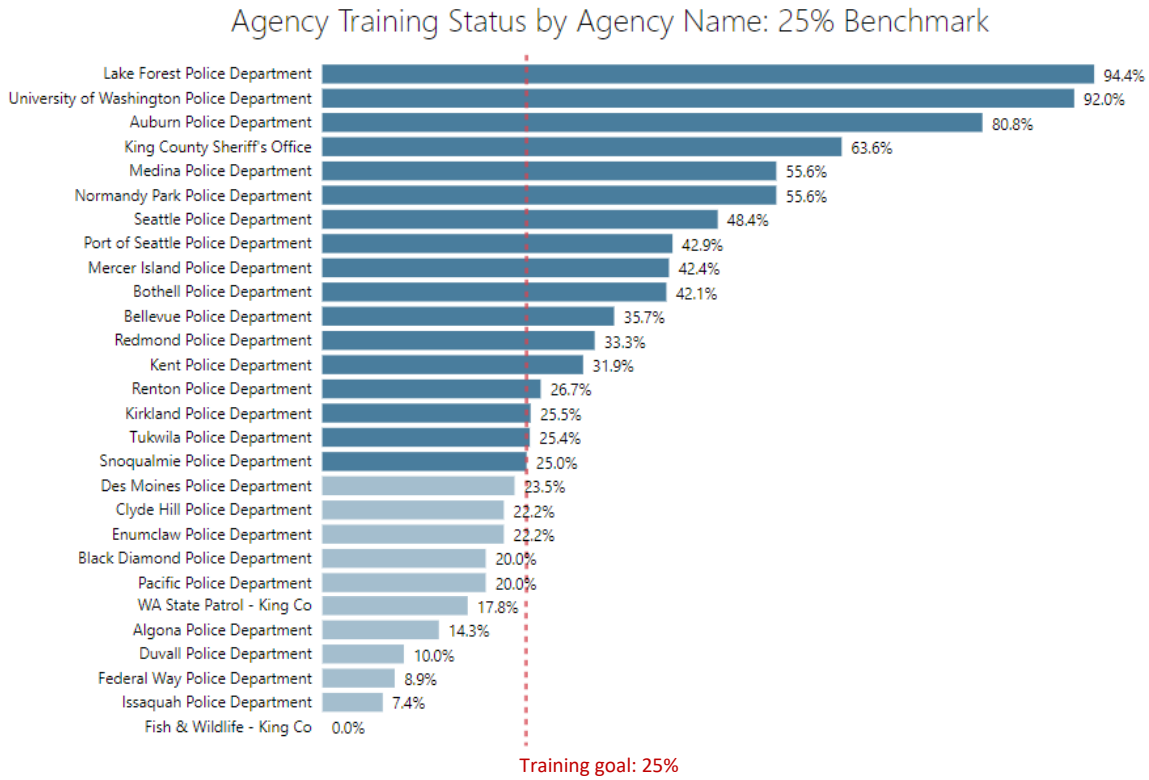
*Percent of officers who have received 40 hours of Crisis Intervention Training.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

DECEMBER 31, 2022



*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

DECEMBER 31, 2022

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 2	**2,624**	**1,221**	**46.5%**	**412**	**154**	**37.4%**	**131**	**44**	**33.6%**	3,167	1,419	44.8%
King Region	2,495	1,198	48.0%	412	154	37.4%	120	44	36.7%	**3,027**	**1,396**	**46.1%**
WA State Patrol - Phase 2	129	23	17.8%							**129**	**23**	**17.8%**
Fish & Wildlife - Phase 2							11	0	0.0%	**11**	**0**	**0.0%**
Phase 1	**1,463**	**700**	**47.8%**	**552**	**151**	**27.4%**	**360**	**132**	**36.7%**	2,375	983	41.4%
Pierce Region	592	152	25.7%	238	65	27.3%	98	31	31.6%	**928**	**248**	**26.7%**
Spokane Region	549	344	62.7%	53	16	30.2%	149	51	34.2%	**751**	**411**	**54.7%**
Southwest Region	322	204	63.4%	50	15	30.0%	86	41	47.7%	**458**	**260**	**56.8%**
WA State Patrol - Phase 1				211	55	26.1%				**211**	**55**	**26.1%**
Fish & Wildlife - Phase 1							27	9	33.3%	**27**	**9**	**33.3%**
Total	**4,087**	**1,921**	**47.0%**	**964**	**305**	**31.6%**	**491**	**176**	**35.8%**	5,542	2,402	43.3%

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.

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

DECEMBER 31, 2022

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 2	**688**	**427**	**62.1%**	**21**	**4**	**19.0%**	**37**	**25**	**67.6%**	746	456	61.1%
King Region	688	427	62.1%	21	4	19.0%	37	25	67.6%	**746**	**456**	**61.1%**
Phase 1	**580**	**535**	**92.2%**				**86**	**70**	**81.4%**	666	605	90.8%
Pierce Region	256	250	97.7%				13	12	92.3%	**269**	**262**	**97.4%**
Spokane Region	213	198	93.0%				47	34	72.3%	**260**	**232**	**89.2%**
Southwest Region	111	87	78.4%				26	24	92.3%	**137**	**111**	**81.0%**
Total	**1,268**	**962**	**75.9%**	**21**	**4**	**19.0%**	**123**	**95**	**77.2%**	1,412	1,061	75.1%

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.
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

DECEMBER 31, 2022

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	**236**	**236**	**100.0%**	**76**	**76**	**100.0%**	**131**	**131**	**100.0%**	443	443	100.0%
Spokane Region	101	101	100.0%				74	74	100.0%	**175**	**175**	**100.0%**
Pierce Region	135	135	100.0%							**135**	**135**	**100.0%**
Southwest Region				54	54	100.0%	27	27	100.0%	**81**	**81**	**100.0%**
WA State Patrol - Phase 1				22	22	100.0%	30	30	100.0%	**52**	**52**	**100.0%**
Phase 2	**212**	**182**	**85.8%**	**135**	**131**	**97.0%**	**77**	**70**	**90.9%**	424	383	90.3%
King Region	212	182	85.8%	135	131	97.0%	68	68	100.0%	**415**	**381**	**91.8%**
WA State Patrol - Phase 2							9	2	22.2%	**9**	**2**	**22.2%**
Total	**448**	**418**	**93.3%**	**211**	**207**	**98.1%**	**208**	**201**	**96.6%**	867	826	95.3%

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.

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

cc: Dr. Brian Waiblinger, DSHS/BHA Medical Director
Dr. Thomas Kinlen, OFMHS Director
Amber Leaders, GOV Senior Policy Advisor
Nicholas Williamson, Assistant Attorney General
Charles Southerland, Western State Hospital – Civil Center CEO
Mark Thompson, Western State Hospital – Gage Center CEO
Eric Carpenter, Eastern State Hospital CEO
Aura MacArthur, Director of Project Management