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

Trueblood Phase 2 Implementation Plan – FINAL

June 24, 2021

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

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Background

All criminal defendants have the 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 has the authority to put the criminal case on hold while an evaluation is completed to determine the defendant's competency.

Generally, if the evaluation finds the defendant competent, and the court agrees they are returned to stand trial, and if the court finds the evaluation shows the person is not competent, the court will order the defendant to receive mental health treatment to restore competency.

In April 2015, a federal court found that the Department of Social and Health Services was taking too long to provide these competency evaluation and restoration services.

As a result of the case Trueblood v. DSHS, the state has been 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. These Trueblood timeframes apply to people who are detained in jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of Trueblood, however, also target people who have previously received competency evaluation and restoration services, who are released and at risk for re-arrest or re-institutionalization.

People who get the treatment and support they need when they need it are more likely to avoid becoming involved with the criminal system. Accordingly, increased demand for competency evaluations can be avoided if more individuals receive community-based treatment and support during times of crisis. Major goals of many of the programs covered in this report include 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 December 11, 2018, the court approved an agreement related to contempt findings in this case. The Trueblood Settlement of Contempt Agreement (agreement) is designed to move the state closer to compliance with the court's injunction. The parties recognize that this plan sets forth markedly ambitious timelines to implement agreement elements within Phase 2. Throughout this document, timelines have been proposed that will challenge the state, and leave little room for unforeseen roadblocks to implementation. As a consequence, the parties agree that failure to meet these timelines will not constitute material breach, provided that the state has made all reasonable efforts to meet the timelines herein. Rather, the timelines outlined for specific elements should be considered in light of all other evidence in any future dispute as to whether the elements of the agreement have been timely implemented within Phase 2.

Phased Implementation

The agreement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within the specifically identified and agreed upon regions as indicated in this document. The agreement could be expanded to include additional phases beyond the initial three.

Phase 1 of the agreement runs from July 1, 2019 to June 30, 2021, and is focused on the Pierce, Southwest, and Spokane regions. During Phase 1, the implementation team has worked to implement the agreement, as further detailed in the Trueblood Phase 1 Final Implementation Plan. Our successes and lessons learned in Phase 1 form the basis for proposing a preliminary implementation framework for Phase 2. Phases run parallel to legislative biennia and began with the 2019-2021 biennium.

Phase 2: July 1, 2021 to June 30, 2023; King County region

Phase 3: July 1, 2023 to June 30, 2025; region to be determined

Phase 1 Accomplishments

As discussed above, the Parties submitted to the Court a Final Implementation Plan which contemplated a Phase 1 of the Contempt Settlement Agreement, running from July 1, 2019 to June 20, 2021. Although many Trueblood programs and reforms have had statewide effect since their inception, Phase 1 is focused on the Pierce, Southwest, and Spokane regions of the state. The Phase 1 plan set "forth markedly ambitious timelines to implement agreement elements within Phase 1."

Unfortunately, during Phase 1 the state of Washington began experiencing a pandemic of historic proportions. By March 2020, the state of Washington began to experience the profoundly disruptive effects of the COVID-19 pandemic—and the efforts to implement the settlement elements were not exempt from these impacts. Following guidelines provided by the state's Department of Health, the Department has had to temporarily slow or stop admissions and transfers to facilities; communal supports have been strained; increased strain has been put on staff through the need to coordinate COVID-19 appropriate procedures and response; and construction projects have been delayed. Nevertheless, despite these challenges, the state has achieved numerous substantial successes during Phase 1.

The state was able to greatly expand the forensic evaluator workforce by hiring an additional 18 evaluators to complete forensic evaluations. In most months, including during much of the pandemic, competency evaluations are completed within the required timelines more than 85% of the time. The

state has expanded the use of telehealth, continued the use of evaluator outstations, and implemented a new data system to track court orders on a granular and systemic level.

The state has also continued to build and operate more inpatient beds for providing inpatient evaluation and restoration. Although construction activities were profoundly impacted by the COVID-19 pandemic, the state opened 50 additional beds at ESH, and will soon complete 40 additional beds at WSH. These renovations will have the effect of increasing beds available for inpatient treatment for patients from across the state. Additional bed construction, not specifically required by the agreement, is also underway at WSH to provide an additional 48 beds.

The state also proposed legislation to modify several aspects of the law related to restoration, as well as diversion at the time of arrest. These bills were passed by the Legislature, and the changes to the law have taken effect.

During July 2020, the state realized multiple substantial milestones. Outpatient Competency Restoration Programs (OCRP) went live in the Spokane and Pierce regions. Due to COVID-related hiring issues, the Southwest region's go live followed shortly thereafter, by August 2020. OCRP is now operating throughout all of the Phase 1 regions. The Parties continue to collaborate and conduct partner outreach to try and best utilize these vital community-based services. Additionally, the state has deployed Forensic HARPS (Housing and Recovery Peer Services) teams throughout the Phase 1 regions, who work to provide residential supports for those participating in OCRP and for high utilizers of competency and restoration services—securing stable, more permanent residential supports for people has proven one of the biggest challenges thus far.

Also in July 2020, the Forensic Navigator program began operations in all three Phase 1 regions. A forensic navigator caseload management system was also successfully deployed in time for the launch of this program. Navigators are now actively serving clients in all Phase 1 regions, and Navigators continue their outreach and education efforts with partners at jails, courts, law enforcement agencies, forensic services (FPATH, FHARPS, and OCRP), and with community-based partners. The Navigators work within the criminal court system to support diversion options for those defendants who have had a competency issue raised, provide information and options to the courts regarding those defendants, and also coordinate services for defendants who are ordered into the OCRP program.

The state also developed and successfully implemented a new enhanced continuing education curriculum for certified peer counselors that focuses on those with lived experience in the criminal justice system. This new "enhanced peer continuing education curriculum" is available not just within Phase 1, but statewide. The state also continues to pivot and move the continuing education

curriculum to an online format due to physical distancing requirements which prohibits in-person training due to the pandemic.

The Forensic Projects for Assistance from Homelessness (PATH—or intensive case management) teams have been deployed in all three regions since March 1, 2020. These teams are performing outreach and engagement to those who have been most impacted by the competency system, and connecting those persons up with a set of resources and services intended to prevent them from having future contact with the criminal court system. In spite of limitations posed by COVID-19, Forensic PATH teams are still able to provide targeted outreach and engagement services to vulnerable individuals. Examples of this include checking jail rosters, outreach to streets/encampments/shelters, and partnering with other community providers.

The state, through work with the Department of Commerce, deployed new funding to support the construction of 16 new crisis and triage beds in the Spokane region. The project is currently under construction and expected to complete during the summer 2021. The state completed assessments to guide future requests for crisis triage capacity decisions and planning. The state also worked with existing and new facilities in the Pierce and Southwest regions to provide funding for enhancements to crisis triage capacity. These enhancements are intended to allow these facilities to be more equipped to handle individuals experiencing a more serious level of crisis, including those who have come into contact with law enforcement. Short-term housing vouchers were also deployed through the crisis triage system to support those who are in crisis but are unstably housed.

The state has worked to enhance the availability of Mobile Crisis Response in the Phase 1 regions. While contracting and contractor hiring were impacted by the pandemic and created delays in deployment, the additional mobile crisis capacity is now deployed in all three Phase 1 regions. Additionally, and to also address the need to bolster crisis response capabilities in the state, funds were secured by the state to allow the Washington Association of Sheriffs and Police Chiefs (WASPC) to deploy additional co-responder grants to local law enforcement in multiple counties and municipalities in the Phase 1 and 2 regions.

During Phase 1, the state has also made investments into statewide workforce development, through offer of trainings to existing workforce, and stakeholdering with colleges through development of career pathway maps, to plant seeds for an expanded future workforce. The state also hired a jail technical assistance team to provide training to jails who detain class members. Finally, the state has increased the level crisis intervention training receive by patrol officers in the Phase 1 regions, and is continuing to provide this training to 911 operators and corrections officers within the Phase 1 regions.

Phase 1 Lessons Learned

Housing Matters; Accessing Housing is a Challenge

Washington state is experiencing an affordable housing crisis, which the COVID-19 pandemic has compounded. Securing clinically appropriate residential supports (housing), as required by the settlement agreement, has therefore been challenging. With limited available affordable housing stock, Phase 1 programs have been relying largely on emergency placements intended for short-term use, like motels as well as transitional housing, shared housing and shelters to meet the immediate needs of the individuals. Anecdotal reports from service providers indicate that many people receiving the residential support services spend the most or all of the time in emergency placement housing, like motels, and some are released right back to homelessness. Many of these people need a higher level of supportive housing to achieve stability, but that housing has reportedly been hard to secure thus far in Phase 1 regions.

The COVID-19 eviction moratorium has had a negative impact on accessing private market landlords per anecdotal reports from FHARPS teams. FHARPS teams report landlords are hesitant to rent to individuals for fear of not being able to evict the individual and are choosing to keep their units vacant instead of risking the inability to evict someone.

Washington State is far behind in the development of affordable housing stock and this challenge will be seen for years to come. The state is employing many strategies including partnerships with the Department of Commerce on their capital procurement for more affordable housing stock. As the implementation of the settlement agreement moves forward, the State will need to better access or generate a more robust system of clinically appropriate residential supports, where this is possible within the scope of the Trueblood Contempt Settlement Agreement.

Communication and Outreach are Paramount

We have learned that ongoing and regular communication among stakeholders is key to avoiding siloed services and making sure everyone, including law enforcement, courts, prosecutors, and defense counsel, understand and seek to make use of new Trueblood programs and services. To be effective, this communication and outreach needs to be deliberate, and go beyond facilitating mere awareness. Even though extensive outreach campaigns were implemented before the launch of certain elements, many system partners were not prepared for the new services, or the partners who were ultimately responsible for engaging the new systems had not participated in the earlier engagement efforts.

For example, the Settlement Agreement resulted in changes to state law to broaden the scope of criminal charges eligible for diversion from arrest when someone has a history of experiencing significant mental health conditions. In that statutory change, regional stakeholders are directed to come up with guidelines for this expanded diversion, but we have seen in Phase 1 that this is not consistently happening and there are no named resources or means of enforcement to move it along.

In Phase 2, the Parties should consider how to help better realize the expansion of arrest diversion under RCW 10.31.110. Relatedly, in those areas in which we have been working with stakeholders around these arrest diversion guidelines, stakeholders are expressing a need for: 1) more immediately-available emergency diversion placements (like crisis triage facilities), and, 2) a single point of contact who will know which emergency facilities and resources have capacity and are appropriate for the individual. Preliminary conversations with the Washington Department of Health suggest that the "WATrac" system may be useful in this regard, but much coordination will be necessary to realize that goal.

Although the statute was also changed to create a presumption against misdemeanor restoration, the Parties have not yet seen a consistent significant decrease in misdemeanor restoration orders. In Phase 2, the Parties should consider how to better outreach and educate courts, prosecutors, and defense counsel whose jurisdictions continue to see high numbers of misdemeanor restoration orders. The Parties might also consider whether there should be additional statutory changes to strengthen the presumption or just fully eliminate restoration for most misdemeanors.

Conversely, and for an example of where outreach and communication were effectively leveraged, the state has already made positive changes in the OCRP eligibility screening practices, even in the short time since we launched OCRP in July 2020. These changes further demonstrate the importance of ongoing regular meetings with stakeholders, including the state, regional prosecutors, defense, and criminal courts, to ensure Trueblood programs are being used to their full potential. One additional opportunity may be better messaging how Forensic Navigators are able to positively affect their clients' recovery paths when Navigator services are fully leveraged by courts, prosecutors, and even defense.

Identifying and Engaging Partners is Challenging

Acknowledging that the Settlement Agreement imposes obligations on state agencies, the universe of reforms sought through the agreement cannot be implemented by the state alone. Effective partnerships are therefore critical to the success of Trueblood programs, yet these partnerships take care to develop and maintain.

Where document or contract review is required, review and approval takes greater time and effort as more partners are involved. Government agencies and community partners often have their own timelines, which must be accounted for in planning. Even within state agencies, teams developing Trueblood "elements" must act with awareness of each other's work.

One illustration of how these concerns risk slowing Trueblood implementation work is in how the mobile crisis contracts were finalized during Phase 1. Each Phase 1 region had different criteria for review and signature of these contracts, and the state agencies needed to allow more time for the regions to develop and provide input that reflect the needs of their respective communities. These conversations ultimately culminated in contract negotiations. The importance of building in adequate time for legal and regulatory review during such negotiations became obvious as the local regions struggled to meet the timelines set by the state. During Phase 1, this process was slowed by the pandemic, but would still have proved unmanageable without the pandemic under the timelines set out by the Phase 1 plan.

Workforce Considerations

A robust, specialized, workforce is required to fully realize the benefits of the Contempt Settlement Agreement. The Department's workforce development team has been conducting interviews with service provider organizations and jails statewide to learn more about the gap between the current available workforce, and the workforce that might be desired to best implement the goals of the Contempt Settlement Agreement. It has become apparent that many stakeholders are largely unfamiliar with the broader forensic mental health system and the work done by other parties beyond their particular mission or range of functions. To address this challenge the Department has worked to create informational trainings that broaden the understanding of the larger system, so all parties involved can better visualize the entire continuum of care and related procedures for the forensic mental health population they serve.

Detail about the challenges associated with Washington's current workforce was shared through the Department's Contempt Settlement Agreement mandated "one time report" to the legislature in June 2021. The analysis that the Department conducted identifies the quantities and types of workers needed for each of the programs within the agreement, and this analysis reflects staffing models utilized in Phase 1, along with estimated staffing needs for Phase 2 and beyond. The analysis also includes findings related to the education and training "pipelines" that prepare individuals to become skilled members of the specialized workforce needed to work with the population served via the agreement. In addition to reviewing staffing numbers and population data, this analysis involved interviews and surveys with law enforcement, jail staff, behavioral health providers, and multiple partners within the educational system. Ultimately, in order to have a specialized workforce that is

skilled in working collaboratively at the intersection of behavioral health and the law, substantial efforts will be needed to enhance the education and training systems for the workforce.

Agreement Elements

1.0 Competency Evaluation – Additional Evaluators

1.1 Assigned Owner

DSHS' Office of Forensic Mental Health Services (OFMHS) is responsible for hiring and employing forensic evaluators and associated staff.

1.2 Statewide vs. Regional

Evaluators support the entire state of Washington, and staff additions are part of a statewide effort toward compliance with the Trueblood injunction.

1.3 Requirements from the Agreement

DSHS will utilize data to determine if the increased evaluator capacity meets the need for in-jail competency evaluations and whether capacity exists to respond to periods of increased demand.

The department will report on capacity to deliver services in light of demand in the semiannual report and include a plan to address the inconsistency going forward.

1.4 Education and Outreach

As referral patterns change and staffing resources shift, information will be shared in one of the following ways (not an exhaustive list): General Advisory Committee meetings, use of email including listservs, Dear Tribal Leader letters, conferences/workshops, and reports to the court including the semiannual report.

1.5 Action Plan and Timeline

a. Data related to determining if increased evaluator capacity meets the need for in-jail competency evaluations and whether capacity exists to respond to periods of increased demand will be provided in the semi-annual report.

b. The information will be used to determine any shifts in current DSHS staff resources and if subsequent decision packages need to be submitted according to the state's budget development timeframes.

2.0 Competency Restoration – Outpatient Competency Restoration Services

2.1 Assigned Owner

Outpatient competency restoration is a service provided in the community through contracts with the Washington State Health Care Authority.

2.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions, in phases according to the plan outlined in the agreement.

During Phase 2, HCA will continue to expand the residential support options available for use by class members using an individualized approach to meet the housing needs of participants, with an emphasis on clinical appropriateness, dignity, security, and affordability.

2.3 Requirements from the Agreement

a. The state will seek funding for outpatient competency restoration (OCR) services in targeted areas (including residential supports as clinically appropriate) and a broader package of treatment and recovery services (including mental health treatment and substance use screening and treatment).

b. The state will identify and develop policies to fully implement outpatient restoration services in targeted areas.

c. Eligibility for outpatient restoration will be decided by the criminal court ordering restoration services.

d. For criminal defendants waiting in jail, an offer of admission to the outpatient restoration services program will occur within the timelines for restoration as outlined by the federal Court.

e. The process for outpatient restoration will provide sufficient information for the court to create tailored conditions for release.

f. Outpatient restoration providers will:
   i. Accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of class members.

   ii. Monitor the person's compliance with the court order in conjunction with the forensic navigator.

iii. Provide clinically appropriate residential support solutions to those identified by a forensic navigator as unstably housed for the duration of their outpatient participation and up to 14 days following transmission of the competency evaluation that occurs at the end of restoration.

iv. Have flexibility in providing residential support solutions, which may include capital development through the Department of Commerce or third-party source, housing voucher programs, existing housing programs, and/or scattered site housing programs.

g. The state will provide outreach and technical assistance upon request to support the implementation of community outpatient restoration services.

2.4 Education and Outreach

a. The Outpatient Competency Restoration Program will make program information available to community partners, tribes, and stakeholders in the region to include behavioral health administrative service organizations, managed care organizations, accountable communities of health, community behavioral health providers, courts, and jails.

b. HCA's OCRP administrator will be available for technical assistance upon request.

c. Information will be available through media such as presentations, webinars, and written and online materials.

d. The OCRP workgroup will identify existing partner and stakeholder groups within the region to conduct targeted outreach and education and will coordinate with other HCA and DSHS Trueblood elements to conduct these activities.

e. DSHS and HCA will meet with targeted partner groups to conduct outreach and education to the provider network. Education about new programs will be provided, as well as alerting potential contractors to contract opportunities.

f. DSHS and HCA will communicate and engage with tribes using existing tribal meetings like the King Regional Tribal Coordination meetings and through Dear Tribal Leader letters.

g. HCA will coordinate with the King County BHASO to contract with providers in the region for OCRP services, or HCA will execute contracts through the BHASO, through a procurement process, or directly with providers. If a procurement is determined, a Request for Proposals (RFP) procurement process will be issued to the regional provider network.

h. HCA, in partnership with DSHS, will conduct outreach, provide technical assistance and training to criminal courts, jails, tribes, and other stakeholders and partners to support Phase 2 implementation of Trueblood elements.

i. HCA will continue to monitor the implementation of the OCRP in the Phase 1 regions, and provide updates as needed.

j. In partnership with DSHS, HCA will complete continuous quality improvement in fidelity to the outpatient competency restoration treatment model.

k. HCA and DSHS will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance. OCRP will participate in ongoing collaboration among system partners and all the Trueblood elements.

l. OCRP will contribute to monthly, quarterly, and semi-annual reports to the courts.

2.5 Action Plan and Timeline

a. December 31, 2020: Invite King County to participate in the Outpatient Competency Restoration Workgroup.

b. March 31, 2021: Identify existing King County partner and stakeholder groups and strategize targeted ongoing outreach and education to those groups.

c. March 31, 2021: OCRP coordinates with Forensic Navigator Program, Forensic Housing and Recovery through Peer Services (FHARPS) and Forensic Projects for Assistance in Transition from Homelessness (FPATH) to align contract efforts to ensure that services begin at the same time.

d. July 1, 2021: Funding becomes available as appropriated by the Washington State Legislature.

e. HCA, subject to adjustment for the final budget, will pursue direct contracting with providers in order to implement this element.

i. Contracts will be finalized by November 30, 2021.

ii. OCRP providers will recruit, hire and train staff with HCA support and technical assistance within four months of contract execution, with services expected to be provided by March 31, 2022.

f. If HCA conducts an RFI and no providers are identified for contracting, HCA will consult with the Executive Committee on how the implementation should be adjusted to implement the OCRP element.

3.0 Competency Restoration – Forensic Navigators

3.1 Assigned Owner

DSHS is responsible for hiring and employing forensic navigators.

3.2 Statewide vs. Regional

DSHS will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

3.3 Requirements from the Agreement

a. The state will seek funding to implement forensic navigators in the Phase 2 regions.

b. Forensic navigators:

i. Will be assigned a caseload of no more than 25. Assignment will occur at the time a competency evaluation is ordered.

ii. Upon assignment and before the hearing, the forensic navigator will gather and provide information to the criminal courts to assist with:

a. Understanding diversion and treatment options to support the entry of court order to divert members from the forensic mental health system.

b. Determining whether a defendant is appropriate for outpatient competency restoration services. This is not a clinical recommendation. Standardized tools or assessments for those not known to the system may be used.

c. Recommending tailored release conditions for those ordered to outpatient competency restoration services.

iii. Will prioritize their caseload to focus on diversion of people eligible for Forensic PATH and may provide less intensive levels of service to people whose competency is unknown and/or who are not yet found to be incompetent.

Will conclude forensic navigator services when a client is found competent or incompetent but **not** ordered by the court into outpatient competency restoration services. The navigator may facilitate a coordinated transition if the circumstances warrant such coordination.

iv. For clients assigned to outpatient competency restoration, the forensic navigator will:

a. Monitor compliance (in partnership with outpatient competency restoration providers) and provide periodic updates to the court. This may include appearing at court hearings.

b. Inform providers if an assigned client is unstably housed and needs residential supports.

c. Coordinate access to housing.

d. Assist client with attending appointments and classes related to competency restoration.

e. Meet individually with clients regularly; perform outreach as needed to stay in touch.

f. Coordinate client access to community case management services, mental health services, and follow up.

g. Assist clients with obtaining and encourage adherence to prescribed medication.

v. For those found incompetent and ordered into outpatient competency restoration services, forensic navigator services will conclude when:

a. Charges are dismissed pending a civil commitment hearing.

b. Client receives a new or amended order directing inpatient admission.

c. Client declines further services after restoration treatment ends.

d. Client regains competency, is found guilty, and is sentenced to serve time.

e. Outpatient competency restoration order is revoked, or new criminal charges cause a client to enter or return to jail.

f. In any other situations not listed above, at the discretion of the state.

vi. The forensic navigator will facilitate a coordinated transition when a client is served in OCRP, and may facilitate a coordinated transition in other situations if the circumstances warrant such coordination. A coordinated transition will include:

a. Facilitated transfer to services within the community behavioral health system using standards for coordinated transition as established through care coordination or similar agreements.

b. Attempt to confirm meeting between client and community-based case manager following transition.

c. Creation of summary of treatment provided during outpatient competency restoration (including earlier-identified diversion options for the individual).

d. Attempt to check-in with client at least once per month for up to 60 days.

e. During this period, the client **does not** count toward the navigator's caseload.

f. Attempt to connect eligible individuals with Forensic PATH services.

vii. The state, through training and technical assistance, will encourage third parties (like jails and prisons where class members are serving sentences) to request the summary of treatment and related treatment records as allowed by RCW 10.77.210.

3.4 Education and Outreach

a. Create and update Microsoft Excel tracking sheet of key partners for Phase 2.

b. Share program one-pager with stakeholders.

c. Provide ongoing technical assistance and schedule question-and-answer sessions as needed.

d. Convene an external workgroup with stakeholders for Phase 2.

e. Develop and send Dear Tribal Leader letters as needed to communicate with tribes and urban Indian health programs.

3.5 Action Plan and Timeline

a. Submit necessary human resources paperwork to create the forensic navigator positions by August 1, 2021.

b. Complete recruitment activities including screening, interviewing, and job offers by November 1, 2021.

c. Hire and complete new employee onboarding process by January 1, 2022.

d. Day one of forensic navigator program operations in Phase 2 region expected January 1, 2022.

4.0 Competency Restoration – Ramp Down of Maple Lane and Yakima

4.1 Assigned Owner

DSHS is responsible for residential treatment facilities. OFMHS oversees the facilities.

4.2 Statewide vs. Regional

Maple Lane and Yakima RTFs support patients across the state of Washington and the closure of those facilities is part of a statewide effort.

4.3 Requirements from the Agreement

a. Yakima RTF will begin ramp down when class member wait times for inpatient competency services reaches a median of 13 days or fewer for four consecutive months, based on mature data, or no later than December 31, 2021.

b. Maple Lane RTF will begin ramp down when class member wait times for inpatient competency services reaches a median of nine days or fewer for four consecutive months, based on mature data, or no later than July 1, 2024.

4.4 Education and Outreach

a. Community partners, tribes, American Indian organizations, stakeholders, and families will receive updated information on the Yakima Competency Restoration Center RTF closure process and timeline via meetings, listserv, and letters.

b. DSHS OFMHS' website will include all relevant ramp down information and official letters to key partners.

4.5 Action Plan and Timeline

Note: In the event Maple Lane or Yakima RTF wait times for class member admission for inpatient competency restoration services is met while in Phase 2 of the agreement, the ramp down plan already developed in accordance with the Phase 1 Final Implementation Plan will be followed.

a. Closure announcement issued – DSHS will begin the closure announcement process for the Yakima Competency Restoration Center RTF by June 30, 2021. Announcement will notify courts, prosecutorial and defense attorneys, and jails of the official closure date. Families of patients with releases of information or court assigned guardianship will receive a separate letter about the impending closure.

b. DSHS will begin meeting with Comprehensive Healthcare to discuss specific closure events by June 30, 2021. Comprehensive Healthcare will provide a facility equipment plan by this time.

c. Admission planning — The RTF will begin work with the DSHS medical director, forensic admissions coordinator, and facility contractor to establish an end date for intakes by August 30, 2021.

d. First 90-day orders — Yakima Competency Restoration Center RTF will no longer accept first 90-day orders by August 31, 2021.

e. Second 90-day orders — Yakima Competency Restoration Center RTF will no longer accept second 90-day orders by September 15, 2021.

f. Transfer planning — Patient transfer planning begins by October 1, 2021. The plan will identify an alternate care setting within the statewide system. Identified beds will be reserved and allocated for the closure effort.

g. DSHS will begin releasing press statements about Yakima's closure by October 1, 2021.

h. 45-day orders — Yakima Competency Restoration Center RTF will no longer accept 45-day orders by November 1, 2021.

i. Deadline for transfer of patients — All patients transferred out of the Yakima RTF by December 13, 2021.

j. Final move out — Comprehensive Healthcare completes move out procedures at the Yakima RTF by December 27, 2021.

5.0 Crisis Triage and Diversion – Additional Beds

5.1 Assigned Owner
HCA is responsible for crisis triage and stabilization facilities in the state of Washington.

5.2 Statewide vs. Regional
The state will implement this element of the agreement in the selected regions in phases according to the plan outlined in the agreement.

5.3 Requirements from the Agreement
The state will seek funding to increase capacity in accordance with the crisis gap plan submitted to the General Advisory Committee in Phase 1.

5.4 Education and Outreach
The crisis triage and diversion support workgroup will partner with DSHS and HCA staff to identify future opportunities to address the development of two new crisis triage/crisis stabilization facilities in the Phase 2 region through the use of Department of Commerce funds. Funds provided to the Department of Commerce through the 2021-2023 biennial budget for this element will be awarded through the RFP process, as able to meet the capacity needs for the region while maintaining the goals of the Trueblood element and while offering increased diversion of the targeted populations.

The crisis triage and diversion support workgroup will partner with the Department of Commerce behavioral health facilities program to solidify capital funding inclusion in RFP process.

HCA will partner with the Department of Commerce to develop a communication plan for coordinating with stakeholder groups, tribes, and managed care entities on how to reach entities within the provider network. The plan will include education about upcoming increases to capacity, as well as information for potential contractors about upcoming opportunities.

HCA will monitor progression of services and data collection on the creation of increasing targeted capacity numbers and will report quarterly and semi-annually to the court.

5.5 Action Plan and Timeline
The state requested funds from the legislature to support two additional 16-bed crisis facilities in the Phase 2 region. If capital funds are granted to the Department of Commerce for this purpose, HCA will partner with them to deploy an RFP for the capital funds in the Phase 2 region by January 31, 2022.

HCA will work with the Department of Commerce in reviewing collected RFP responses by February 28, 2022.

The Department of Commerce will issue awards for capital funding for increased bed capacity for crisis triage/stabilization facilities by April 30, 2022. Contracts will be executed by June 30, 2022 for the capital awards.

Construction will begin according to the proposals submitted in the procurement process. Successful bidders for the RFP generally are able to begin construction within six months after contracting processes are finalized. Construction review, zoning and other community siting issues may impact the locations of the facilities, which may cause delays. Given this timeframe and those challenges, construction is estimated to begin December 2022.

6.0 Crisis Triage and Diversion – Enhancements

6.1 Assigned Owner

HCA is responsible for crisis triage and stabilization facilities in the state of Washington.

6.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

6.3 Requirements from the Agreement

The state will seek and make funds available, through the BHASO, to community providers of crisis stabilization and/or triage facilities for enhancements.

6.4 Education and Outreach

a. Building upon the information in the crisis triage/stabilization report and addendum, the state will work directly with BHASOs and community partners, tribes, and urban Indian health programs to identify available resources in the Phase 2 region for enhancing licensed crisis triage and diversion support services to meet the needs of rural and urban jurisdictions and strengthen partnerships with local law enforcement. Outreach efforts will include discussion with the King County BHASO and potential providers about possible solutions to creating additional crisis triage capacity, both in the form of possible beds and hourly services.

b. HCA will communicate the contracting process and timeline to parties interested in enhancing crisis triage/stabilization services. HCA will work with contracting services to develop how enhancement of services will allow for increased referrals and acceptance from law enforcement. HCA will coordinate with stakeholder and partner groups to announce final contracts and contracting language.

c. HCA will develop a communication plan by coordinating with stakeholder groups and managed care entities about how to reach entities within the provider network. The plan will include education about upcoming increases to capacity, as well as information for potential contractors about upcoming opportunities.

d. HCA will monitor progression of services and data collection on the enhancements and will report quarterly and semi-annually to the court.

6.5 Action Plan and Timeline

a. HCA, with DSHS partners, will collaborate with tribes, urban Indian health programs, stakeholders, and BHASOs and their contracted crisis triage/stabilization service providers, on the goals of this element by October 15, 2021.

    i. Building upon the crisis triage/stabilization report and addendum HCA, BHASOs, providers, tribes, urban Indian health programs, and stakeholders will review current inventory and utilization of existing crisis stabilization service providers and facilities as well as facility licensing/certification barriers. This work has begun and is ongoing, but will be completed by October 15, 2021.

b. Based on funding from the Legislature issued for the fiscal year 2021-2023 biennial budget, available beginning July 1, 2021, HCA will contract, through the BHASO, the enhancement funds to crisis triage/stabilization service providers based on identified needs, and needs identified within the crisis triage/stabilization report and addendum.

    i. Crisis triage/stabilization service enhancements, subject to adjustment based on the final budget, will be contracted through the BHASO. Under this approach, HCA contracts with the BHASO and the BHASO in turn subcontracts with providers.

        a. HCA will transmit proposed contracts to the BHASO by August 31, 2021.

        b. The BHASO will be expected to approve the proposed contracts, after negotiation with HCA, by October 31, 2021. If the contracts have not been executed by October 31, 2021, HCA will continue to engage with the BHASO and continue reasonable efforts to fully execute the contract.

        c. The proposed contracts will require that the BHASO deploy the enhancements within four months from the date of contract execution. Assuming contracts are approved by the expected timeline, enhancements would be deployed by February 1, 2022. If the BHASO is unable to deploy the enhancements within that timeline, HCA will provide technical assistance, and continue reasonable efforts to support the BHASO in fully deploying the enhancements.

c. Data collection and monitoring on the enhancements to crisis triage/stabilization service providers will commence upon the first receipts of services, invoices, or contract deliverables.

7.0 Crisis Triage and Diversion – Residential Supports; Short-term Vouchers through Crisis Triage and Stabilization Facilities

7.1 Assigned Owner

HCA is responsible for crisis triage and stabilization facilities in the state of Washington.

7.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

7.3 Requirements from the Agreement

The state will seek funding to provide short-term housing vouchers for use in crisis triage and stabilization facilities. Vouchers cover a maximum of 14 days, but at the discretion of the facility, could be extended an additional 14 days.

Note: To be responsive to the evolving needs in providing crisis triage services, Health Care Authority plans to engage hourly crisis service providers during Phase Two. The Parties recognize that the language in the Contempt Settlement Agreement specified that the short-term housing vouchers were "to be deployed throughout Crisis Triage and Stabilization Facilities." However, the Parties agree that deploying these vouchers through the crisis and triage hourly service providers is not inconsistent with the goals of the agreement, and recommend through this Final Implementation Plan that vouchers may also be made available to these hourly providers.

7.4 Education and Outreach

a. HCA will disseminate information to crisis triage and stabilization service providers on availability of short-term emergency vouchers.

b. HCA will collaborate with stakeholders and other interested parties in the King County region.

c. Initial outreach to potential stakeholders and partners will include, but is not be limited to, regional judges, attorneys, prosecutors, jails, courts, tribes, peer counselors, consumers, consumer advocacy groups, general public, housing providers, crisis providers, and community behavioral health providers.

d. HCA will coordinate with stakeholder groups, MCOs, and BHASOs to conduct outreach to the provider network. Outreach will include education and alerting potential contractors on upcoming contract opportunities.

e. HCA will communicate the contracting process and timeline to interested parties.

f. HCA will coordinate with stakeholder groups to announce final contracts and contracting language. HCA, in partnership with the other Trueblood elements, will conduct outreach and provide technical assistance to criminal courts and other stakeholders, to support contractors offering short-term emergency vouchers.

g. HCA will continue to monitor the implementation of the short-term emergency voucher contracts in phase 1 regions, and provide updates as needed.

h. HCA will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance.

i. HCA will contribute to quarterly and semiannual reports to the courts.

7.5 Action Plan and Timeline

a. Identify regional providers who offer crisis stabilization services in King County.

b. Funding approved by the Washington State Legislature will be available by July 1, 2021.

c. Emergency vouchers, subject to adjustment based on the final budget, will be contracted through the BHASO. Under this approach, HCA contracts with the BHASO and the BHASO in turn subcontracts with providers.

   i. HCA will transmit proposed contracts to the BHASO by August 31, 2021.

   ii. The BHASO will be expected to approve the proposed contracts, after negotiation with HCA, by October 31, 2021. If the contracts have not been executed by October 31, 2021, HCA will continue to engage with the BHASO and continue reasonable efforts to fully execute the contract.

   iii. The proposed contracts will require that the BHASO deploy the vouchers within four months from the date of contract execution. Assuming contracts are approved by the expected timeline, vouchers would be deployed by February 1, 2022. If the BHASO is unable to deploy the vouchers within that timeline, HCA will provide technical assistance, and continue reasonable efforts to support the BHASO in fully deploying the vouchers.

d. Ongoing program monitoring will continue through the Trueblood Quarterly Dashboard. The dashboard will include King County data two quarters after all King County emergency

voucher contractors begin providing services. This is contingent on King County providers submitting accurate and timely data.

8.0 Crisis Triage and Diversion – Residential Supports; Forensic HARPS

8.1 Assigned Owner

HCA is responsible for crisis triage and stabilization facilities in the state of Washington.

8.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

8.3 Requirements from the Agreement

a. Technical assistance will be provided to criminal courts and other stakeholders and includes using residential supports and other services for outpatient competency restoration services.

b. If a forensic navigator assesses someone participating in outpatient competency restoration services as "unstably housed," that person is eligible for residential supports for the duration of their participation in the services. This will cease if referred to inpatient services. For those opined as competent, it may continue for up to 14 days following transmission of the competency evaluation.

c. The state will develop residential supports using procurement. Providers procured through this process could deliver residential supports in a way that meets community needs, which might include capital development through the Department of Commerce or a third party, housing voucher programs, leveraging existing local housing programs, or scattered site housing programs.

d. The state will seek funding to provide residential support capacity associated with outpatient competency restoration in each region.

e. The state will seek an additional 10 percent funding as described for outpatient competency restoration to be used for clinically appropriate residential support capacity for the population identified in (f).

f. The state will implement residential support capacity per the phased schedule. This capacity offers housing support options that target individuals who are clinically assessed to need more intensive support immediately following discharge from crisis triage and stabilization facilities. Eligibility requirements include:

i. Have had at least one prior contact with the forensic mental system in the past 24 months, or were brought to a crisis triage or stabilization facility via arrest diversion under RCW 10.31.110 as determined by the crisis triage and stabilization provider;

ii. Need assistance accessing independent living options and would benefit from short-term housing assistance beyond the 14-day vouchers;

iii. Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the crisis triage and stabilization facilities or the short-term voucher as described in the agreement at § III.C.2.a;

iv. Are unstably housed;

v. Are not currently in the outpatient competency restoration program; and

vi. Do not meet Involuntary Treatment Act (RCW 71.05) commitment criteria.

g. The Forensic HARPS program is available to individuals clinically assessed to benefit from the Forensic HARPS program in outpatient competency restoration.

h. People eligible for Forensic PATH are provided access to residential supports.

8.4 Education and Outreach

a. HCA will coordinate with the Washington State Department of Commerce to leverage local coordinated entry, deed recording fees, and housing and essential needs resources.

b. Principles of the Substance Abuse and Mental Health Services Administration Permanent Supportive Housing model will be disseminated throughout all projects including forensic navigators.

c. Training on Permanent Supportive Housing model principles for all Forensic HARPS teams will be conducted prior to any services being provided.

d. HCA will disseminate information to crisis triage and stabilization service providers on availability of short-term housing vouchers.

e. HCA will collaborate with stakeholders, tribes, urban Indian health programs, and other interested parties in the King County region.

f. Initial outreach to potential stakeholders and partners will include, but not be limited to, regional judges, attorneys, prosecutors, jails, courts, tribes, peer counselors, consumers, consumer advocacy groups, general public, housing providers, crisis providers, and community behavioral health providers.

g. HCA will coordinate with stakeholder groups, MCOs, and BHASOs to conduct outreach to the provider network. Education about new programs will be provided, as well as alerting potential contractors on upcoming contract opportunities.

h. HCA will communicate the contracting process and timeline to interested parties.

i. HCA will coordinate with stakeholder groups to announce final contracts and contracting language. HCA, in partnership with the other Trueblood elements, will conduct outreach and provide technical assistance to criminal courts and other stakeholders, to support the Forensic HARPS program services.

j. HCA's Forensic HARPS internal workgroup will partner with the forensic navigator workgroup, the outpatient competency restoration workgroup, and the DSHS/HCA communications team to provide information to stakeholders, community partners, tribes, urban Indian health providers, and program participants in the King County region.

k. HCA will continue to monitor the implementation of the Forensic HARPS programs in the Phase 1 regions and provide updates as needed.

l. HCA will complete continuous quality improvement to the fidelity to the Housing First and Permanent Supportive Housing models of service delivery.

m. HCA will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance.

n. HCA will contribute to the quarterly and semi-annual reports to the courts.

8.5 Action Plan and Timeline

a. Identify regional supportive housing programs (within community mental health agencies, tribes, and urban Indian health providers) that are currently in existence in King County by February 28, 2021.

b. Forensic HARPS will coordinate contracting efforts with OCRP, Forensic Navigators, and Forensic PATH by March 31, 2021.

c. Funding becomes available as appropriated by the Washington State Legislature by July 1, 2021.

d. HCA, subject to adjustment for the final budget, will pursue direct contracting with providers in order to implement this element.

   I. Contracts will be finalized by November 30, 2021.

   II. Forensic HARPS providers will recruit, hire and train staff with HCA support and technical assistance within four months of contract execution, with services expected to be provided by March 31, 2022.

e. If HCA conducts an RFI and no providers are identified for contracting, HCA will consult with the Executive Committee on how the implementation should be adjusted to implement the HARPS element.

f. Short-term housing vouchers will be available to organizations that provide crisis stabilization services in King County consistent with the time line described in section 7.5 above.

g. Training to all Forensic HARPS teams upon contract execution will include how to complete the data tracker/spreadsheets, the Permanent Supportive Housing model, and enhanced peer services continuing education.

h. King County's Forensic HARPS program(s) will collect the same data metrics as the Phase 1 regions at the onset of program services commencing in King County.

9.0 Crisis Triage and Diversion – Mobile Crisis Response (MCR)

9.1 Assigned Owner

HCA is responsible for community health care including mobile crisis programs in the state of Washington.

9.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

9.3 Requirements from the Agreement

a. The state will request a recommendation from the Washington Association of Sheriffs and Police Chiefs and regional MCR providers on reasonable response times for the region.

b. The state will seek funding to increase MCR services for the region.

c. The state will request a plan for providing MCR services. This includes new MCR services and should include proposing numbers, credentialing, and location of mental health professionals. The plan will be tailored to meet the needs of the region, considering the need for timely response throughout the region.

    i. The plans and any resulting contracts for services require providers make MCR services available 24/7.

    ii. Services are accessible without fully completing intake evaluations and/or other screening and assessment processes.

    iii. Contracting entities include response time targets, after considering the WASPC and regional MCR providers' recommendations.

d. In Phases 2 and 3, parties use reported MCR data to inform future funding requests and potentially add contractual requirements to meet response-time targets.

e. Co-response teams of law enforcement and mental health professionals are encouraged to rely on MCRs to accept individuals identified as needing mental health services.

9.4 Education and Outreach

a. For each region, the following entities will require written education and outreach materials, webinars and regional presentations:

i. Crisis teams

ii. Behavioral health providers

iii. Law enforcement agencies

iv. Emergency departments

v. Crisis settings such as evaluation and treatment centers, crisis stabilization units, respite, and triage

vi. Tribes and urban Indian health providers

vii. DSHS administrations (Developmental Disabilities Administration and the Aging and Long-Term Support Administration) and other social service providers

viii. Ombuds and consumer-run organizations

ix. First responders and ambulance companies

b. Outreach and education will focus on creating awareness of the MCR service and how to request those services.

c. HCA will include outreach and education expectations in their contract with the BHASO for the MCR service and provide oversight of outreach.

d. These will commence at the start of the MCR Trueblood enhancements contracts.

e. HCA will assist with messaging about MCR services in advance of the regional MCR contracts.

9.5 Action Plan and Timeline

a. HCA will continue to partner with WASPC as participation in the Phase 2 region implementation process begins by July 1, 2021.

b. Selected regional partners, including the BHASO, MCR teams, and law enforcement, will identify participants to collaborate in developing regional timeliness expectations before July 31, 2021.

c. HCA will begin holding regional meetings with King County MCR providers to review current timeliness data and discuss opportunities to increase response times and increase collaboration with co-responder teams by August 31, 2021.

d. HCA will draft request for plans with timeliness standards for King Region based on funding allocated by the Legislature and post for BHASO's response by October 31, 2021.

e. BHASO response to request for plan is due December 31, 2021.

f. HCA, DSHS, and WASPC delegates review request for plans by January 31, 2022.

g. BHASOs receive feedback and submit changes by February 28, 2022.

h. HCA will negotiate enhancements to MCR contract language with BHASOs and execute contracts by April 30, 2022. Contracts may be standalone or embedded within existing contracts through an off-cycle amendment.

i. BHASOs negotiate with the subcontractor/provider to implement strategies identified on the plan with the service provision by July 1, 2022.

j. BHASOs and HCA provide outreach and education campaigns within the region to ensure local system partners are aware of the enhanced services and how to seek them by September 30, 2022.

k. BHASOs will submit enhanced MCR supplemental transactions in the Behavioral Health Data System by January 31, 2023.

10.0 Crisis Triage and Diversion – Co-Responders

10.1 Assigned Owner

HCA is responsible for community health care including mobile crisis. WASPC administers the co-responder program in the state of Washington.

10.2 Statewide vs. Regional

The state will integrate this element of the settlement in selected regions in phases according to the plan outlined in the agreement.

10.3 Requirements from the Agreement:

The state's implementation plan (as described in IV.D.) describes how the state supports and encourages integration of these programs into the other elements of the agreement.

10.4 Education and Outreach

The state will work with WASPC to create a fact sheet or other appropriate educational materials about mental health field response teams.

10.5 Action Plan and Timeline

The state will continue quarterly collaboration meetings with WASPC. The state will continue encouraging and inviting WASPC participation in both the General Advisory Committee and other Trueblood project teams.

11.0 Crisis Triage and Diversion – Forensic PATH

11.1 Assigned Owner

HCA is responsible for community health care in the state of Washington.

11.2 Statewide vs. Regional

HCA will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

11.3 Requirements from the Agreement

a. Contract with community providers to provide intensive case management services to high utilizers. Develop strategies for assertive outreach and engagement. Develop a community collaboration effort to identify and coordinate services for those most at-risk.

b. Offer the following services to those identified as eligible for forensic PATH for a six-month period:

   i. Intensive case management (including outreach and engagement activities occurring outside a competency referral)

   ii. Engagement activities

   iii. Housing supports using the HARPS model, which includes securing and maintaining housing, peer support, and rent or other housing subsidies in the amount of up to $1,200 per month for up to six months

   iv. Transportation assistance

   v. Training or accessing resources and other independent living skills

   vi. Support for accessing healthcare services and other non-medical services

c. Create effective data tracking system and reporting structure to Trueblood coordinator for tracking coordination activities.

d. Reduce forensic referrals for competency evaluations.

11.4 Education and Outreach

a. Forensic PATH will make program information available to tribes, urban Indian health providers, and stakeholders in the region. An HCA Trueblood program manager will be available for technical assistance as needed.

b. HCA will coordinate with existing tribes, urban Indian health providers, stakeholder groups, MCOs, and BHASOs to conduct outreach to the provider network. Education about the Forensic PATH program will be provided by the HCA Trueblood program manager. Additional technical assistance will be provided as needed. Prioritization of services for the program will continue to focus on individuals with two or more competency evaluations in the last two years who are homeless and not connected to treatment.

c. HCA, in partnership with other Trueblood elements, will conduct outreach and provide technical assistance to the homeless safety net system, criminal courts, treatment providers, tribes, urban Indian health providers, and other stakeholders on request to support Phase 2 implementation of Trueblood elements*.
*Note: This list is not intended to automatically exclude similar potentially qualifying entities.

d. HCA will continue to monitor the implementation of the Forensic PATH programs in the Phase 1 regions, and provide updates as needed. Outreach contacts and program enrollment will be monitored to ensure Forensic PATH is making efforts to connect with individuals throughout the region including rural areas to individuals with multiple competency evaluation orders in the last two years.

e. The referral list for those eligible for Forensic PATH services will be disseminated to MCOs and BHASOs in order to strengthen care coordination efforts for this vulnerable population.

f. HCA will utilize information obtained from monitoring efforts to complete ongoing and targeted technical assistance on assertive engagement strategies for Forensic PATH teams. Forensic PATH will participate in ongoing collaboration among all the Trueblood elements.

g. HCA will contribute to the monthly, quarterly, and semi-annual reports to the courts.

11.5 Action Plan and Timeline

a. Identify regional outreach and engagement programs currently in existence in the Phase 2 region by May 1, 2021.

b. The level of funding approved by the Washington State Legislature, effective July 1, 2021, will determine the number of Forensic PATH teams. The following strategies will be employed based on the number of teams funded.

c. HCA, subject to adjustment for the final budget, will pursue direct contracting with providers in order to implement this element.

   i. Contracts will be finalized by November 30, 2021.

   ii. FPATH providers will recruit, hire and train staff with HCA support and technical assistance within four months of contract execution, with services expected to be provided by March 31, 2022.

d. If HCA conducts an RFI and no providers are identified for contracting, HCA will consult with the Executive Committee on how the implementation should be adjusted to implement the FPATH element.

e. HCA will conduct specialized training for staff hired within the Phase 2 region by July 31, 2022. Training will focus on effective outreach and engagement strategies to the most vulnerable individuals on the referral list for forensic PATH services who are homeless or unstably housed and not currently receiving treatment services.

f. King County's Forensic PATH program(s) will collect the same data metrics as the Phase 1 regions at the onset of program services commencing in King County. These data will be reported quarterly and semi-annually.

12.0 Education and Training – Crisis Intervention Training (CIT)

12.1 Assigned Owner

The Criminal Justice Training Commission (CJTC) is responsible for conducting crisis intervention training for law enforcement entities.

12.2 Statewide vs. Regional

The CJTC will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

12.3 Requirements from the Agreement

a. The state will seek funding so that the CJTC provides the 40-hour enhanced crisis intervention training courses to 25 percent of officers on patrol duty in law enforcement agencies within the phased regions.

b. The state will seek funding so that the CJTC provides all corrections officers and 9-1-1 dispatchers employed by governmental entities within each phased region, except those employed by the Department of Corrections or federal entities, at least eight hours of CIT.

12.4 Education and Outreach

a. Law enforcement agencies are familiar with CIT training. The CJTC will contact agencies in the Phase 2 region to provide education on additional training opportunities, funding, and the goal to send 25 percent of patrol officers to the enhanced CIT training.

b. CIT 40-hour classes have been offered in King County since 2010, reducing the number of law enforcement officers that will need training in Phase 2.

c. Those agencies located within King County will receive training as administered by the CIT-King County program already in operation at CJTC. The 40-hour enhanced CIT training is region-specific and includes local resources, contacts, and procedures for dealing with individuals in a behavioral or substance abuse emergency.

d. The CJTC will meet with police chiefs, sheriffs, and agency training managers to assist with coordinating training, budget, and staffing needs for this agreement. For agencies within King County, it will be coordinated with the CIT-King County program.

e. The CJTC will continue to work with the state office of 9-1-1 telecommunications about how the agreement will impact 9-1-1 training during the coming fiscal year.

f. County and local jail personnel need to complete at least eight hours of CIT training as well. The eight-hour course focuses on signs, symptoms, and intervention strategies related to behavioral emergencies with which they are most likely to come into contact. For those agencies within King County, it will be coordinated with the CIT-King County program.

12.5 Action Plan and Timeline

a. CIT 40-hour classes will be offered in King County administered by the CIT — King County Program in Phase 2.

b. CJTC will determine the need to extend contract agreement with the Washington State 9-1-1 Office to deliver the telecommunicator (911) classes into Phase 2.

c. Conduct and complete a training audit of law enforcement agencies in Phase 2 to determine number of officers remaining.

d. Complete the necessary CIT for dispatch/9-1-1 courses by June 30, 2023.

e. Complete the necessary 40-hour enhanced CIT courses by June 30, 2023.

f. Complete the necessary CIT for corrections courses by June 30, 2023.

13.0 Education and Training – Technical Assistance to Jails

13.1 Assigned Owner

DSHS is responsible for providing technical assistance to jails as part of the Trueblood agreement.

13.2 Statewide vs. Regional

The state will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

13.3 Requirements from the Agreement

a. The state will include peer support specialists as they continue providing educational and technical assistance

13.4 Education and Outreach

a. DSHS team leads will continue to collaborate and interact with King County Jail staff and participate in any workgroups that may form for the purposes of identifying and addressing training needs or other forms of technical support.

b. King County Jail staff can use the Jail Technical Assistance website (https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/resources) to share information, training resources, upcoming opportunities, and solicit feedback.

13.5 Action Plan and Timeline

a. Ensure collaboration efforts include one or more HCA subject matter expert or peer support specialists.

b. Continue to meet monthly, or as needed, to complete work on training materials and website.

c. Starting in December 2020, engage mental health and nursing leadership at King County Correctional Facility and other King County jails to determine specific training needs. Collaborate on development of targeted training to meet identified needs among jail staff.

d. Continue to deliver scheduled monthly training webinars statewide, while ensuring that King County jails are informed of the availability of this training.

14.0 Workforce Development – Enhanced Peer Support

14.1 Assigned Owner

HCA is responsible for peer support programs in the state of Washington.

14.2 Statewide vs. Regional

The state will implement this element of the agreement in selected regions in phases according to the plan outlined in the agreement.

14.3 Requirements from the Agreement

a. The state will create a peer counselor continuing education enhancement program for certified peer counselors that includes specialized training in criminal justice.

b. The state will provide ongoing training for these peer support specialists and targets the training and support to assist in establishing these positions in the programs outlined in the agreement.

c. These enhanced peer support specialists are integrated into the following programs:

   i. Technical assistance to jails

   ii. Forensic PATH

   iii. Outpatient competency restoration

   iv. Forensic HARPS

d. The state will explore the possibility of federal funding for peer support specialists to encourage wider use of this role.

14.4 Education and Outreach

a. Outreach and education will focus on providing information about enhanced certified peer counselor roles and activities.

b. The Enhanced Peer Supports Program administrator will work in partnership with the regions and other Trueblood implementation teams to utilize the FAQ, fact sheet, DBHR peer support webpage, Office of Recovery Partnership distribution list, recorded webinars, and other communication materials as needed.

a. Discussions on operationalizing peer services will occur with the technical assistance to jails, Forensic PATH, Forensic HARPS, and outpatient competency restoration teams.

b. Inform the peer community, tribes, urban Indian health providers, stakeholders, jails, forensic navigators, and other relevant partners about certified peer counselors' roles and activities.

c. Inform the peer community, tribes, urban Indian health providers, stakeholders, jails, forensic navigators, and other relevant partners about Enhanced Peer Supports Program continuing education curriculum.

d. Education and outreach will also be provided to other groups as needed and identified.

14.5 Action Plan and Timeline

a. Procurement of virtual platforms to transition the curriculum from an in-person training format to a virtual learning format will occur by February 28, 2021.

b. Transition the enhanced peer support curriculum entitled "The Intersection of Behavioral Health and the Law" from an in-person training format to a virtual format by January 31, 2022.

c. Conduct ongoing evaluation and satisfaction with the enhanced peer support training through anecdotal and formal feedback process by July 31, 2022.

d. Provided that funding is allocated by the legislature, procure additional continuing education module development by October 31, 2021.

    I. Train the trainer for additional continuing education module by February 28, 2022.

    II. Add additional continuing education modules to the curriculum focusing on diversity and equity by February 28, 2022.

e. Technical assistance to Trueblood element providers in Phase 2 on how to operationalize enhanced peer support within their organizations in alignment with startup dates for other Trueblood elements.

15.0 Workforce Development

15.1 Assigned Owner

DSHS is responsible for providing workforce development for DSHS staff and providing limited training resources to the forensic mental health community.

15.2 Statewide vs. Regional

Workforce development evaluation and support will be implemented as part of the statewide effort.

15.3 Requirements from the Agreement

a. Hire or contract workforce development specialists assigned to the functional areas of community, inpatient, and law enforcement. Duties include:

   i. Participate in workgroups

   ii. Conduct training needs survey/gap analysis

   iii. Develop master training plan(s)

   iv. Develop and coordinate training including standardized manuals and guidelines

   v. Collaborate with community-based organizational workforce development staff

   vi. Evaluate training programs

b. Prepare an annual report on a. above that includes recommendations about specific workforce development steps needed to ensure success of the Trueblood agreement. Distribute the report to executive committee, and key and interested legislators.

15.4 Education and Outreach

Continue to actively participate in regional and statewide groups and teams on workforce development and use the DSHS Workforce Development website (https://www.dshs.wa.gov/bha/workforce-development) to publish reports and share information. Seek to participate as new workforce development-related groups are formed.

15.5 Action Plan and Timeline

a. Continue to develop training materials, which can include guidebooks, presentations, web-based content and other forms of training or reference material as needed.

b. Continue to deliver trainings throughout Phase 2.

c. Continue to work at a statewide level to determine staffing challenges (e.g., positions that are difficult to recruit and retain; skills deficits in applicants, newly hired and experienced staff).

d. Engage with service providers in King County to determine staffing challenges specific to the Phase 2 geographic area.

e. Engage with education and training entities in King County (e.g., University of Washington and Shoreline Community College) regarding existing and potential programs that could address the staffing challenges identified by service providers essential to serving the Trueblood population.

In Closing

The purpose of this Phase 2 implementation plan is to lay the foundation for implementation and overall planning in the King County region. Because the plan sets out ambitious timelines, and unforeseen circumstances may arise, the parties expect to learn as implementation proceeds. Any necessary changes or adjustments to the plans and timelines in this document will be addressed with the committees created by the contempt settlement agreement as well as with the Court.