

STAKEHOLDER INPUT TO THE TRUEBLOOD TASK FORCE

KEY ISSUES AND THEMES

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I. Background

Trueblood v. DSHS (Trueblood) is a case challenging unconstitutional delays in competency evaluation and restoration services for individuals with a mental disability that may prevent a defendant from assisting in their own defense. As a result of this case, Washington State (State) has been ordered to provide court-ordered in-jail competency evaluations within 14 days and competency restoration services within 7 days. *Trueblood* class members are those individuals who are detained in city and county jails awaiting a competency evaluation or restoration services. Reforms and programs resulting from the *Trueblood* case may benefit both current class members and those individuals who are at risk of becoming class members.

The Trueblood Task Force (Task Force), a collaboration between class counsel, the Department of Social and Health Services (DSHS), the Attorney General's Office, and the Governor's Office, was created as part of the ongoing work to enforce the federal court's order under *Trueblood*. The goal of the Task Force is to craft a solution to the problems in Washington State's forensic mental health system. Please see Appendix A for a list of Task Force Core Members.

The Task Force has taken the following positions:

- Many of the problems with untimely competency evaluations can be prevented if fewer people with mental illness enter the criminal justice system.
- When people are able to get the treatment they need when they need it, they are more likely to avoid becoming entwined in the criminal justice system.

However, the Task Force believes there is a mental health crisis in the state, with the demand for all forms of mental health services far outstripping the availability of services, including competency evaluation and restoration services. The group's premise is that by providing access to appropriate behavioral health¹ services which are designed to reduce the number of individuals entering the criminal justice system, the state will become better able to meet the constitutional competency evaluation and restoration services timelines. Experience to date has shown that adding evaluators to determine competency and beds to restore competency is having little impact on reducing the demand for either; and, while 94% of competency evaluations for individuals in jail now occur within 14 days, the state continues to struggle to meet the designated timeframe for restoration services.

In lieu of continuing to seek additional contempt orders through litigation, which has yielded hefty contempt fines but failed to eliminate delays for class members, Plaintiffs agreed to undertake a new and ambitious settlement process with the state. The parties agreed to host a series of stakeholder meetings throughout the state to seek input from those directly involved in the forensic (and broader) mental health system on how to reform the system. Stakeholder

¹ 'Behavioral health' refers to mental illness, substance use disorders and co-occurring mental health and substance use disorders.

input gathered from these meetings is intended to inform future negotiations and the development of a comprehensive settlement agreement.

The Trueblood Task Force sought and received court approval to engage the services of the Technical Assistance Collaborative, Inc. to support the work of the Task Force and to facilitate the stakeholder sessions. The purpose of this report is to provide a summary of the discussions, including themes that emerged, challenges and barriers identified by stakeholders, and recommendations to improve the system.

II. Brief Description of the Opportunities to Educate and Obtain Feedback from a Broad Range of Stakeholders

The Task Force employed a multi-pronged approach to educate stakeholders about the Trueblood Task Force and to gather stakeholder input on potential solutions for improving the forensic mental health system.

Stakeholder Webinar

In late January 2018, a broad range of stakeholders were invited to participate in a kick-off webinar facilitated by representatives from the Task Force. The purpose of the webinar was to educate stakeholders about the *Trueblood* case, the creation of the Task Force, and the proposed series of opportunities for stakeholders to provide input on how to improve the forensic as well as the broader mental health system. During the webinar, stakeholders were asked to respond to key questions of interest to the Task Force, providing immediate input on issues such as needed enhancements to the forensic mental health system and the array of stakeholders that should be engaged for additional input.

Stakeholder Listening Sessions

The initial series of stakeholder meetings was intended to generate discussion and gather information from stakeholders representing similar touchpoints within the forensic (and broader) behavioral health system. Separate sessions were held with representatives from the courts, behavioral health organizations (BHOs), law enforcement, class members and their families, county officials, tribal leaders, and the state legislature. Participants were invited to attend in person or to join from off-site via the use of technology, including webinars and conference calls. Participants were asked for their input in the following areas:

- Major barriers to accessing services for clients and gaps in services for individuals with mental illness
- Services and aspects of the system that are working well and have been positive or beneficial to individuals who access the mental health system
- Recommended solutions to improve the mental health system or to address barriers to people with mental illness receiving services

Stakeholder Regional Meetings

A second series of stakeholder sessions was held at locations throughout the state in recognition of the differences stakeholders may experience interfacing with the criminal justice system and accessing behavioral health services based on their geographic location. Sessions were held in rural and urban parts of the state, with invitations to the broad base of stakeholders within each designated “region.” Since these sessions were held in diverse locations, participants were encouraged to attend in person. For individuals who could not attend in person, an option to participate remotely through the use of technology was made available. Participants in these regional sessions were asked for their input into a more in-depth exploration of *Trueblood* issues including:

- Diversion from the criminal justice system
- Potential changes to restoration — process, eligibility, and alternative settings
- The effectiveness of newly developed or enhanced approaches and services that impact the need for competency evaluation and restoration
- Access to information and data necessary to determine the appropriate disposition for individuals with behavioral health disorders who interface with the criminal justice system

Two aspects of the regional meetings are worth noting. First, the diversity of stakeholders participating in most regions provided opportunity for sharing perspectives on the impact of *Trueblood* issues across the criminal justice and behavioral health systems. When attendance permitted, these discussions occurred in small, multi-stakeholder groups to encourage greater individual input and cross-systems learning.

Second, the agenda included a presentation of state and county data on trends in referrals for competency evaluations and restoration (Please refer to Appendix C, *Trueblood* Task Force, King County Regional Meeting.) Several key themes emerged from the data:

- Since 2013, referrals for competency evaluation and restoration have continued to increase steadily.
- The increase in referrals for competency evaluation/restoration does not appear to be the result of an increase in arrest rates — the number of referrals for competency evaluation/restoration increased by 104% from January 2013 to August 2017, while the number of unduplicated persons arrested declined by 5% during the same period.
- The rate of determinations of competency and non-competency are relatively consistent for individuals charged with felonies and those charged with misdemeanors.
- Half of all referrals for competency evaluation originate in King, Pierce, and Spokane counties, which also comprise half of the state’s population.
- Half of all referrals for restoration services also originate from King, Pierce, and Spokane counties.
- Between January 2013 and August 2017, some counties experienced significant increases in referrals for competency restoration while other counties experienced significant decreases. Individual county referral rates were not consistent for felonies

and misdemeanors; nor was there a pattern of increased or decreased referrals from counties that implemented the local Behavioral Health tax.

Stakeholder Participation

In total, more than 300 individuals participated in the kick-off webinar, stakeholder listening sessions, and regional meetings. Most participated in person. Participants included: state legislators; local government officials; tribal leaders or their representatives; judges from municipal, district, and superior courts; prosecutors; public defenders; sheriffs; police; jail staff; BHOs; behavioral health service providers; community service providers; advocates; and class action members/consumers and their family members. Defendants separately held stakeholder meetings for staff at Eastern and Western State Hospitals.

Please see Appendix B for a list of the stakeholder listening sessions and regional meetings. Please see Appendix C for sample slide decks used to facilitate the listening sessions and regional meetings.

III. Themes Regarding Gaps in Care and Barriers to Care

There was unanimous agreement among stakeholders throughout the state that too many individuals with mental health and substance use disorders are involved with the criminal justice system. Representatives from law enforcement and jails were especially vocal about how their roles in responding to and “housing” individuals with significant behavioral health issues are overtaking their intended roles of enforcing laws and protecting public safety. There was also agreement that this dilemma is in part the result of the lack of resources to support a robust array of readily accessible services that would prevent individuals from ever coming into contact with the criminal justice system. Absent a behavioral health system that provides timely response and access to services, the police are viewed as the quickest, if not the only, solution to intervening with individuals with behavioral health problems.

Gaps in Services and Barriers to Care that Impact the Need for Competency Evaluations and Restoration

All stakeholder participants agreed that providing prompt community-based treatment and supports to individuals with behavioral health disorders would reduce the need for competency evaluations and restoration services. They described barriers to care and a lack of services throughout the state.

Gaps in Behavioral Health Services that Could Divert Individuals from Involvement with the Criminal Justice System

There was unanimous agreement among stakeholders about the lack of and need for the following services:

- **Housing/residential services** that are safe, affordable, and connected to case management and services and supports. The lack of affordable housing was a need

resoundingly identified by stakeholders in urban, rural, and tribal communities in all areas of the state. There were different opinions on what type of housing was needed. Behavioral health stakeholders were stronger advocates for more independent options such as permanent supportive housing, while representatives of the courts, law enforcement, and families advocated for residential settings with various levels of supervision.

- **Mobile crisis response services** that provide prompt intervention and de-escalation in order to avoid the need for law enforcement to be engaged. Even when trained in crisis intervention, law enforcement can be viewed as threatening to individuals with behavioral health conditions, causing further escalation of behaviors in a crisis situation. Direct contact with a mobile crisis worker can defuse volatile situations that otherwise often lead to arrests.
- Stakeholders recognized that not all contacts with police can or should be avoided. However, contact with law enforcement could facilitate access to treatment and avert incarceration if police had access to a **triage/evaluation center** where individuals could be assessed by a trained clinician, 24 hours a day, 7 days a week. This center should be accessible to consumers, family members, community members, and most importantly to law enforcement, allowing them to intervene when called upon and to promptly return to their primary job protecting the public.
- **Secure Crisis Support Units (CSUs)** that can admit individuals with more aggressive behaviors and who may not agree to stay voluntarily. Some communities do have CSUs but they are not “hardened,” so they can only serve individuals who stay voluntarily and who are deemed appropriate for the facility. Absent a secure setting, jail serves as the fallback for many individuals.
- **Case Management**, with reasonable caseloads that allow staff to have frequent and direct contacts with individuals as needed. There was agreement that the behavioral health system is complex and can be difficult to navigate, especially for individuals in need of stabilization or who have chronic behavioral health conditions. Such individuals can easily fall through the cracks without strong oversight and assistance in accessing the services they need.
- **Culturally competent providers** are lacking for tribal communities. Mental health and substance use disorders are perceived very differently within the Native American culture. Their views must be recognized and their culture honored by treatment professionals in order for diagnosis and treatment to be possible for tribal members. When available, tribal communities rely on Indian Health Services (IHS) for treatment; however, IHS is not always available and struggles to attract mental health professionals in rural parts of the state.
- **Inpatient psychiatric beds** are needed for some individuals to achieve stabilization. State hospital bed shortages impact both the civil and criminal justice processes, limiting access and causing delays in both evaluation and restoration.

Stakeholders also identified a lack of “middle-tier” services that, once an individual is in a stable setting, could help them on their journey to recovery and ultimately prevent the need for competency evaluation and restoration. These services include:

- **Peer support/recovery support** provided by individuals with lived experience. Unlike professionals, peers can engage individuals to participate in treatment and services by sharing their personal experiences, providing empathy, and offering hope. Peer/recovery support services exist in some communities, but there is a need to expand the capacity of such programs, targeted to prevent involvement with the criminal justice system.
- **Supported education and supported employment** provide individuals with meaningful activity and purpose, promote recovery, and assist individuals in increasing their income through earned wages. Employment is associated with improved health and behavioral health outcomes.

Barriers to Care

In addition to identifying the lack of housing and housing supports as a crucial gap in services, stakeholders identified the lack of safe and affordable housing as a significant barrier to engaging individuals in needed treatment and sustaining their ongoing participation. Housing instability (e.g. difficulty affording and paying rent, overcrowding, frequent moves) and homelessness divert focus from wellness to survival, and contribute to missed appointments, unfilled prescriptions and lost medications, and exacerbation of mental health symptoms that often lead to preventable interactions with crisis intervention services and law enforcement. Individuals also shared that competency restored during inpatient treatment can deteriorate quickly when an individual returns to “the street.”

Stakeholders identified the lack of funding for services as a major barrier to care. Various participants shared examples of more robust, readily accessible behavioral health services being available in the past. Examples included ready access to prescribers, intensive case management services with maximum caseloads of 25, and Programs of Assertive Community Treatment (PACT) that met the fidelity criteria associated with positive outcomes. The erosion of federal block grants and state funding and the increased reliance on Medicaid were identified as contributing to today’s insufficient funding for services at the same time that the demand for services has multiplied. Various participants pointed out that while more individuals with behavioral health disorders have Medicaid coverage, many of the services and supports needed to divert individuals from involvement in the criminal justice system are *not* Medicaid-reimbursable. Absent state funding for these services, such as outreach and housing, more individuals with behavioral health disorders are homeless and have insufficient community support, and as a result are more likely to interface with law enforcement.

Many stakeholders identified as a barrier to care the lack of qualified, well-trained staff providing critical behavioral health services. Staffing shortages have resulted in reductions in hours of service availability, particularly after normal business hours and on weekends, and extended wait times for services such as crisis response and clinical/medication evaluations.

Law enforcement expressed frustration with the length of time it often takes for mobile crisis workers to respond when called. Rural counties identified the inability to hire Designated Mental Health Professionals (DMHPs) and families described being unable to access a DMHP during weekend hours, instructed to call the police or to go to the emergency department instead. Conversely, in rural areas with limited law enforcement personnel, crisis teams may be available to respond but will not go off-site without law enforcement to accompany them.

Stakeholders also agreed that “just” having services available is not enough. Participation in behavioral health services is voluntary, and some individuals may become a danger to themselves or others if they do not engage in treatment and services. Depending on the interpretation of this standard, an individual can be actively symptomatic and acting in a manner that is perceived as threatening by others. The right to refuse treatment is seen by many stakeholders as a barrier to accessing needed care. Family members shared numerous stories of calling the police in an effort to “coerce” their loved ones to accept treatment, while others contacted law enforcement to ensure their loved ones would be in a safe place rather than on the streets. Depending on the charges filed or the number of repeated incidents involving law enforcement and the courts, the result may be a referral for competency evaluation/restoration.

The inability to identify and intervene earlier with individuals with emerging mental health and substance use disorders presents a barrier to care. Families described situations in which they sought help for concerns with their family members, but the symptoms and behaviors they described did not rise to the level of obtaining a response from school personnel or a behavioral health professional. Situations had to rise to the level of a crisis/emergency before “the system” would respond, often resulting in police intervention and arrests.

Additional barriers to care identified include the lack of transportation, especially in rural and tribal communities; the lack of communication between systems; and the inability to share information at all levels — with family members, between treatment providers, and across systems (see more in-depth examples of this issue later in this report).

IV. Concerns Regarding Competency Evaluation and Restoration

Stakeholders shared numerous concerns based on their experiences with competency evaluation and restoration. Washington’s law was described as “complex, over-reaching and very narrowly focused.” Since 1998, competency restoration can be required for both misdemeanor and felony charges. Crimes that occur as a result of an individual’s mental illness, such as trespassing or disorderly conduct, can result in an order for competency evaluation and possible restoration. Prior to *Trueblood*, competency evaluations and restoration services occurred for the most part in two state psychiatric hospitals. Even with the addition of beds in the state hospital and state-operated residential treatment facilities, the time required for competency restoration can result in an individual with a serious mental illness spending far greater time in an institutional setting than an individual without a mental illness who is sentenced and incarcerated for the same crime.

Competency restoration may require an individual to take prescribed medications and to participate in classes until such time as they can understand their legal proceedings and assist in their defense. However, gains achieved from the process can be very short-lived for an individual with a mental health disorder:

- Some individuals return to jail, refuse to take medications, and decompensate — and the need for restoration starts all over again.
- Some individuals face legal proceedings, serve time in jail, are released from jail with little to no transition planning or linkage to the behavioral health treatment system, decompensate, and interface with law enforcement — and the need for restoration starts all over again.
- Some individuals have charges dropped, are released from jail with little to no engagement in the behavioral health treatment system, decompensate, and interface with law enforcement — and the need for restoration starts all over again.

An additional concern expressed by family members is that individuals with co-occurring conditions such as autism, traumatic brain injury, and development disabilities are often ordered into the process for competency restoration. Families expressed concern that these conditions cannot be stabilized with psychotropic medications, and individuals are not likely to gain the ability to participate in their legal defense as a result of the required classes. Families described several examples of their loved ones waiting for an evaluation in jail or prison where they further deteriorated and in some cases, were put into isolation.

All of these scenarios result in the commitment of significant resources from both the criminal justice and mental health systems, with little long-term benefit and, stakeholders would argue, cumulative, damaging consequences for individuals and their families.

V. Strengths of the Current System - What is Working Well and Which Programs Should be Replicated?

Most stakeholders were able to identify services, programs, and practices currently available across the behavioral health and criminal justice systems that are impacting or will potentially impact the involvement of individuals with behavioral health disorders with the criminal justice system.

Effective Behavioral Health Services and Approaches

Stakeholders offered strong support for:

- Peer support specialists and recovery coaches, where they are available. Some communities have added peers to crisis response teams to help support engagement.
- ACT/PACT teams that adhere to the standards for services that research supports are associated with positive client outcomes, otherwise referred to as ‘meeting fidelity.’

- Telehealth to provide greater access to behavioral health clinicians for evaluations and prescription of medications, including for tribal communities.
- Secure detox beds.
- Residential treatment facilities where individuals can be taken for short-term (up to 14 days) treatment/stabilization.
- Jail in-reach, with a behavioral health case manager engaging an individual and establishing a plan of care prior to release.

Effective Approaches Implemented by Law Enforcement, the Courts, and Jails

Stakeholders offered strong support for strategies implemented across the criminal justice system to better serve individuals with behavioral health disorders:

- A warm handoff from 911 to the crisis intervention line instead of calling the police.
- Crisis intervention training for law enforcement.
- Treatment court/community court was described as very successful for individuals who are competent and agree to participate.
- Some county jails have a mental health unit, with staff who work with individuals who are in jail, but also spend a lot of time working in the community. Clinical staff determine individuals' mental health needs, make connections with community treatment/services, and work with court staff to develop discharge plans. Case managers ensure that services are in place post-release and follow up to ensure that individuals connect with services.

Trueblood Grant-Funded Initiatives

In order to help address the issues at the forefront of the *Trueblood* case, the Court has so far approved the allocation of \$17 million (from assessed fines) in grants to counties for approaches that will divert individuals from needing competency evaluation or restoration. The grants are being dispersed in phases. Projects originally funded targeted services at points 2 and 4 of the Sequential Intercept Model.² More recent grants funding services targeted at Intercepts 1 and 5 will begin in July 2018. Funded projects must have the ability to identify class members served, identify and collaborate with key stakeholders, meet intended outcomes, develop plans for ongoing sustainability, and submit quarterly reports on services provided.

Programs and Approaches Recommended for Replication

Stakeholders were asked to identify model programs implemented by the behavioral health and criminal justice systems that they felt result in better outcomes for individuals with mental health disorders, and that, if replicated, would be effective in impacting the demand for competency evaluations and restoration services.³

² Sequential Intercepts for Criminal Justice-Behavioral Health Partnerships, accessed on May 8, 2018 at: <https://www.prainc.com/wp-content/uploads/2015/10/SIMBrochure.pdf>.

³ Evaluating the effectiveness of these programs and their performance outcomes was beyond the scope of this report.

- **Thurston County — Drexel House** is a transitional living program in Olympia that provides housing with case management and support services onsite. A co-located day program is available.
- **King County — Familiar Faces** was created as a health and human services response to individuals with behavioral and physical health needs who cycle through the criminal justice system as a result of social challenges. The approach involves working across systems, using an intensive case management approach to facilitate diversion as well as re-entry; jail release planning; all parties working from a single care plan; and creating access to information regarding involvement with the courts, with the intent to “quash” warrants and dismiss charges.
- **King County — Law Enforcement Assisted Diversion (LEAD)** is a pre-booking diversion pilot program that allows law enforcement officers to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution. By diverting eligible individuals to services, LEAD is committed to improving public safety and public order by reducing the criminal behavior of people who participate in the program.
- **Yakima County — Residential treatment facilities** are reported to be successful in helping some individuals to gain competency and to agree to participate in therapeutic courts.
- **Pierce County — The Pierce County District Court Resource Center** provides access to a variety of social services and programs for justice-involved individuals in one centralized location. Services such as homelessness prevention, substance use disorder assessments, connections to employment and housing, a clothing bank, and more are provided in a coordinated and timely manner, resulting in better outcomes for the individuals served and for the community.
- **Snohomish County — The Jail Mental Health Program** has mental health professionals that conduct competency evaluations within the required timeframes. Jail mental health services focus on release as quickly as possible, and post-release planning to facilitate continuity of care.
- **Snohomish County — Compass Triage Center** provides crisis and non-medical sobering support for referrals directly from law enforcement and emergency medical technicians (EMTs) in an attempt to divert individuals in behavioral health crisis from local emergency departments and jails. Length of stay can vary from several hours to several days.

VI. Recommendations for How to Address Issues Related to the Demand for Competency Evaluation/Restoration

Diversion

As previously stated, most stakeholders supported diverting individuals with mental health and co-occurring mental health and substance use disorders from interface with the criminal justice system as an upstream approach to reducing the demand for competency services.

Strategies with Broad-Based Stakeholder Support

- Access to housing/residential beds
- Prompt access to a full continuum of mental health and co-occurring disorder treatment, including the use of telecare
- High-touch case management and care coordination services
- Prompt mobile crisis response
- Co-response with law enforcement, when needed, to help defuse crisis situations and provide assessment of an individual's appropriateness for treatment in lieu of incarceration
- 24/7 triage centers, readily accessible to law enforcement for drop-off and disposition. Centers must provide evaluations by mental health professionals and prompt transition to needed treatment.
- Pre-plea disposition court diversion programs that may include treatment and conditions of participation.

Stakeholders suggested that the following elements would be necessary for diversion to be successful:

- Modifications to the civil commitment process
- Readily available housing
- Treatment
- Case management to serve as a point of contact throughout the process
- Peer support
- Transportation

Concerns Related to Diversion

Funding: All stakeholders identified the need for an infusion of resources to support a highly responsive behavioral health system statewide. Most agreed that diversion would be a cost-effective approach in the long run, but recognized that services and capacity will need to be created and funded for a period of time until the benefits of a more robust service system are realized. Representatives of the legislature were especially concerned about the cost of proposed enhancements to behavioral health services throughout the state. In light of competing budgetary concerns, stakeholders were concerned that the legislature might find it more prudent to direct funding to meet the legal obligations of *Trueblood* rather than to take on funding improvements to the system.

Representatives of the courts also indicated that their resources are stretched thin. Additional disposition courts will require additional court time, space, and personnel, all of which will also need funding to support them.

Limited Focus: Some stakeholders expressed concerns that diversion is only focused on the "front end." *Trueblood* class members have had increased access to crisis diversion services, but not the opportunity for an ongoing therapeutic relationship due to insufficient community-based capacity. Diversion efforts need to be paired with efforts to engage people in ongoing

treatment and supports to increase the likelihood of preventing further contact with the criminal justice system.

Lack of Information: Law enforcement expressed frustration about the inability to obtain important behavioral health information on individuals when they are called to intervene. The lack of mental health/substance use disorder information such as confirmed diagnosis, history of treatment, and current medications, impedes their ability to determine whether diversion or jail is the more appropriate disposition. Co-response with mental health staff is a strategy that some departments are undertaking, as the mental health staff often know clients or are employed by a provider and have greater access to clinical information.

Changes in Restoration

The topic with the least consensus among stakeholders throughout the state involved proposed changes to restoration, including which charges require competency evaluation/restoration and implementation of community-based restoration.

Crimes Requiring Restoration

Stakeholders were asked if they would support the elimination of competency restoration for all misdemeanor charges, and if not, if there were certain charges they would support exempting from restoration. Representatives from the behavioral health system and public defenders were most in support of eliminating restoration for misdemeanors, while prosecutors and judges were least supportive of this option.

There was greater agreement on eliminating the requirement for restoration for certain charges, though different thoughts about which charges should be exempt. Some suggested that restoration should be waived for nonviolent crimes, while others were more in favor of exempting for crimes that aren't committed against another person. Charges stakeholders agreed should not require restoration included trespassing, criminal mischief, shoplifting, disturbing the peace, and unlawful camping. Others suggested waiving for some felonies, including Class C felonies and certain drug-related charges. Stakeholders also agreed that restoration should not be required for charges filed as a result of behaviors by individuals on civil holds in mental health treatment settings, or for charges against individuals who have conditions that cannot be restored, such as persons with intellectual and developmental disabilities or traumatic brain injury.

Law enforcement suggested that restoration should continue to be required for BARRK offenses – burglary, arson, and robbery, rape and kidnapping. Judges agreed that their greatest concerns involved violent offenses and domestic violence.

Stakeholders suggested that for the elimination of restoration for certain crimes to be effective:

- A continuum of readily available mental health and substance use disorder services, affordable housing, and residential programs is needed. Prosecutors have flexibility to reduce charges, which can reduce the demand for restoration, and expressed a

willingness to do so if they believe the mental health system will provide prompt evaluation and access to services with supervision.

- Prosecutors and judges need information about an individual's mental health and substance use disorder history and participation in treatment to help facilitate an appropriate decision regarding charges and need for restoration.
- Judges would feel more comfortable if a risk assessment was conducted by a mental health professional to determine whether an individual should be diverted to treatment or restored and returned to face criminal charges.

Concerns Related to Changes in Restoration

Most stakeholders agreed that changes in restoration should not be made absent better access to services through the civil, voluntary behavioral health system. No one wants to send the message that committing crimes is the only path to gaining access to the broadest array of mental health services an individual may need. On the other hand, some prosecutors warned that if the civil behavioral health system does not provide adequate treatment and oversight, they will refer even more individuals for restoration to ensure that they are not released without supervision and the services and supports they need.

As described above, court representatives suggested that access to information about an individual's clinical history and participation in treatment would be important for determining the most appropriate disposition of a case. However, the courts do not have access to this information and may be less willing to divert from a competency evaluation as a result. Finally, absent a more accessible community-based system, some stakeholders were hesitant to eliminate orders for competency evaluations, commenting that the order for competency evaluation starts the process for gathering information for an appropriate disposition and may be the first step toward identifying an individual's behavioral health disorder.

Regardless of changes in the restoration process, stakeholders agreed that the time for restoration, especially for misdemeanors, is too short to create lasting change. Without access to housing and community-based services, the gains achieved through competency restoration are not sustained.

Community-Based Restoration

Stakeholders were asked if they would support an option for community-based restoration (CBR), and if so, who should be eligible for the option. Many stakeholders thought the option was worth exploring, though there were different ideas about who should be eligible.

Responses included:

- Having the option will have little impact if it is targeted to only the lowest-risk population; eligibility shouldn't be limited to the same population that qualifies for diversion.
- People who have started taking medication in jail could be referred for CBR rather than waiting for transfer to a state hospital.

- Individuals who have a stable living situation, in-home support, and coverage for their medications would be good candidates for CBR.

There was general consensus that individuals charged with nonviolent offenses and misdemeanors would be the best candidates, and that those with alleged sex offenses or violent crimes should not be considered.

Similar to their feedback on changes to required competency restoration, judges and prosecutors were more likely to support CBR after a health care provider or mental health provider made the determination of appropriateness/eligibility using a state-approved, standardized assessment. Information that should be available to make the determination includes a mental health history, current medications, types of current charges, and prior involvement with the criminal justice and restoration systems.

Some stakeholders recommended that expanded services facilities⁴ could be better used as a CBR setting, diverting individuals from state hospital restoration, as opposed to serving as a step-down from state hospital admission (as currently used).

Stakeholders suggested that for CBR to be effective, individuals must also have access to supports that Medicaid doesn't cover, such as outreach and engagement, housing assistance, flexible funds to cover basic necessities, and intensive day treatment approaches such as a partial hospitalization program.

Concerns Related to Community-Based Restoration

Stakeholders agreed that CBR would require funding – otherwise counties may view it as another unfunded mandate.

Also, the court representatives indicated that they do not have access to the information they've suggested as necessary to make a decision regarding CBR. Stakeholders are concerned that use of this option will be limited until confidentiality restrictions are addressed and the information needed for appropriate disposition can be shared.

VII. Conclusion

More than 300 stakeholders representing a broad range of perspectives within the behavioral health and criminal justice systems statewide participated in webinars and in-person meetings with members of the Trueblood Task Force to provide feedback on, and recommendations for how to reform, the forensic (and broader) mental health system. All stakeholders agreed that too many individuals in Washington State with behavioral health disorders (mental illness, substance use disorders and co-occurring mental health and substance use disorders) are

⁴ An expanded services facility is a licensed residential setting intended to provide community placement for individuals with complex personal care and behavioral health needs who are leaving state and community psychiatric hospitals and have no other placement option due to their complex behavior, medical, chemical dependency, or mental health needs.

involved with the criminal justice system. This level of involvement has contributed to a demand for competency evaluation and restoration services that continues to grow. The state's investments in responding to this demand are struggling to keep pace. Most stakeholders agreed that increasing access to comprehensive community-based behavioral health services would increase the well-being of people with mental illness and decrease burdens on the forensic mental health and criminal justice systems.

There was unanimous agreement among stakeholders that the availability of safe and affordable housing with individualized services and strong case management would impact the demand for competency evaluation and restoration, by diverting individuals from interfacing with the criminal justice system and by supporting individuals transitioning from inpatient treatment and incarceration to stable living in the community. Stakeholders recognize that there is a cost associated with creating this capacity. However, this would be a repurposing of how funding is spent over time - from a crisis-oriented approach that waits for people to get sick and encounter the criminal justice system, to a public health approach that directs its resources to helping people get and stay well, through outcome-oriented behavioral health services that can prevent and divert encounters with the criminal justice system.

Attachment A: Task Force Members

Members of the Trueblood Task Force Core Team

- ▶ David Carlson, Plaintiff's Counsel, Disability Rights Washington
- ▶ Chris Carney, Plaintiff's Counsel, Carney Gillespie Isitt
- ▶ Rashi Gupta, Senior Policy Advisor, Office of the Governor
- ▶ Randy Head, Assistant Attorney General, Attorney General's Office
- ▶ Amber Leaders, Assistant Attorney General, Attorney General's Office
- ▶ Kathryn Leathers, General Counsel, Office of the Governor
- ▶ Kim Mosolf, Plaintiff's Counsel, Disability Rights Washington
- ▶ Alexa Polaski, Plaintiff's Counsel, Disability Rights Washington
- ▶ Nick Williamson, Assistant Attorney General, Attorney General's Office

Attachment B: Schedule of sessions/meetings

Trueblood Task Force Stakeholder Sessions

Date	Type of Session/Participants	Location
February 13, 2018	Listening Session for Judges, Prosecutors and Public Defenders	Tacoma
February 18, 2018	Listening Session for BHOs	Lacey
February 26, 2018	Listening Session for Sheriffs, Jails and Law Enforcement/Burien	Burien
March 16, 2018	Listening Session for Advocates	Seattle
March 16, 2018	Listening Session for Families and Class Action Members	Seattle
March 29, 2018	Listening Session for Legislators and Their Staff	Olympia
April 2, 2018	Regional Stakeholder Session/King County	Seattle
April 2, 2018	Regional Stakeholder Session/Snohomish County	Everett
April 16, 2018	Regional Stakeholders/Thurston County	Tumwater
April 16, 2018	Regional Stakeholders/Pierce County	Tacoma
April 24, 2018	Regional Stakeholders/Westside Rural	Tumwater
April 25, 2018	Regional Stakeholders/Clark County	Vancouver
April 27, 2018	Regional Stakeholders/Spokane County	Spokane
April 27, 2018	Regional Stakeholders/Eastside Rural	Gonzaga University
May 1, 2018	Listening Session for County Officials and Tribal Leaders	Webinar

Trueblood Taskforce: Consumers, Friends, and Family Meeting

March 16, 2018

Presented by:

Alexa Polaski, DRW, Plaintiffs' Counsel; Randy Head, AAG, Defendants' Counsel
Trueblood v. DSHS

Facilitated by:

Sherry Lerch, Senior Consultant and Jacob Mihalak, Consultant, Technical
Assistance Collaborative

AGENDA

Topic
Welcome and Introductions
<i>Trueblood</i> Taskforce Background Information
Why Are We Here Today?
Negotiation Schedule
The Mental Health System
Facilitated Discussion – Current Problems
Facilitated Discussion – Current Progress
Facilitated Discussion – Future Solutions
What Else?
Wrapping Up...Q & A
Adjourn

Background Information

▶ The Case

- ▶ *A.B. by and through Trueblood v DSHS* --“Trueblood”
 - ▶ Case challenged unconstitutional delays for competency evaluation and restoration resulting in:
 - ▶ 14 days to complete evaluation
 - ▶ 7 days to admit for restoration

▶ The Class Members

- ▶ Individuals detained in city and county jails awaiting competency services

▶ The Task Force

- ▶ Collaboration between Class Counsel, DSHS, Attorney General’s Office and the Governor’s Office

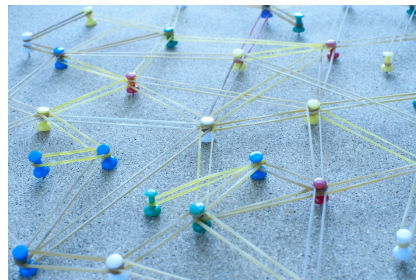
Why Are We Here Today?

- ▶ We need input from individuals and their support networks about innovative improvements to the mental health system.
- ▶ What do you see as the current problems, current progress, and future solutions?
- ▶ We want to hear all ideas, even unusual or unpopular ones. Now is the time to rethink the status quo.
- ▶ This is just the beginning. We don’t have to design solutions or come to an agreement on the path forward today.

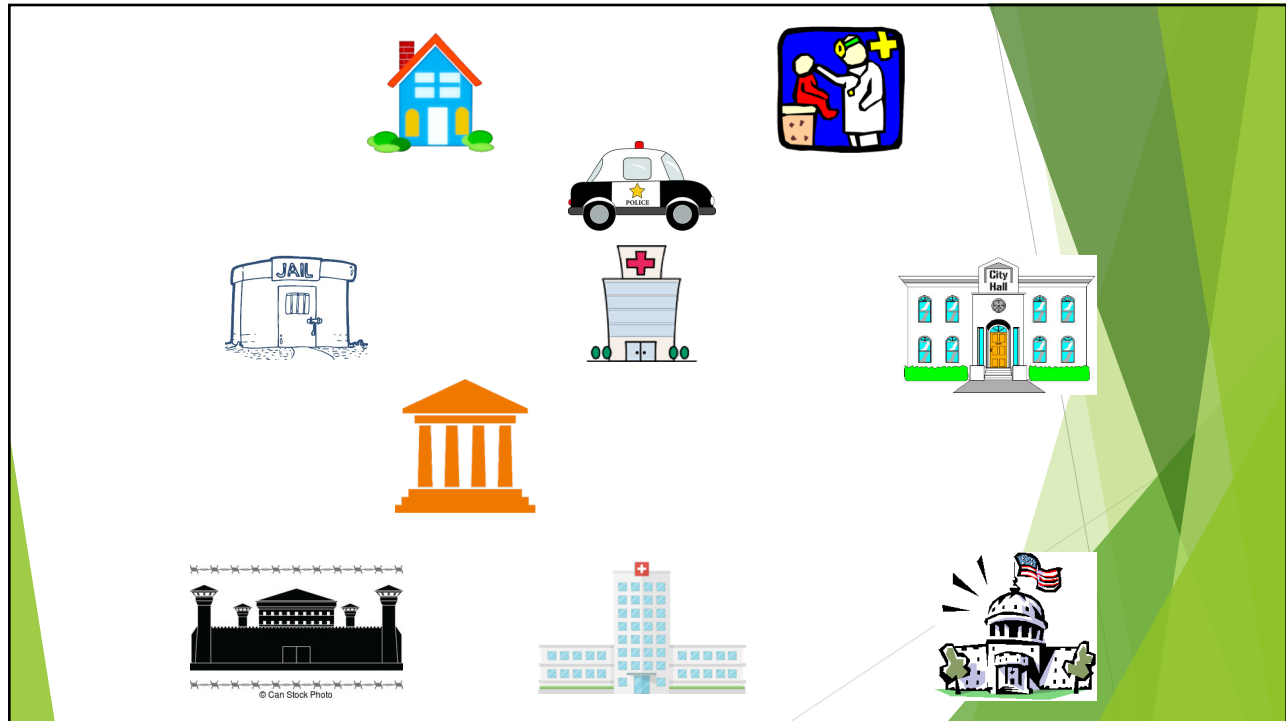


Negotiation Schedule

- ▶ Now to April 2018
 - ▶ Gather information
 - ▶ Convene Stakeholders across the state to gather input
- ▶ April 2018 to August 2018
 - ▶ Draft a plan
 - ▶ Seek input on the plan
 - ▶ Revise plan
- ▶ August 2018 to November 1, 2018
 - ▶ Seek Court approval
 - ▶ Submit for inclusion in the Governor's 2019-2021 biennial budget
 - ▶ Seek Legislative funding



The Mental Health System
Its all connected



Facilitated Discussion - Current Problems

QUESTIONS TO ANSWER

- ▶ What are issues with the mental health services you are currently receiving?
- ▶ What do you see are the major issues with the forensic and community mental health system?
- ▶ Is there a gap in receiving services between community providers, jail, and in facilities?
 - ▶ Have you had any release or discharge planning from jails or facilities?
 - ▶ Issues with case management?
- ▶ How do housing, transportation, and employment supports affect your access to mental health services?

Facilitated Discussion - Current Progress

QUESTIONS TO ANSWER

- ▶ Have you had any successful experiences in getting mental health services?
- ▶ What has been working well in the system?

POINTS TO CONSIDER

- ▶ What have I done, or seen others in my role do, that has had a positive impact on my mental health care

Facilitated Discussion - Future Solutions

QUESTIONS TO ANSWER

- ▶ What supports do you need to be in place to access mental health services?
- ▶ What can others do in their roles to improve the mental health system or address barriers to people with mental illness receiving services?
- ▶ If you could change one thing about the mental health system immediately, what would it be?

POINTS TO CONSIDER

- ▶ Statutory changes
- ▶ DSHS process changes
- ▶ Court process changes
- ▶ Community process changes
- ▶ Services that are underutilized, underdeveloped or missing
 - ▶ Mobile crisis
 - ▶ CIT
 - ▶ Diversion
 - ▶ Low-barrier housing
 - ▶ Substance use treatment



What Else?

- ▶ **OTHER AREAS FOR CONSIDERATION (if not previously discussed)**
 - ▶ Housing
 - ▶ Employment
 - ▶ Support networks
 - ▶ Interactions with Law enforcement and data sharing
 - ▶ Case Management
 - ▶ Discharge planning



QUESTIONS?

ONLINE USERS: YOU CAN USE YOUR CHAT FUNCTION TO “RAISE YOUR HAND” AND POSE QUESTIONS TO THE PRESENTERS.

Contact Info

- ▶ Trueblood Taskforce Email:
- ▶ truebloodtaskforce@dshs.wa.gov

- ▶ Trueblood Websites:
- ▶ <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/trueblood-et-al-v-washington-state-dshs>
- ▶ <https://www.disabilityrightswa.org/cases/ab-v-dshs/>

Trueblood Taskforce: King County Regional Meeting

April 2, 2018

Presented by:

Kim Mosolf, DRW, Plaintiffs' Counsel; Amber Leaders, AAG, Defendants' Counsel; Christopher Carney, CGI Law

Trueblood v. DSHS

Facilitated by:

Sherry Lerch, Technical Assistance Collaborative

AGENDA

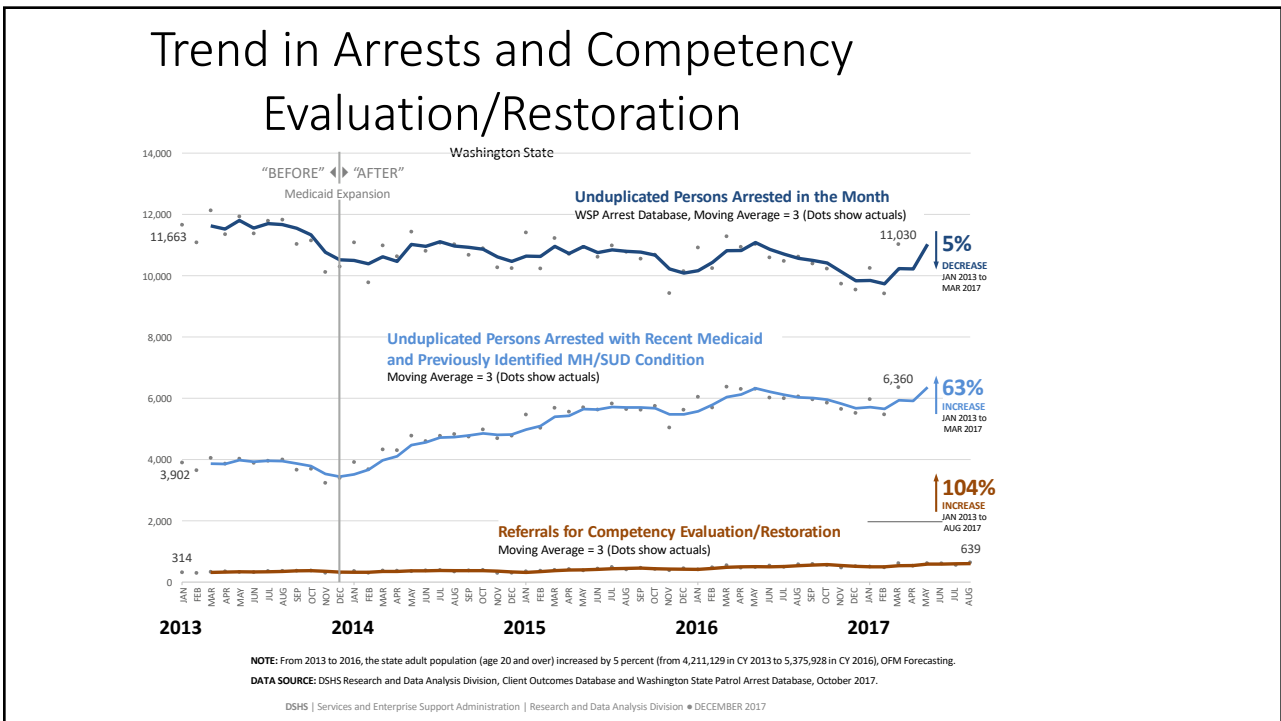
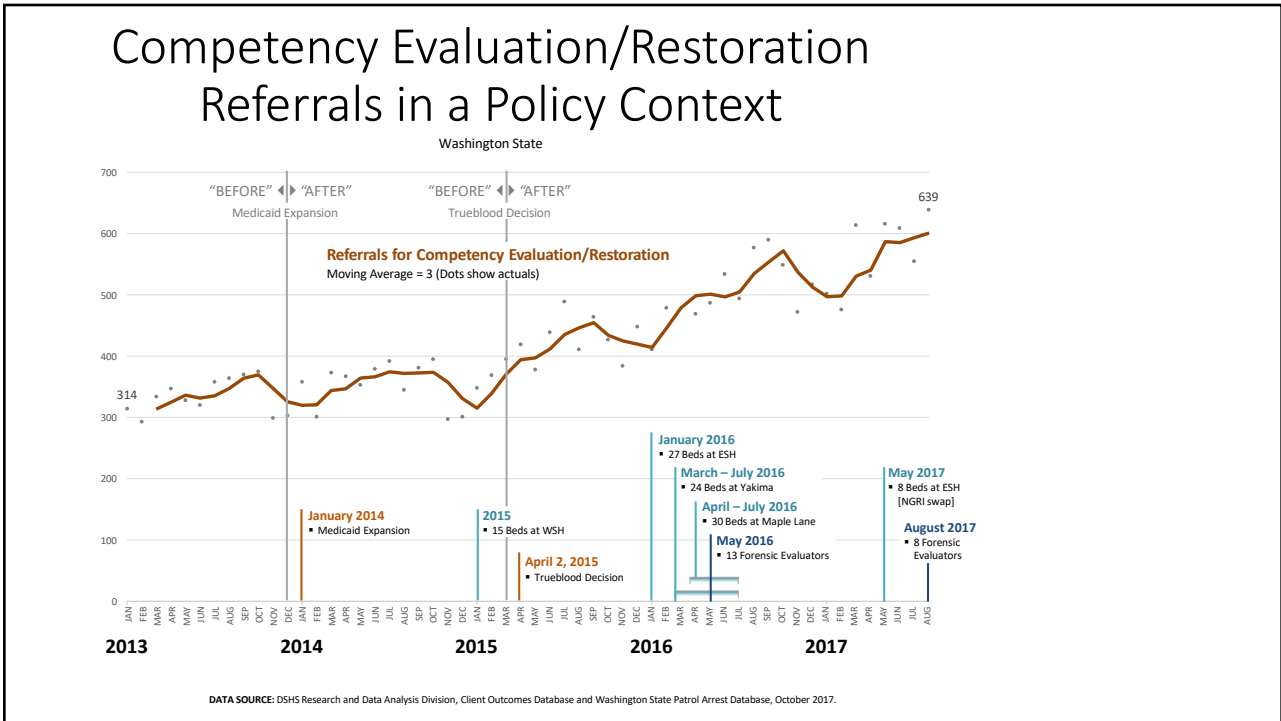
Topic
Welcome and Introductions
Who Are We and Why Are We Here Today?
Review of the Data: What Does it Tell Us?
Small Group Facilitated Discussion <ul style="list-style-type: none">• Changes in Restoration• Diversion Supports• Current Programs or Practices• Information and Data Sharing
Wrapping Up...Q & A
Adjourn

Who Are We and Why Are We Here Today?

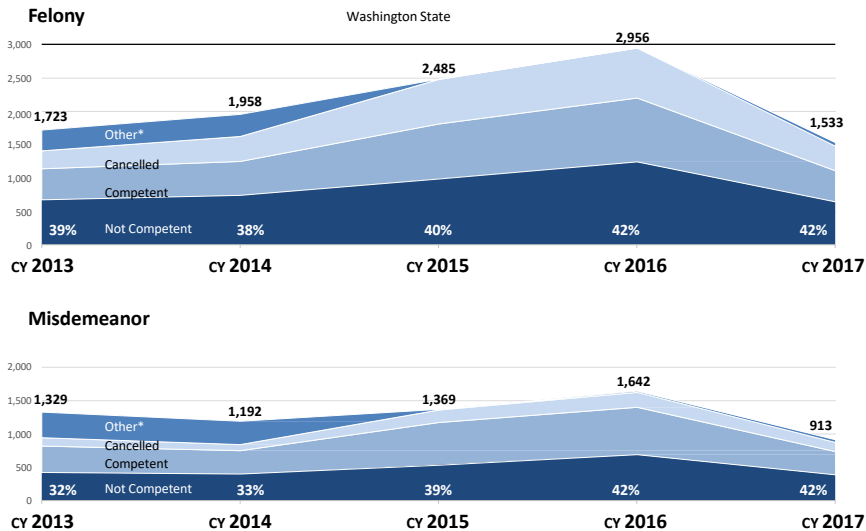


- The Trueblood team is looking into a variety of solutions to the lack of restoration beds that are currently available. We need input on solutions that can be implemented realistically, safely, and successfully in your region.
- Many of you play a role in a diversion model. The Trueblood team is looking to understand which of the models work well, how they can be improved and what are your biggest challenges in working with individuals with mental illness and criminal justice involvement.
- The Trueblood team is looking to understand what current programs or practices that address the issues identified in *Trueblood* are currently working in your county.

Data Sharing – What Does the Data Tell Us?



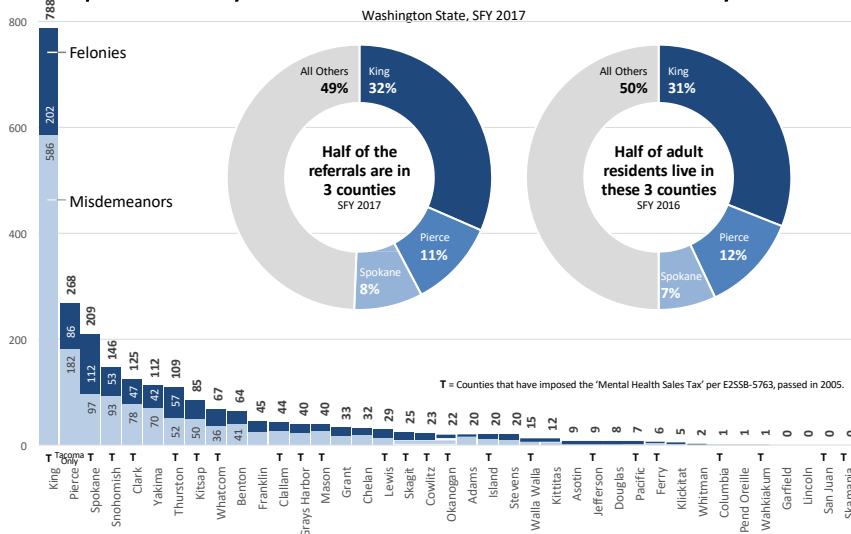
Trend in Competency Evaluation Determinations



DATA SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database and Washington State Patrol Arrest Database, October 2017.
NOTE: Other equals "Still in Process," "Other," "Missing."

DSHS | Services and Enterprise Support Administration | Research and Data Analysis Division • DECEMBER 2017

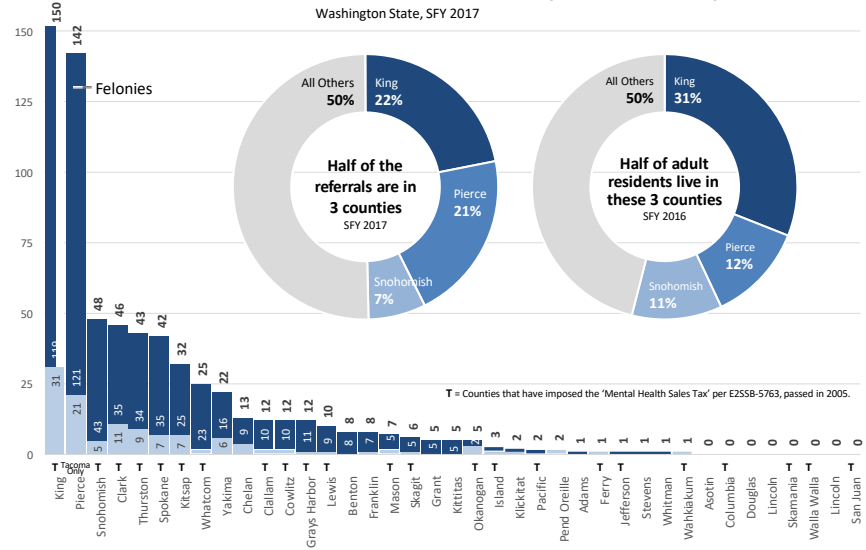
Number of Misdemeanor and Felony Competency Evaluation Referrals by County



DATA SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database and Washington State Patrol Arrest Database, October 2017.
Population distribution from the Washington State Office of Financial Management, Forecasting Division, November 2017.

DSHS | Services and Enterprise Support Administration | Research and Data Analysis Division • DECEMBER 2017

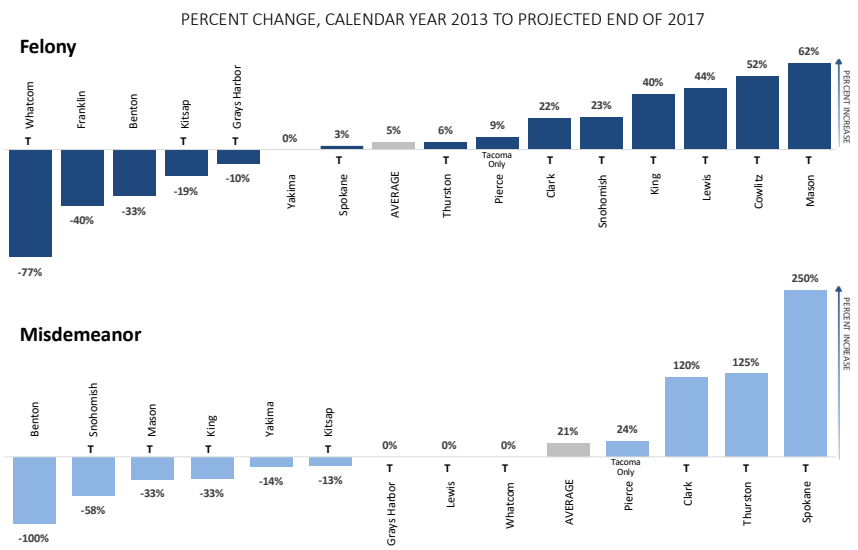
Number of Misdemeanor and Felony Restoration Referrals by County



DATA SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database and Washington State Patrol Arrest Database, October 2017. Population distribution from the Washington State Office of Financial Management, Forecasting Division, November 2017.

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Percentage Change in Competency Restoration Referrals



NOTE: Data for counties with fewer than 10 referrals is suppressed. T = Counties that have imposed the 'Mental Health Sales Tax' per E255B-5763, passed in 2005.

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Increase in Competency Referrals: past 5 years

Factors Considered

- State Population: increased 5%
- Arrests: Total number unchanged; rate decreased
- Medicaid Expansion: impact since January 2014
 - Increased number with medical coverage
 - Increased number with documented Mental Illness and/or Substance Use Disorders
- Legal System Changes: Trueblood decision March 2015
- Increased Capacity (facilities and staffing): build it and

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Analysis Division • DECEMBER 2017

Small Group Facilitated
Discussions

CHANGES IN RESTORATION

- **Ending restoration for misdemeanor and low-level felony charges**
 - What is needed to make this change realistically, safely, and successfully in your region?
 - What practical impact does this have on the forensic mental health system? The broader mental health system?
 - What are some possible unanticipated consequences?
- **Community-based restoration treatment**
 - Eligibility:
 - Who should be eligible?
 - Who makes the determination of eligibility?
 - What information is necessary to make this determination?
 - Where are these community sites located? What do they provide beyond restoration treatment, if anything?
 - What is needed to make this change realistically, safely, and successfully?
 - What are some possible unanticipated consequences?
- **Other Ideas?**

DIVERSION SUPPORTS

- Diversion Models — For example... law enforcement/mental health co-response; mobile crisis response; crisis stabilization centers; intensive case management; housing supports; prosecutorial diversion or specialty courts; or promoting stabilization in and after jail.
 - Which of these diversion models work well with each other? How so?
 - Which of these diversion models need improvement in how they work together? How so?
 - Concentrating on one or two of these models: What are the biggest challenges in serving people with mental illness and criminal justice involvement?
 - What resources are needed in order to expand arrest diversion?

CURRENT PROGRAMS OR PRACTICES

- What efforts to address the issues identified in *Trueblood* are currently working in your county? Why?

INFORMATION AND DATA SHARING

- **Identifying people with a history of competency evaluation and restoration treatment**
 - What specific information is currently available to you?
 - Who needs access to this information and why?
 - When is this information needed in order to make the biggest impact?
 - How could your access to this information be improved?
 - What are some possible unanticipated consequences?
- **Information about a person's current and past behavioral health needs and treatment**
 - What specific information is most useful and is it currently available to you?
 - Who needs access to this information and why?
 - When is this information needed in order to make the biggest impact?
 - What challenges exist in accessing or sharing this information?
 - How could your access to this information be improved?
 - What are some possible unanticipated consequences?

QUESTIONS?

ONLINE USERS: YOU CAN USE YOUR CHAT FUNCTION TO "RAISE YOUR HAND" AND POSE QUESTIONS TO THE PRESENTERS.



Contact info

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 - <https://www.disabilityrightswa.org/cases/ab-v-dshs/>