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

Semi-Annual Report 4

September 28, 2021

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

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List of Abbreviations in this Document

AAG – assistant attorney general
AHAB – Affordable Housing Advisory Board
ASO – administrative service organization
ASPD – antisocial personality disorder
BHA – Behavioral Health Administration, part of DSHS
BHASO – behavioral health administrative service organization
BPD – borderline personality disorder
CIT – Crisis Intervention Training
CJTC – Criminal Justice Training Commission
CMS – Centers for Medicare and Medicaid Services
CPC – certified peer counselor
CS/CT – crisis stabilization/crisis triage
DBHR – Division of Behavioral Health and Recovery, part of HCA
DCR – designated crisis responder
DSHS – Department of Social and Health Services
DOH – Department of Health
DRW – Disability Rights Washington
ESH – Eastern State Hospital
ETR – exception to rule
FDS – Forensic Data System
HARPS – Housing and Recovery through Peer Services
HCA – Health Care Authority
MCR – mobile crisis response
MOCT – mobile outreach crisis team
MOU – memorandum of understanding
OCRP – Outpatient Competency Restoration Program
OFMHS – Office of Forensic Mental Health Services, part of DSHS
PATH – Projects for Assistance in Transition from Homelessness
PHS – Pioneer Human Services
RDA – Research and Data Analysis, part of DSHS

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

Preamble

This is the September 2021 semi-annual report; the SAR is published in March and September each year through the duration of implementation of the Trueblood Contempt Settlement Agreement. This report primarily covers implementation-related progress during the first half of 2021.

The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new programs launched in summer 2020 and now have at least one year of operations completed.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes where possible. For this third SAR, a greater number of elements contain programs with data available to view. Most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. It is still premature for evaluative data for these new programs. As with the launch of any major new program, it will take time to receive usable and reliable data for in-depth reporting. As programs continue their operations and mature, this report will expand over time to include more data and reporting elements. With few exceptions data is current through June 30, 2021. Exceptions are clearly noted.

Accordingly, the data formats shown may also be modified as programs mature. Data on program participation will typically be included in the SAR after programs have been operational for at least two calendar quarters.

Impacts of the COVID-19 Pandemic

In March 2020, the COVID-19 pandemic began impacting Trueblood implementation efforts. The state of Washington has experienced an ongoing state of emergency since mid-March 2020, and this has affected aspects of operations and preparations for service enhancements. Initial effects included supply procurement challenges, impacts on construction, and delays to competency evaluation interviews when there was no safe way to interview a defendant. Rapid changes in the early spring and summer required significant adaptations, and responding to COVID-19 outbreaks in many of our facilities has required additional changes since the pandemic started. As permitted by evolving employee, client, and contractor safety considerations, the state is continuously undertaking efforts to minimize impacts to settlement activities, but impacts are ongoing and inevitable. More recently, in summer and fall 2021, the COVID-19 delta variant has intensified the pandemic's impacts, and the governor mandated that most state employees become vaccinated. Primary implementation impacts due to the delta variant and the vaccine mandate will become clearer in time for the March 2022 SAR. Other specific COVID-19 impacts, as well as the state's efforts to overcome those impacts, are discussed in more detail below.

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 puts the criminal case on hold while an evaluation is completed to determine the defendant's competency.

Generally, if the evaluation finds the defendant competent, they are returned to stand trial, 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 (DSHS) was taking too long to provide these competency evaluation and restoration services.

As a result of this case, 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. Now that state-contracted outpatient competency restoration services began July 2020, outpatient restoration services must likewise be provided within seven days of receipt of a court order. Trueblood applies to people who are detained in jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of Trueblood also target people who have previously received competency evaluation and restoration services, who are released and at risk for re-arrest or re-institutionalization.

Many of the problems with untimely competency services can be prevented if fewer people experiencing mental illness enter the criminal court system and instead receive community-based treatment. People who get the treatment they need when they need it are more likely to avoid becoming involved with the criminal court system. A major goal 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 the Settlement Agreement related to the contempt findings in this case. The Settlement Agreement is designed to move the state closer to compliance with the Court's injunction. The Settlement Agreement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified geographic regions. The Settlement Agreement includes three phases of two years each and can be expanded to include additional phases. Services and regions implemented in each phase are evaluated and continued into future phases of the settlement.

Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium.

- Phase 1: July 1, 2019 to June 30, 2021 Pierce County, Southwest, and Spokane regions

- Phase 2: July 1, 2021 to June 30, 2023 King County region
- Phase 3: July 1, 2023 to June 30, 2025 region(s) to be determined.

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

Definitions

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

Agreement: Trueblood Contempt Settlement Agreement or Settlement Agreement

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

CJTC or the Commission: Washington State Criminal Justice Training Commission

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

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

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

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

Forensic Projects for Assistance in Transition from Homelessness or FPATH: An intensive case management program that identifies people most at risk of referral for competency restoration. Individuals identified on a referral list generated by Research and Data Analysis (RDA) have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those individuals most vulnerable to access housing, treatment and

resources in an effort to divert them from future intersections with law enforcement. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

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

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

Health Care Authority or HCA: Washington State Health Care Authority

Mobile crisis response or MCR: Enhancements to the current crisis delivery system ensure that services quickly intervene in behavioral health crisis situations to prevent arrests, and incarceration, and to quickly connect clients to needed treatment.

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

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

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

Evaluation and Monitoring Overview

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

Project Monitoring

The department will provide ongoing project monitoring analyses through monthly and quarterly reporting. Monthly monitoring reports will provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness metrics, and slowing the rate of growth in competency evaluation referral volume. Most commonly, this information is available as part of the monthly reports to the court-appointed monitor and can be found on DSHS' Trueblood website[1]. Quarterly reporting on implementation elements (e.g., FPATH and the Forensic Navigator Program) will provide timely information on client engagement in implementation programs. Monitoring measures to be tracked will include:

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

Trueblood quarterly dashboards will be produced containing client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for the elements listed below. Data come from a range of sources, and largely from tools or system adaptations still under development. Additional program measures may be added as feasible. HCA is working to identify and implement long-term data collection tools for programs, as well as strategies to optimize data quality, and efficient sharing, to support timely reporting. Programs designated for this quarterly dashboard include:

- FPATH
- FHARPS
- Forensic Navigator Program
- OCRP
- Mobile crisis response

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

- Crisis housing vouchers

Compliance with Crisis Intervention Training targets will also be monitored through the quarterly dashboard. Preliminary examples of quarterly dashboards are displayed in the applicable implementation plan Element - Data sections of this report.

Quarterly reporting timeline: Available program data are currently reported on a semi-annual basis through the SAR. RDA is working with various teams within DSHS and HCA to establish a reliable and efficient data processing system for reporting quarterly data. This requires establishing a coordinated infrastructure including but not limited to secure data transmission and storage; automated data error checks; a framework to download, merge, and package data; data definitions and counting rules; and validated code and templates for data analyses and reporting. Building the infrastructure is complex due to the number of data sources, different collection/reporting methods, data changes, and data quality issues. Once data and data processes are stabilized and mature (see below), the time from submission to Trueblood dashboard reporting will decrease, assuming that data providers submit required data in a timely manner. The goal is quarterly reporting that will begin in 2022, with quarter 4, 2021 data (through December 31, 2021). King County providers (Phase 2) are expected to be added to program reporting within two quarters of program providers submitting complete data.

Data maturity — the point at which data are consistently entered and submitted — takes time, particularly for new programs, most of which are using interim data collection methods until more efficient ones can be deployed. Several programs also had updates to the data collection elements, impacting data processing.

All client-level data is aggregated to protect client confidentiality and suppression guidelines are being followed. Data tables included in this report reflect what was possible to produce from existing data received by the report deadline. Draft tables reflect what is anticipated to be ready in future reports. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served increase.

Longer-term Impact Analyses

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

- Use of mental health and substance use disorder treatment services
- Rates of housing instability

- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

RDA's evaluation will encompass both an assessment of the overall phased regional impact of Settlement Agreement components on outcomes, and to the extent feasible given program design, data availability, and resource constraints, the impact of specific components (e.g., the FPATH program).

Timeline

Monitoring metrics will be produced on a monthly or quarterly timeline, including continuation of existing monthly reporting streams. Longer-term impact analyses and evaluation results (i.e., estimates of the impact of Settlement Agreement activities) are expected to be produced on the following schedule.

1. Impacts on measures derived directly from FDS data (substantial compliance timeliness metrics, number of competency evaluation referrals, and number of competency restoration referrals) will be tested on a semi-annual basis beginning two quarters after the implementation of all major Settlement Agreement components in July 2020. Initial tests of statistical significance of impacts in the first six months of full implementation are included in this report.

2. Impacts on behavioral health access and social outcome metrics will require significantly more time to measure. These measures are produced on a global scale for all Medicaid beneficiaries and require a 12-month measurement window, seven months of data maturity[2], one month of global measure production and testing, and one month for analysis of results for the Trueblood population. Analysis of first-year impacts (through the period ending June 30, 2021) on these measures will be available in March 2022.

3. Preliminary estimates of the impact of specific Settlement Agreement components based on propensity-score matching methods will be available no earlier than March 2022. This assumes that the initial study populations will include persons entering services during the first six months of program operations, with a minimum six-month follow-up period, seven months for data maturity, and at least two months for data integration, analysis, and reporting.

[2] Data maturity is the point at which data is consistently entered and submitted, based on standards established in contracts. Behavioral health metrics rely on mental health and substance use disorder treatment encounters recorded in HCA's ProviderOne billing system. Social outcome metrics, such as arrest data, are recorded in Washington State Patrol databases. These data require significant time to mature due to lag-time in data entry and transmission.

Region-wide Impact of Trueblood Implementation on Competency Referral Volume

To assess the impact of the new Trueblood programs on competency referral volume, RDA conducted an interrupted time series analysis, comparing referral rates in Trueblood Phase 1 regions to the balance of the state (regions where the new programs have not yet been implemented). Based on data for the first nine months of implementation (July 2020 through March 2021 the following was found:

- A small decrease in the rate of referrals for competency evaluations in Phase One counties compared to the balance of the state (this decrease was not statistically significant).
- No change in the rate of referrals for competency restorations.
- No change in the rate of referrals for other sub-populations, including Trueblood (in-jail) referrals and inpatient referrals.
- Current trends in referral volume are likely influenced by the COVID-19 pandemic more than Trueblood-focused interventions at this time.

Subsequent tests of statistical significance on year one impacts with respect to competency referral volume will be available in Fall 2021.

Implementation Plan Elements

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

Each element's report considers the following five items as they relate to the element specifically and to the Settlement Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) data pertaining to the element. As previously described, data for new programs takes time to mature. Data tables included in this report reflect data through June 30, 2021, with exceptions noted. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served in the new Trueblood programs increase.

Competency Evaluation – Additional Evaluators

The Settlement Agreement requires hiring 18 additional forensic evaluators over two years. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines, evaluators can also be assigned to address the need of completing non-Trueblood forensic assessments (such as specialized forensic risk assessments for the NGRI population in forensic beds, civil petitions, Not Guilty by Reason of Insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state. Furthermore, with up-to-date forensic risk assessments, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity.

Current Status and Areas of Positive Impact

From July 1, 2019 to June 30, 2020, OFMHS hired 13 evaluators meeting the Settlement Agreement requirements for fiscal year 2020. In fiscal year 2021, OFMHS hired 10 additional forensic evaluators with start dates ranging from July 1, 2020 to June 1, 2021. Five of these positions were elements of the Settlement Agreement while the additional five evaluators filled pre-existing vacancies. With staff movement naturally occurring, as of August 1, 2021, 72 of the 74 positions are filled and recruitment is occurring to fill the two vacancies. The new hires have allowed OFMHS to complete jail-based competency evaluations within 14 days for 81-94 percent[3] of clients from January through June 2021. Aided in part by the OFMHS training programs, WSH is able to staff clinical psychologists that complete the treatment reports to the court for civil commitment, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations). Staffing forensic evaluators have allowed a record number of forensic risk assessments (FRAs) to be completed. During the first seven months of 2021, 97 FRAs have been completed as compared to 85 in all of 2020 and 40 in 2019 at WSH. While completion of risk assessments for the NGRI population at the state hospitals assists in vacating forensic beds that can be occupied by those in need of inpatient competency restoration services, completion of competency evaluations for class members remains prioritized over other types of evaluations, including FRAs.

Areas of Concern

In Fiscal Year 2021, Washington state had its second highest number of referrals for all competency evaluations (4,686[4]) to date. While there was a slight decrease in all referrals, levels remained near record highs despite shutdowns due to the pandemic and even though 12 fine-funded contempt programs and three state-funded prosecutorial diversion programs were

[3] *Table 8. Class member status at WSH and ESH (totals) – Jail-based competency evaluations.* Jan. 2021-June 2021, Mature Data. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Final Monthly Report to the Court Appointed Monitor. August 31, 2021, p. 19.

[4] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2021.

operating. Without these programs, demand for evaluations likely would have increased even more in the past and even during the pandemic. The arrival of COVID-19 in late winter 2020, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for months during the pandemic. Even as the criminal court system has re-opened, COVID-19 infections continue to result in decreased in-person access to clients and fewer beds with which to serve our clients.

Recommendations to Address Concerns

Specifically, a meeting was held at the end of July 2021 with defense counsel in King County to discuss timelines for jail-based evaluations and the use of telehealth. Ongoing ad hoc meetings with Pierce County defense counsel to maximize scheduling using a block scheduling format has allowed for evaluations to be completed in an expeditious manner. DSHS will work with the legislature supporting several initiatives related to Trueblood such as clarifying HCA's role in outpatient restoration, addressing the good cause exception process, and providing more clarity around record access by forensic evaluators. Internally, the department worked with our information technology team to nearly complete development of a real-time report tracker database for evaluators across the state to allow for the ability to shift resources as needed. This database is currently being updated to provide enhanced data to supervisors. Furthermore, the department continues to work with various jails to establish a telehealth presence to complete evaluations remotely. Video technology conferencing for competency evaluations is seeing more interest from jails and other entities seeking to continue evaluations while minimizing physical contact/proximity of clients and staff due to the COVID-19 pandemic.

OFMHS has reached out to all county jails in the state as well as tribal and municipal jails to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). Currently, additional jails with telehealth capacity on the west side of the state include city jails in Aberdeen, Kent, and Issaquah, and county jails in Skagit, Island, King (King County Correctional Facility [KCCF] in Seattle, Maleng Regional Justice Center [MRJC] serving south King County in Kent, and South Correctional Entity [SCORE] in Des Moines), Skamania, Kitsap, Thurston, Mason, Pacific, Jefferson, Wahkiakum, Whatcom, Clallam, and Clark counties.

Jails on the east side with telehealth capacity now include those in Ferry, Benton, Franklin, Grant, Klickitat, Spokane, Okanogan, Whitman, and Stevens counties. In addition, Airway Heights Corrections and the Colville Tribal Jail now have VTC capabilities.

OFMHS continues to work with and educate jails, VTC users, and IT staff to address issues and provide ongoing support for video evaluations. Additionally, support is being provided for video evaluations conducted at Western State Hospital, and all evaluations at RTFs (Maple Lane, Fort

Steilacoom Competency Restoration Program, and Yakima). OFMHS has also added the capability to use Zoom for Healthcare in addition to the DSHS VTC Cisco application to provide an alternative application to enable expanded use.

A VTC/telehealth workgroup has been established with representation from evaluators, evaluator supervisors, and OFMHS staff regarding the technology side of implementation. This workgroup acts as a discussion forum to present ideas and issues pertaining to VTC, tracks progress with jail implementation, and is working to develop work instructions for evaluators. A shared mailbox has also been established to more expediently route issues to staff working on VTC issues.

Establishing this technology in multiple locations around the state (especially in rural areas) allows OFMHS to conduct more evaluations, thereby helping to meet court-ordered requirements, makes it easier for attorneys to be present for their clients' interviews, and minimizes risks for all those involved during this pandemic.

Data – Competency Evaluation – Additional Evaluators

DSHS continues to utilize data from FDS to determine whether the evaluator capacity (current and funded increase) maintains substantial compliance with the injunction with respect to in-jail competency evaluations. Timeliness metrics are shown in Figure 1.

The department examined the number of orders filed by the courts between January 2017 and December 2020 and projected the number of evaluation orders through June 2023 using an exponential smoothing forecast model[5]. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood Agreement and Engrossed Substitute Senate Bill 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

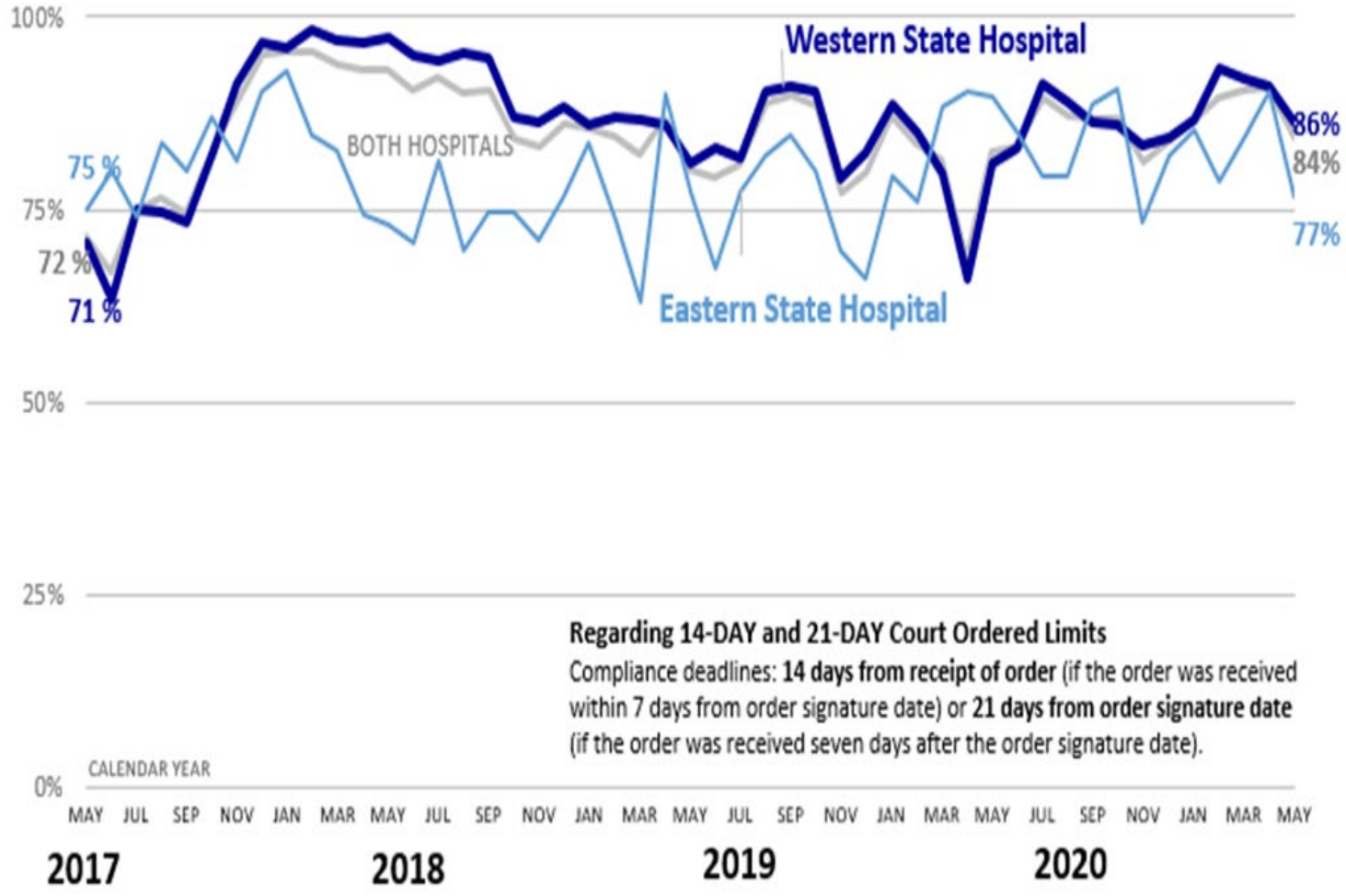
Projections indicate that the number of evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74.0 FTE in the FY2022 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, which may present evaluation capacity challenges in peak months. The department continues to monitor caseloads regularly, and during periods of increased demand, OFMHS management/staff prioritize jail-based cases. OFMHS and RDA are also working with court partners to gather more information on the backlog of cases in the court system because of the pandemic.

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

FIGURE 1.

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

Percent complete or closed within court ordered limits



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

NOTE: Refer to page 15 and footnote 2 for additional details on jail-based competency evaluation completion rates.

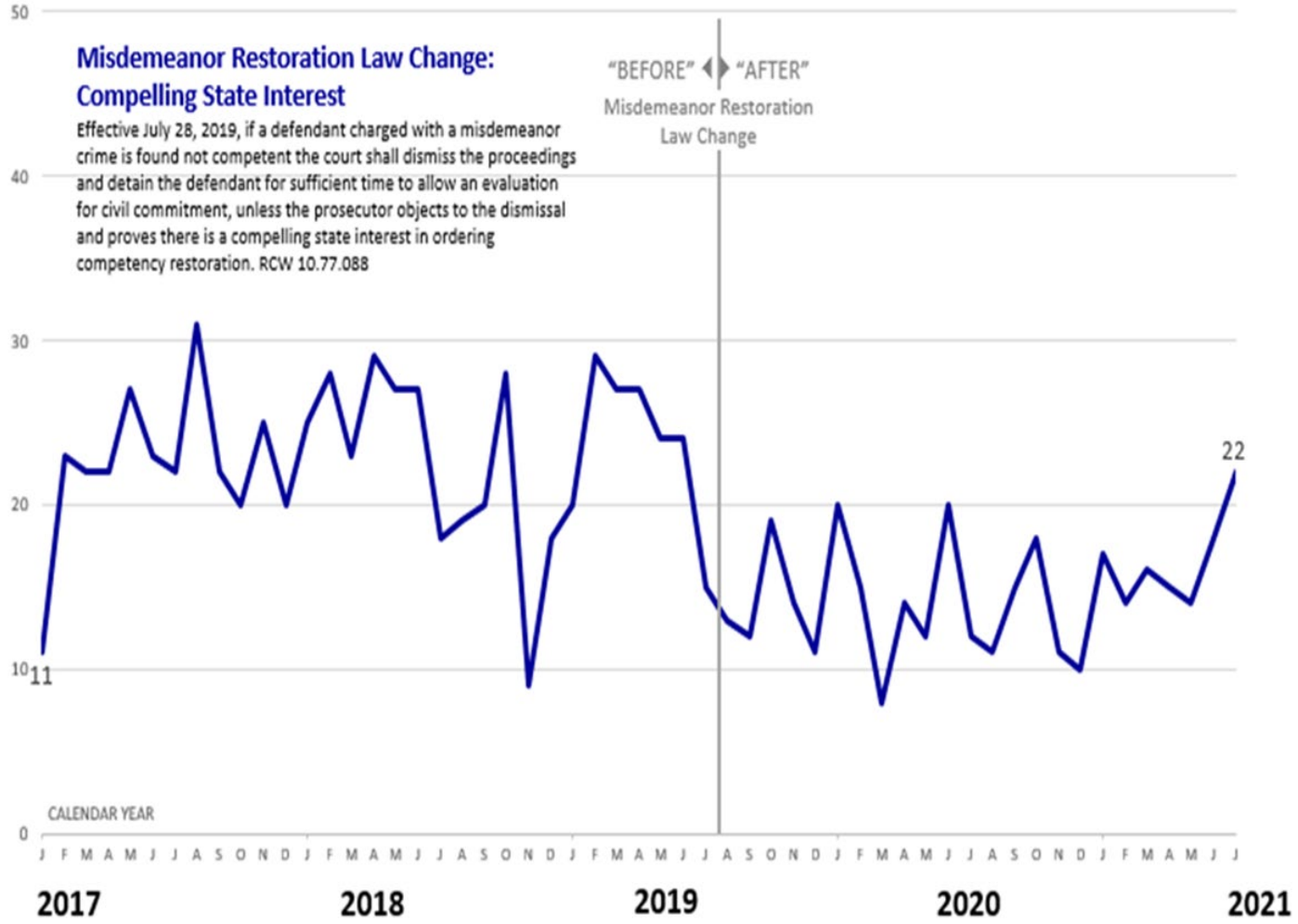
Data – Competency Restoration – Misdemeanor Restoration Orders

As part of the Settlement Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supported legislation towards this goal. ESSB 5444 was signed into law by the governor on May 9, 2019 and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. A technical correction bill was pursued during

the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. The department continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088). Misdemeanor restoration orders have decreased slightly since the 2019 law change. During the 24-month period prior to the 2019 law change courts issued an average of 23 misdemeanor restoration orders per month, which decreased to an average of 15 per month during the 24-month period after the law change. In July 2021, 22 misdemeanor restoration orders were issued statewide (Figure 2).

FIGURE 2.

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



DATA SOURCE: Forensic Data System (FDS).

Competency Restoration – Community Outpatient Services

The Outpatient Competency Restoration Program element of the Settlement Agreement is managed by the Health Care Authority in collaboration with the department. DSHS will continue providing court-ordered inpatient competency restoration services; however, OCRP provides an option for courts to order community-based restoration services in a less-restrictive environment for defendants with appropriate acuity levels. The intent of OCRP is to provide the most appropriate level of care to the individual, ideally closer to their home community. Providing restoration services in a safe and cost-effective environment, while utilizing the newly available community treatment program, should hopefully reduce the number of people wait-listed to receive competency restoration in an inpatient setting.

Current Status and Areas of Positive Impact

In consultation with key partners and stakeholders, a program model has been developed and implemented. A consulting firm, Groundswell Services, Inc., also conducted a review, which assisted in this model's development by providing evidence-based critique and analysis of other states' OCRP models.

OCRP is operational in all three Phase 1 regions. Contractors in the Pierce and Spokane regions have been providing services since July 1, 2020, and due to impacts from COVID-19 and workforce hiring challenges, the contractor in the Southwest region was delayed in their ability to accept clients into the program. The Southwest region program began operations on September 1, 2020.

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

- Publications for use with participants and stakeholder groups to ensure accurate messaging is happening regarding OCRP.
- An OCRP transition plan has been developed to coordinate element involvement prior to a participant releasing from jail or starting OCRP services.
- HCA has requested that the department's Jail Technical Assistance program develop a training for jail transition and mental health staff on the OCRP and Forensic Navigator programs. Training was provided in April 2021 and was scheduled to be provided in August.
- Quality assurance reviews are completed in all instances where an individual is removed from the OCR program and returned to an inpatient restoration facility or jail to ensure policy and contract deliverables are being followed and to identify service gaps to inform

program development and future success. DSHS and HCA leadership meet monthly to review the findings and identify best practices.

- Monthly case staffing events occur between Settlement Agreement elements to ensure communication and program coordination for shared participants.

- OCRP conducts a quarterly Learning Collaborative where clinicians from the programs come together and receive training on the Breaking Barriers Competency Restoration Program or discuss strengths and barriers to implementation to standardize process or make improvements.

OCRP has been collaborating with FHARPS teams to utilize OCRP client support funds to acquire housing units specifically for Trueblood Class Members, with priority given to OCRP participants. Currently, Frontier Behavioral Health in the Spokane Region has a memorandum of understanding with Pioneer Human Services that reserves units in two different housing locations that offer permanent supportive housing and transitional housing where appropriate participants can be placed immediately or after a brief stay in a hotel/motel. Lifeline Connections in the Southwest Region has recently received a grant to purchase a home in Clark County where transitional housing will be provided. Lifeline Connections will use OCRP client support dollars to also reserve units for Trueblood Class Members, with priority given to OCRP participants as well.

Areas of Concern

A single provider has been identified in each implementation region. This could be problematic for the more rural regions, although the provider contracts require services be available to the entire region. If problems arise with the contractor, a new procurement would be required. Individuals within multiple county regions may find transportation to the OCRP services challenging; however, the volume of appropriate OCRP orders is not sufficient to warrant additional contracted providers at this time.

Another continued concern is consistent support for this program by system partners. DSHS and HCA continue to meet directly with all municipal, district and superior courts in the implementation regions to engage court staff in process coordination, and to generate support for utilization of this program for qualified individuals. These system partners will control the flow of patients into the outpatient programs, and their reluctance could frustrate the success of the programs.

Removal rates have been continuously reviewed since inception of the program and efforts continue to identify best practices to prevent removals. Removals do appear to have plateaued in recent months, with only one removal happening since April 2021.

Recommendations to Address Concerns

Providers have established mechanisms to provide remote and virtual services to individuals in rural communities, as needed, with the goal of serving individuals in person as much as possible. Additionally, continuity of care plan development is an important contingency to address the potential for a region's contracted provider to discontinue services or be terminated. To date, no challenges have been identified in providing services regionwide.

DSHS and HCA will continue to engage court partners in discussions of this new program. Currently, contractor agencies are included in collaboration and engagement activities in all of the Phase 1 regions and relationships are being developed among the programs. HCA, in partnership with DSHS, is working to engage King County for Phase 2 implementation of OCRP. Staff from the King County Prosecuting Attorney's Office and staff from the King County Department of Public Defense participate in the planning and implementation of OCRP in King County. Since March 2020, both HCA and DSHS have been participating in the King County Competency Continuum workgroup that includes membership from King County law enforcement, defense counsel, prosecution, judges, county staff, and advocates. HCA and DSHS have met with specific partner groups to include Spokane County Office of Public Defense, Pierce County Criminal Justice Steering Committee, Washington District Court Judges Association, Spokane County Prosecuting Attorney's Office, and DSHS forensic evaluators.

In April 2021 HCA issued a request for information for King County provider agencies that may be interested in implementing OCRP, FHARPS or FPATH services. In May 2021, WebEx presentations were held for interested agencies. In July 2021, HCA and DSHS met with the King County Provider Network meeting consisting of licensed behavioral health agencies in King County. Since then, HCA has been reaching out directly to interested providers and other agencies in King County to gauge interest in providing services in that region.

HCA has worked with current OCRP providers to address workforce challenges. HCA has allowed one provider to utilize an "in-training" mechanism to hire a master's level clinician who is working toward licensure. In collaboration with King County providers, a strong area of concern is hiring, and this "in-training" option may be utilized in future contracts.

The Jail Technical Assistance program has provided training, at OCRP's request, for jail transition and mental health staff regarding OCRP as well as best practices for coordination with forensic navigators, OCRP, and other Trueblood elements when a person is releasing from jail. Forensic navigators continue to engage court staff in discussion about release timing and program needs to ensure individuals can adequately connect to programs once released.

Removal reviews are conducted by the OCRP administrator in collaboration with the assigned providers and forensic navigators. HCA and DSHS leadership meet monthly to review the removal review findings and make recommendations for best practices in the prevention of

removals or identification of commonalities among those removed. Reviews have found that removals are appearing to plateau, with only one removal from the program since April 2021. We attribute this to multiple factors including increased experience of the programs; coordination among all the program elements; courts working with the assigned forensic navigator to order clinically appropriate individuals to the program; and increased consultation for at-risk participants. We continue to review commonalities of unsuccessful participants and share that information with court staff to inform the decision to order future participants. Commonalities noted include history of non-compliance with community-based services; program refusal upon order; and medication refusal.

Data – Competency Restoration – Community Outpatient Services

OCRP services began on July 1, 2020. Between July 1, 2020 and June 30, 2021, 32 individuals were enrolled in OCRP (Appendix B, Table 1). Most enrollments were for felony restoration orders (91 percent) and participants were mostly male (91 percent), 18-29 years old (44 percent), non-Hispanic White (66 percent), and unstably housed or homeless (78 percent). Of the 22 individuals discharged (Appendix B, Table 2), 36 percent were opined competent or had their conditional release revoked. More than two-thirds of individuals (68 percent) were in the community at the time of discharge, and nearly one-quarter (23 percent) were admitted to inpatient services at a state hospital or residential treatment facility. Data by region are not reported due to the small number of cases.

Program data is from interim Microsoft Excel data trackers until each provider incorporates required data into their record systems. Adjustments are underway to also collect some information through the Navigator Case Management system. Data should be considered preliminary as the program and data collection are still evolving.

Forensic Navigators

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

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

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

Current Status and Areas of Positive Impact

Forensic navigators have also been in close contact with attorneys and outpatient competency restoration programs and have referred program participants to outpatient forensic service providers in the three Phase 1 regions. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators have continued to facilitate connections for eligible clients to housing and recovery programs as well as to forensic peer services and case management supports even when class members are not ordered into outpatient restoration, and after the forensic navigator has been discharged and is no longer actively assigned to the client.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one that primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not extend to a larger group of people for whom competency to stand trial has been raised, particularly those for whom a competency evaluation is ordered at or after their release from jail. Thus far, forensic navigators have also been serving those individuals. However, as the volume of clients grows, there may come a time when forensic navigators must prioritize their caseloads for class members. While the Forensic Navigator Program has had open communications and contact with stakeholders around this issue, it remains an area of concern.

Outreach and education that occurred prior to go-live does not seem to have resulted in the desired level of understanding of the program by court partners. Program staff continue to engage and inform prosecution, defense, and judges to develop a shared understanding of this new program. Meetings are ongoing and discussions continue with prosecutors, defense, and bench in all three Phase 1 regions in partnership with HCA.

As with any new program, there have been lessons learned in what works for these programs to interface smoothly. DSHS and its service partners are working well together in order to iron out these programmatic alignments. Extensive process mapping, with the use of RACI matrices, has been completed. The value stream mapping has aided communication between the Forensic Navigator Program and partner programs OCRP, FHARPS, and FPATH. The VSM process further resulted in decreased gaps within participant programs for more streamlined processes and operational efficiencies.

Recommendations to Address Concerns

Continue to focus forensic navigator time and resources primarily on Trueblood class members who are awaiting forensic evaluation or restoration services in jail while simultaneously serving those who may not meet the definition of class member. In the Pierce and Spokane regions, caseload prioritization requires focus on class members. We will continue to conduct focused outreach to the courts on this topic in each region indicating the willingness of the program to continue to provide warm hand-offs for this population to applicable agencies and entities in all circumstances, even when the forensic navigator is discharged and no longer actively assigned to the client.

Data – Forensic Navigators

A total of 1,009 people were assigned a forensic navigator between July 1, 2020 (program start) through June 30, 2021 (Appendix C, Table 1). The majority of individuals assigned a navigator were male (75 percent), half (54 percent) were between the age of 30 to 49, and more than (61 percent) were non-Hispanic White. Over half (59 percent) were charged with a felony, and 41 percent were charged with a misdemeanor.

Forensic navigators worked to gather information for the courts for nearly all individuals assigned a navigator during the reporting period (99 percent, Appendix C, Table 2). Client meetings, interviews or observations were conducted with over half (63 percent) of individuals assigned a navigator. A recommended service plan was completed for 66 percent of individuals. About one in four individuals (27 percent) received a referral to other community services. The most common types of referrals were to other Trueblood partner programs; 19 percent received a referral to the FPATH program and 14 percent received a referral to FHARPS.

A total of 870 individuals were discharged during the reporting period, with an average length of stay in the program of 36 days (Appendix C, Table 3). One-third (34 percent) of cases were closed because the individual was determined competent; 26 percent of cases were closed because the individual was ordered by the court to receive inpatient restoration. One-third (35 percent) of individuals in the Spokane region were discharged after they were released from jail on personal recognizance.

Data for the program is collected through the Navigator Case Management System (NCM). The program continues to make improvements to data collection and data quality. Data should be considered preliminary as the program and data collection are still evolving.

Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

DSHS opened two competency RTFs to provide additional inpatient competency restoration services in 2016. The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order. Maple Lane Competency Restoration Program is staffed with a combination of state and contract employees. Yakima Competency Restoration Program closed in August.

Both facilities were scheduled close as part of the overall integrated system changes contemplated in the Trueblood Contempt Settlement Agreement. Yakima was scheduled to close by December 31, 2021, but closed on August 13 due to staffing issues. Maple Lane has a hard closure date of July 1, 2024. In late June 2021, it was mutually decided between BHA and Comprehensive Healthcare to close the Yakima Competency Program by August 14. All patients would be transferred out by July 30. This decision was reached during contract negotiations and Comprehensive expressed, that even with the retention funds that BHA was able to secure this legislative session, it was unable to recruit and retain staff through December 2021. On June 30, 2021 Comprehensive Healthcare issued its notice of termination. The Director of Residential Treatment Facilities worked closely with the other facilities to ensure that all 16 remaining patients were placed in the appropriate setting. By July 26, all patients had been placed. Out of those remaining 16, four were found competent and returned to jail. As part of the Settlement Agreement, low median wait times for inpatient competency services can trigger an earlier closure. For Maple Lane, it is four consecutive months of a median wait time for admission of nine days or fewer.

The waitlist median times may be impacted by several projects associated with the Settlement Agreement. This includes statutory changes for misdemeanor restoration effective July 28, 2019; the net addition of four total forensic wards coming online at Eastern and Western state hospitals during summer and fall 2020 (adding 90 beds); and new outpatient competency restoration programs coming online as part of the agreed on new services stemming from the Phase 1 regions: Pierce and Spokane began OCRP on July 1, 2020 and in the Southwest region on September 1, 2020.

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup is developing full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for Maple Lane. Based on the closure of the Yakima restoration program, the current plans may be adjusted to reflect lessons learned from the recent closure. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations during ramp down after the official closure notification is given. At this time, staffing remains at stable levels and within typical turnover margins. Currently, the director of RTFs is working with her chain of command to come up with both recruiting and retention strategies for the Maple Lane Competency Restoration Program. This planning is in the beginning stages. As ideas are developed and implemented, this group will be updated.

Recommendations to Address Concerns

DSHS is continuously monitoring turnover, morale, and other factors, and is actively taking steps to neutralize those affects now that Yakima has closed. Given the potential variability in closure dates due to agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient is discharged. Additionally, our contract oversight of the contractor at Maple Lane will focus on the contract requirements to ensure sufficient staffing. The Residential Services Manager will work closely with the Director of Residential Treatment Facilities on staffing challenges for the DSHS side of operations at Maple Lane.

Data – Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

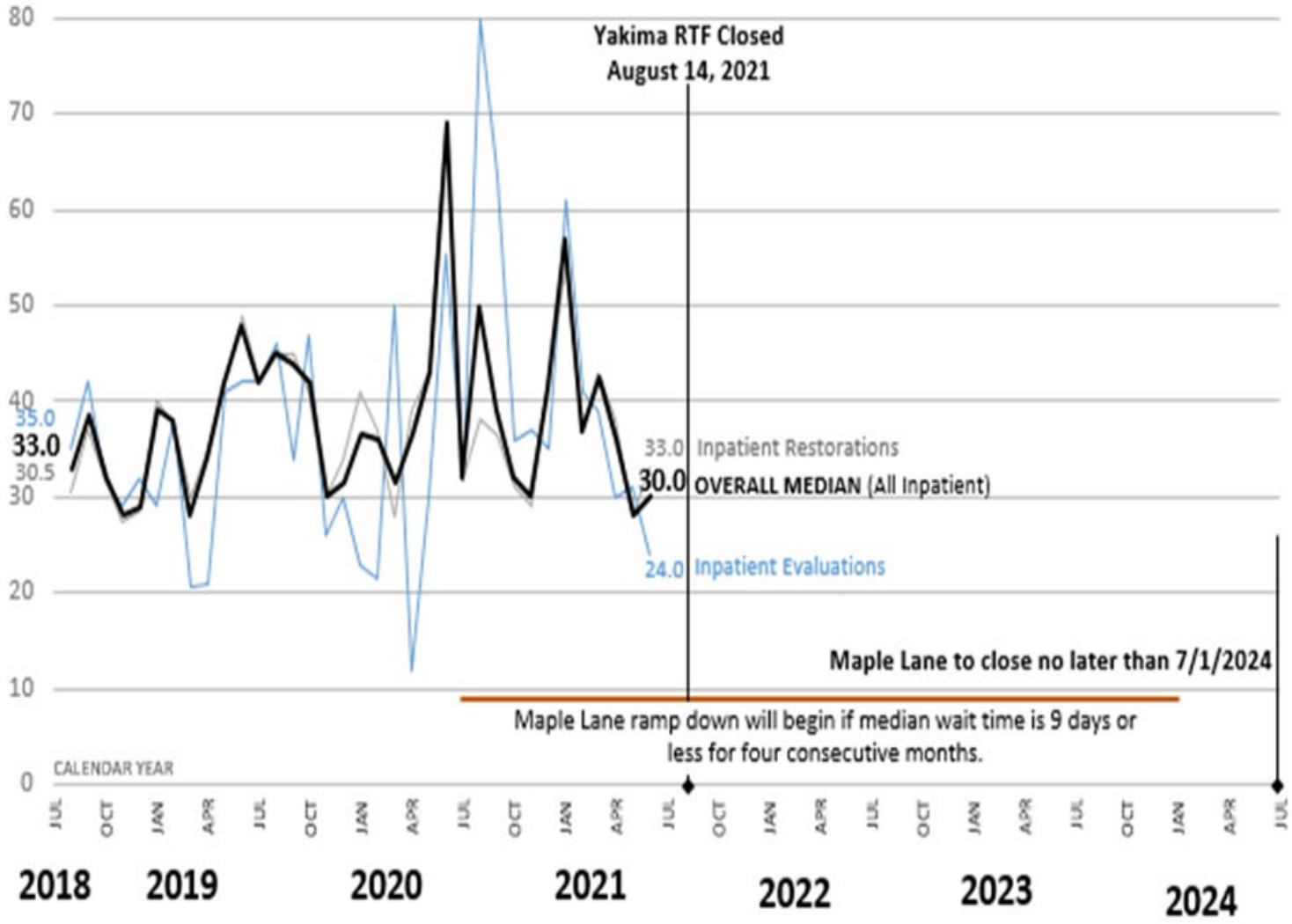
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services on a monthly basis (Figure 3). The Yakima RTF closed August 13, 2021. In July 2021, the median wait time for inpatient competency services was 30 days. The ramp down of Maple Lane will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 3.

Closure of Maple Lane and Yakima Residential Treatment Facilities

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

JULY 2021



DATA SOURCE: BHA Forensic Data System.

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

Crisis Triage and Diversion – Additional Beds and Enhancements

Washington state crisis stabilization/crisis triage (CS/CT) facilities are designed to deliver short-term clinical interventions in a safe, structured environment, and to offer support and behavioral health crisis stabilization services in a community setting. These Department of Health-licensed community behavioral health agencies serve their communities by providing least restrictive alternatives to care. This allows individuals to be treated by a multi-disciplinary team for the purpose of diverting individuals from arrest, detention, and lengthy hospitalizations. Services within the facilities are short term and focus on stabilizing and returning the individual back to their community. While an emphasis is placed on voluntary admissions, these facilities are also designated to work with first responders to accept police referrals, drop-offs and police holds.

Through the Trueblood implementation plan, HCA sought to enhance CS/CT services to divert individuals at risk for involvement in the criminal court system. Using capital funding, HCA worked with the Department of Commerce to expand bed capacity in the Spokane region. HCA also worked with existing CS/CT service agencies in the Pierce and Southwest regions to improve their ability to accept law enforcement referrals, drop-offs, and police holds in the interest of preventing people from being jailed when mental health treatment is indicated. Lastly, HCA funded emergency hotel/motel vouchers to be provided to people experiencing homelessness in Phase 1 regions post-crisis triage/stabilization services. These vouchers are distributed by the CS/CT sites to prevent individuals from cycling through the crisis system or legal system. HCA provided funding for short-term housing supports through the FHARPS services to link individuals requiring additional assistance to supports within their community.

Current Status and Areas of Positive Impact

Additional Crisis Beds

HCA supported the Department of Commerce in issuing a request for proposals for the expansion of 16 new beds for crisis stabilization in the Spokane region with the successful bidder identified as Spokane County and the City of Spokane. After a thorough and competitive bidding process for a social service provider, Pioneer Human Services was selected as the operational agency for the Mental Health Crisis Stabilization Facility. The HCA, DSHS, and Department of Commerce scheduled monthly meetings with Spokane County and Pioneer Human Services to receive updates on the construction efforts and to address any operational needs once construction ended to adhere to the FIP timeline and to avoid any delays. The state was informed on February 4, 2021, that there was a projected delay due to construction material shortage and COVID-19, and that construction for the Spokane 16-bed facility projected opening date of July 1, 2021, would be delayed 4-6 weeks with a projected mid-September opening. These steps listed below were initiated to address a need to move this project along in more timely fashion.

- As the contract for construction resided with the Department of Commerce, DSHS and HCA coordinated efforts to address concerns that were creating the delay.

- Placing an emphasis on addressing identified delays, the state moved from scheduled monthly check-ins to bi-weekly check-ins with PHS/Spokane county representatives.

- This increased oversight expanded to the state working with PHS to question the status of all factors associated with the construction of the facility including hiring of staff, licensing, community outreach, communication, purchasing of equipment and encouraging a referral process with Frontier Behavioral Health and community hospitals and BH agencies.

    - Efforts with staff hiring included scheduling work force administrators from both HCA and DSHS to provide technical assistance and identify sources for employment. The state also reviewed various service programs, educational institutions with social work and nursing programs, and online job sites as resources to advertise work force needs.

    - Regarding licensing and certification efforts, the state reached out to DOH to develop increased understanding of their certification process and steps involved in licensing a facility. Currently, there is a subject matter expert that is working alongside other state agencies to immediately respond to licensing or certification concerns.

- Pioneer was requested to submit bi-weekly progress updates, highlighting any anticipated delays and if discovering any delays to report that directly to state.

On May 14, 2021, in a communication from Pioneer Human Services, it was identified that Spokane did not anticipate opening its doors for admissions in mid-August as expected but would still be completing their construction of the facility. Once construction was complete, they would receive the Certification of Occupancy. Actual admissions were not anticipated to begin "until late-September to mid-October."

Based on this new timeline, the state moved its frequency of meetings from biweekly to weekly meetings with the HCA program manager utilizing phone calls, conducting conversations between Spokane County and Pioneer Human Services to address all concerns and reduce added delays. The meeting attendees include representatives from four state agencies. This now put at the disposal of Spokane County and Pioneer Human Services, the Department of Commerce, Department of Health, DSHS, and HCA. The outcome of these meetings is reported weekly to the leadership of HCA and DSHS.

The state is using Spokane County and Pioneer Human Services project managers to provide construction updates and to meet with their project contractor and subcontractor for weekly

walk-throughs and updates on completion steps. As of July 2, 2021, Spokane reported not anticipating any additional delays with construction and with the assistance of the collaboration of other state agencies to address needs such as licensing and certification, needs were also being addressed swiftly for concerns of DOH inspections, fire marshal inspections and National Provider Identifier numbers assigned.

Through reviewing of the contractual deadlines and requirements from the three construction contracts that Spokane was awarded from Commerce, it was discovered that the delay of the contract put operational funding for the facility in jeopardy. Commerce informed HCA that the use of the funds would end on June 30, 2021, and there was no option for extending that timeline. HCA then set out to work with its finance department to seek funding sources that could provide operational funding for Pioneer and then worked to put those funds into contract to allow Pioneer to continue its hiring process, purchase of services and supplies and provide funds necessary for the ramp up of services. To address the transportation need and to better serve other Spokane regional counties, HCA, through its contracts with WASPC, began conversations which allowed WASPC funding to purchase two new Honda Odyssey vans. The use of these vans will address transportation concerns and support individuals from rural counties to seek crisis services and to return to their county of origin once stabilization services are complete.

HCA continues to address operational concerns with Pioneer Human Services as they can present as opportunities for delays if not addressed often and regularly. One such area of concern which the state is addressing included assisting with workforce concerns. With anticipated workforce needs high in the Spokane region, HCA is providing PHS with an operational/start-up contract that will support incentives for hiring key positions; technical assistance from HCA's BH workforce manager has also occurred. At present, PHS reports that they are still interviewing and have extended several offers for profession staff. Other areas of engagement include:

- Maintaining open communication with community partners, agencies, and other first responders who will be making referrals once the facility opens.

- Establishing MOUs with community partners.

Crisis Enhancements

On July 24, 2021, HCA received notification from Beacon Southwest of the closure of Elahan Place in the Southwest region. Lifeline Connections remains operational in the Southwest region to support the residents there. The crisis enhancement funds allocated to Elahan Place have been reallocated to other Phase 1 stabilization facilities.

HCA currently contracts with three licensed community behavioral health agencies, one in each of the three Phase 1 regions. Funds in these contracts are intended to enhance the community behavioral health agencies' ability to provide crisis stabilization services to acute populations and to increase police drop-offs, referrals, and holds. Enhancement examples include:

- Additional staff and salary enhancements to reduce turnover
- Facility improvements
- Infrastructure such as technology, medical equipment, and furniture
- Client experience enhancement strategies such as weighted blankets for individuals experiencing anxiousness, art supplies, exercise equipment, and headphones with noise suppression
- Programmatic supplies that promote wellness
- Transportation through the purchase of vehicles as well as the use of taxi and rideshare services
- Specialized training for staff to work with acute populations

Challenges in serving individuals in congregate settings due to COVID-19 have been significant. Department of Health guidelines include reducing the number of people confined to the space due to physical distancing requirements and other changes in procedures meant to lessen the potential for disease spread. Agency staff dealing with their own personal concerns, including their risk for infection, makes providing crisis stabilization services more challenging. When vaccinations became available, it was the expectation of the facilities that they would soon be able to provide more intense care for more class members and potential class members; however, as variant strains of COVID-19 multiplied, facilities have continued to utilize measures of precaution to ensure the safety of the clients and of the attending staffers. Contracted facilities report that the increased cost of testing materials and PPE remains a concern as they are spending more and more to maintain and sanitize for overall safety and this cost is above their reimbursement funded amount. Additional concerns are:

- Workforce reduction due to fear of exposure and direct contact with symptomatic individuals.
- Increased difficulty filling vacant positions as more potential staffers are looking for virtual or limited contact employment opportunities.

- Facilities reporting an increase in the length of stay as services they would normally link individuals to for follow up care are also reducing the number of individuals they are serving and admitting.

- Reduction in the number of referrals from law enforcement has been reported from facilities where they have reduced their crisis bed availability to maintain social distancing.

Each contracted agency providing CS/CT services that received enhancement funds in the Phase 1 regions report continued efforts to increase its relationship with law enforcement to receive referrals, drop-offs and holds.

Areas of Concern

Intentional planning is required to address the needs of individuals who are referred by law enforcement as either drop-offs or holds as most facilities did not envision this population for their services. To address this, facilities were provided with enhancement funds to increase their staff as needed or to retain staff that might have been recruited to other higher paying facilities or industries. Without these ongoing Trueblood enhancement funds, resources and staffing may be insufficient or ill-prepared to meet the needs of this population and law enforcement personnel are unlikely to utilize the facility as a viable option if referrals are infrequently accepted. Competing services and dwindling numbers of employment capable populations are seen nationwide in this workforce, which is concerning. HCA has created a workforce administrator who works with Trueblood contracted services to provide technical assistance for addressing this need.

CS/CT facilities provide services 24 hours per day, 365 days per year throughout the state, so CS/CT facilities must be able to provide timely behavioral health assessments, evaluate behaviors, and rapidly stabilize individuals presenting as symptomatic. Individuals admitted from a police hold are required to be examined by a mental health professional within three hours of arrival, not counting time periods prior to medical clearance, if needed. Therefore, it is important that facility standards be reevaluated and redesigned to provide brief optimal services. HCA has worked with the Department of Health to support the use of recliners for individuals requiring only a short-term stay of under 23 hours reserving the standard beds for individuals who merit longer treatment stays, enabling the CS/CT facility to utilize the beds for individuals requiring longer respite and stabilization.

Similarly, another concern revolves around the ability to break individual cycles of perpetual crisis by introducing immediate housing and follow-up supports. An aspect of these supports includes funding emergency hotel/motel vouchers that were designed to aid in supporting individuals who would have historically cycled through the crisis system. Additional steps

include exploring the use of per diem services for individuals that require less intensive follow-up care.

It has been previously noted that the current crisis service delivery landscape in Washington state is very dynamic. This was very evident in the Trueblood Phase 1 regions where some providers closed facilities such as Telecare in the Southwest region; however, Lifeline Connections opened, filling some of the void left by Telecare's closure. Other changes in the behavioral health landscape include the unexpected closure of Elahan Place in the Southwest region reported to the HCA on July 24, 2021. The newly created Recovery Response Crisis Stabilization center in the Pierce region began admissions on August 18, 2021. Additionally, the nearly completed Spokane Crisis Stabilization facility is scheduled to begin admissions by October 15, 2021. The addition of these resources will help support the needs of the regions where they are situated.

Recommendations to Address Concerns

HCA will continue to work with CS/CT providers to enhance their ability to serve people with mental illness being diverted from arrest and jail. To address the behavioral health workforce shortages that exist statewide, HCA has created a workforce administrator who works with Trueblood-contracted services to provide technical assistance for addressing workforce needs.

The planned enhancements are intended to increase the expertise and infrastructure to support this population and improve coordination with law enforcement. Despite the reluctance initially expressed by providers, they have been open to learning more about how to serve the population and are accepting the enhancement opportunities offered through the Trueblood implementation plan.

HCA has met with community behavioral health agencies to discuss the creation of community based per diem services to provide follow-up care for an individual once discharged from a CS/CT facility. This service will provide a behavioral health safety net and work to ensure a safe and successful transition of care. This per-diem service will further assist in reducing the number of individuals diverted into CS/CT facilities by providing increased community oversight and services. HCA is working with Lifeline Connections in the Southwest region to improve the referrals and drop offs from law enforcement. To date the numbers of law enforcement drop-offs are significantly less in the Southwest region versus the other two Phase 1 regions.

The three Phase 1 regions reported the following information in their last quarterly reports:

- The Southwest region accepted 11 drop-offs or law enforcement involved individuals
- The Spokane region accepted 65 drop-offs or law enforcement involved individuals

- The Pierce region accepted 138 drop-offs or law enforcement involved individuals

To address the dynamic nature of the crisis service provider network, HCA staff has engaged in relationship building with crisis provider organizations and their regional partners. HCA staff will continue to provide technical assistance and resources as implementation progresses, including linking these providers with resources and making them aware of related initiatives that will further support strong crisis service systems. HCA is once again collaborating with the Department of Commerce along with an interagency selections of subject matter experts (SME) in the development of a request for proposals to support the addition of two 16-bed CS/CT facilities in the King region for Phase 2 of the Trueblood implementation plan.

Emergency hotel/motel vouchers provide an important opportunity to decrease an individual's contact with law enforcement and to lessen their likelihood of either being arrested or hospitalized. Voucher use, along with the opportunity to partner with the FHARPS teams, has allowed for a warm handoff while providing needed support and housing. Funding for this service may require adjustment to address a larger geographic population and to ensure adequate ability to serve clients. Emergency vouchers to support any individuals presenting in need has allowed for the expansion of these services.

Data – Crisis Triage and Diversion – Additional Beds and Enhancements

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

Crisis Triage and Diversion – Residential Supports

Residential supports connect individuals with housing through peer support and subsidies for costs such as application fees, security deposits, and several months of rental vouchers while individuals are assisted with finding more permanent housing support. This model fosters engagement with other individuals who have lived experience and are certified to provide peer support.

Current Status and Areas of Positive Impact

Michael Donovan accepted the position of FHARPS program manager, taking over the role from Nicole Mims on July 1, 2021. Prior to this, he helped stand up the Forensic Navigator Program at DSHS in 2020 and served as a navigator in the Pierce region. Michael also has experience as a program coordinator for the Trueblood contempt funded, transitional supported housing program in King County. He has begun providing targeted technical assistance to FHARPS teams in the phase 1 regions around evidence-based strategies for engaging Trueblood class members who have been diagnosed with antisocial personality disorder and borderline personality disorder traits, focusing on non-clinical interventions for certified peer counselors.

The four Phase 1 FHARPS teams continue to enroll, house, and provide targeted supports to individuals who have had engagement with the forensic mental health system. Each team has assisted individuals to obtain temporary, transitional, and permanent housing. FHARPS teams are very aware of the need individuals have for other community-based services and each team has referred multiple clients to supported employment programs as well as medical, dental, or eye care in their local communities.

HCA staff continue to facilitate regularly scheduled meetings in all three regions to improve care coordination, increase ease of communication and service delivery, and provide technical assistance to the teams in each region. FHARPS peers attended a multi-week, half-day training on intentional peer support, exploring ways to create mutual relationships where power is negotiated, co-learning is possible, and support goes beyond the traditional notion of "service." Ongoing technical assistance is also being provided to FHARPS teams specifically around data collection and service delivery. HCA provided instruction on how to submit data through a new automated process and began automated data validation for each of the FHARPS teams in August 2021.

HCA continues to review and approve or deny requests for exceptions to the rule on a case-by-case basis, when need is demonstrated and clients might otherwise reenter the criminal court or forensic systems. Since initiating this process, HCA has approved over 25 requests for extensions, when FHARPS providers have reported that clinically unique individuals who have shown improvement in the program would likely experience unstable housing and/or homelessness if FHARPS support services and/or subsidies were not extended.

Emergency Housing Vouchers
One of the five crisis stabilization facilities located in the Phase 1 regions unexpectedly closed on July 31, 2021. HCA worked immediately to reallocate housing subsidy funds to the two other facilities who utilize the most housing vouchers. Each of the remaining four facilities continues to issue short-term housing vouchers to people discharging and who are experiencing homelessness.

HCA has also created and distributed a discharge planners toolkit to each of the four crisis stabilization sites to enhance their knowledge of community-based supportive housing resources and programs for the broader population of those with a clinical need. The goal is to ensure that everyone exiting these facilities who utilizes a short-term housing voucher is also connected to community-based programs for ongoing support and linkage to resources.

Areas of Concern

The effects of COVID-19 continue to directly affect FHARPS teams' ability to stably house individuals for longer periods of time. FHARPS teams continue to engage with landlords who express a reluctance to fill their vacancies due to the statewide eviction moratorium. Landlords have stated they would rather leave their units empty than "risk" occupying them and having difficulty removing the tenant. Multiple hotels and motels have now also reduced the number of maximum days an individual can stay from 30 days to less than two weeks to avoid the perceived risk of a tenant's rights transformation.

Master leasing has been an option for FHARPS-contracted behavioral health providers since the program launched in March 2020. However, most of our community partners have not pursued this housing method. HCA sent a letter of support to FHARPS teams to address concerns, clarify questions about how to structure master leasing, and highlight resources that could help providers use the master leasing strategy.

Recommendations to Address Concerns

At the request of FHARPS teams and other Trueblood projects to address challenging behaviors of individuals enrolled in the various programs, the FHARPS program manager will provide technical assistance and training on specific interventions related to ASPD and BPD, areas in which he has specialized training. ASPD and BPD have been found to represent a criminogenic blend of traits that are overrepresented in the forensic samples, and due to the stigma that surrounds participants with traits of either, targeted technical assistance on best practices when engaging individuals with personality disorders will be offered on at least a monthly basis. The teams have also attended trainings on motivational interviewing and other evidenced-based techniques to help participants overcome their barriers to successful placements in housing.

Using short-term housing subsidies to aid people in obtaining shelter-based housing including hotels, motels, and other temporary placements is necessary due to the number of unhoused people coupled with a lack of permanent supportive housing vouchers/subsidies across our state. Unhoused and unstably housed populations are also a mixed group of people, some of whom prefer shelter-based strategies and some of whom do not. FHARPS teams use housing subsidies to obtain shelter-based housing solutions when a person has expressed a clear desire for shelter-based housing, or in some cases, for brief periods of time, when shelter-based strategies appear to be the only available option. HCA encourages FHARPS teams to have communicated with individuals the temporary nature of a shelter-based solution at the outset of any shelter-based housing placement and to have articulated a plan for when and how an individual will be able to access more permanent housing solutions. As part of the effort by HCA to continue to support providers by remaining flexible in our efforts, HCA has also begun creating guidelines for use of housing subsidies particularly for motels, hotels, and other shelter-based strategies, and for use in master leasing projects.

Providers expressed concern around increased liability when engaging in master leasing projects and HCA was able to alleviate many of these concerns since HCA can share program dollars for housing-related needs across programs. HCA program managers met with multiple FHARPS providers to provide technical support regarding these projects and at least two master leasing projects are expected within the next contract year.

Disability Rights of Washington issued an RFP regarding housing acquisition projects using Trueblood contempt funds and one of our providers in the Southwest region was awarded the housing acquisition funding to purchase housing for the Trueblood class member population[6]. DRW and HCA are also going to present to the Affordable Housing Advisory Board this fall on housing efforts. HCA is working on a presentation to encourage AHAB to prioritize Trueblood class members and potential class members as a priority population. In a continued effort to braid together all housing resources and subsidies, DBHR is also working with the Department of Commerce so that FHARPS teams will be able to access long-term housing vouchers and increase housing stability for FHARPS-eligible individuals through the Community Behavioral Health Rental Assistance Program.

The following success story details the work the FHARPS teams do to support an individual through the process:

An FHARPS-eligible individual who was approved for an exception to rule and who has been working with FHARPS for approximately eight months had gone through multiple instances of detox. The individual was moving from hotel to detox programs on a regular basis, which was making it difficult to work on long term housing goals. She was initially not ready to begin thinking about entering a

[6] The Spokane region also received an award, and the King region received an award for Phase 2 of the Settlement Agreement implementation.

longer-term substance use disorder treatment program, but eventually and independently sought out that treatment and completed the program. She was successful in a hotel after treatment for more than 30 days and remained sober, while she was able to work with a peer counselor on longer-term-housing goals. She was able to access a shared rental unit, paid for with FHARPS subsidies and remained successful in this housing with continued FHARPS supports. Subsidy funds were also made available to aid the client with car repairs and subsequent employment services. She has been receiving retention services twice monthly and recently reported securing full-time employment. She is thankful for the opportunities provided to by FHARPS team and the 'hand up' to get back on her feet. She stated, "My next goal is to reach one year of sobriety. Oh, and to get a raise!"

Data – Crisis Triage and Diversion – Residential Supports

Residential supports are provided through two mechanisms: (1) crisis housing vouchers provided by crisis triage and stabilization facilities; and (2) the FHARPS program. A data tracker was created for each program as an interim data collection tool until a long-term solution is identified and implemented by HCA. Facilities and FHARPS providers submit the data as required by their HCA provider contracts. Data should be considered preliminary as the program and data improvements evolve.

Vouchers Data

The crisis stabilization and triage facilities contracted to provide housing vouchers distributed 197 vouchers to 143 individuals between December 1, 2019 and June 30, 2021 (Appendix D, Table 1). Spokane distributed the majority of vouchers (58 percent). The total amount disbursed was $195,044 and the average amount per recipient was $1,364. Voucher recipients leaving CS/CT facilities were there based on referrals from a number of sources including hospitals (47 percent) and self-referrals (17 percent).

Overall, most voucher recipients were male (66 percent), between 30 and 39 years old (60 percent), and non-Hispanic White (64 percent). Starting March 1, 2020 (when FHARPS began), some voucher recipients were referred to FHARPS, where they may be eligible for additional support. Based on matching housing voucher and FHARPS program data, about two-thirds (64 percent) were referred to FHARPS, 59 percent were enrolled, and 50 percent were housed or sheltered through FHARPS. The majority of initial housing placements through FHARPS were shelter/emergency placements (89 percent), which includes motels. Not all voucher recipients are eligible for FHARPS. Case notes indicate some recipients were referred to other housing support programs not tracked in the available data.

FHARPS Data

A total of 760 individuals were referred for FHARPS services from March 1 to June 30, 2021 (Appendix E, Table 1). Of these referrals, 461 (61 percent) were contacted[7] and 418 (55 percent) were enrolled.

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 50 percent of referrals. Crisis stabilization and triage (CS/CT) facilities referred 136 individuals. In the Spokane region, CS/CT facilities made up 23 percent of referrals, and 39 percent of initial contacts by FHARPS staff occurred at CS/CT facilities in Spokane region. Outpatient behavioral health facilities were responsible for 20 percent of referrals. The majority of initial contacts were made by phone (71 percent); this rate was highest in the Southwest region (99 percent).

Two-thirds of individuals (66 percent) enrolled in FHARPS were male, 57 percent were between 30 and 49 years old, and 55 percent were non-Hispanic white. Most individuals were homeless at the time of enrollment (76 percent).

Of those enrolled, 98 percent opted to receive housing support services and subsidies, and 86 percent were housed or sheltered during the reporting period (Appendix E, Table 2). About 68 percent of first housing types were emergency/shelter placements, which includes motels. Over six in 10 (64 percent) individuals enrolled between March 1, 2020 and June 30, 2021 were also discharged during the period, with an average length of support of 155 days (Appendix E, Table 3). The average total subsidy support received by those discharged was $5,095.

Among individuals with closed cases, 34 percent were closed due to loss of contact, 15 percent transitioned to other housing support, 15 percent received the maximum subsidy without transition to other program support, and 13 percent transitioned to self-support. Housing status at program discharge was unknown for 37 percent of individuals (consistent with the loss of contact rate), while 31 percent were stably housed, and 18 percent were homeless.

Data quality improvement efforts continue. Additional details will be provided as data mature and improve.

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

Crisis Triage and Diversion – Mobile Crisis and Co-responders

Currently in Washington, mobile crisis response services are provided 24 hours per day, 365 days per year throughout the state, under HCA's contracts with regional Behavioral Health Administrative Service Organizations. MCR is an integral part of the regional behavioral health crisis system and is designed to provide community-based services to individuals experiencing, or at imminent risk of experiencing, a behavioral health crisis. MCR offers law enforcement and first responders an option for diverting people from the legal system while providing community-based interventions supporting people through least restrictive community-based behavioral health options intended to support and stabilize acute symptomology. The goals of these services are engagement, symptom reduction, and stabilization. In some large rural communities, MCR services are provided by designated crisis responders while other communities are served by dedicated crisis interventionists. According to contract, MCR teams are required to meet a response time of two hours or less. Based on community discussions with the three Phase 1 regions, the majority of MCR teams report that they are responding within 90 minutes or less.

Current Status and Positive Impacts

Under the Trueblood implementation plan, HCA sought to enhance the regional MCR service provision by working with the BHASO to identify what enhancements would be needed in their region to support the goals of the implementation plan. These enhancements will support and provide supplemental assistance to traditional MCR services. The three Phase 1 regions designed their enhanced services to provide a timelier response to community crisis calls and to ensure acceptance of referrals from law enforcement as well as from co-responder teams.

Additional supports will be seen in Washington state with the activation of the 988 crisis line. This crisis line will provide support for individuals in crisis through the deployment of behavioral health professionals and certified peer counselors with life experience rather than law enforcement officers. This additional level of intervention will aid in the reduction of arrest while also supporting the needs of the individual experiencing an emotional or behavioral health crisis. The legislature intends to establish a coordinated crisis hotline center and crisis services system to save lives by improving the quality of aid and the access to behavioral health crisis services. The crisis line will comply with the national suicide hotline designation act of 2020 as well as the Federal Communication Commission's rules adopted to ensure that all Washington residents receive a consistent and effective level of crisis behavioral health services no matter where they live, work, or travel in the state. Another goal of the crisis line is to provide higher quality support for people experiencing behavioral health crises through investment in new technology to create a crisis call center system to triage calls and link individuals to follow-up care. Other efforts to improve crisis services include the expansion of crisis teams, to be known as mobile rapid response crisis teams, as well as a wide array of crisis stabilization services such as 23-hour crisis stabilization units based on the living room model, crisis stabilization centers,

short-term respite facilities, peer-operated respite services, and behavioral health urgent care walk-in centers. The overall crisis system shall contain components that operate like hospital emergency departments that accept all walk-ins, ambulance, fire, and police drop-offs.

The addition of CPCs to existing mobile crisis teams will be implemented statewide. The goal of adding CPCs to the mobile crisis teams is to improve engagement and infuse a sense of hopefulness in individuals experiencing behavioral health crisis. In their role as a member of the mobile crisis response team, the CPC will offer emotional support, share knowledge, teach skills, provide practical assistance, connect individuals with community resources, and offer opportunities for recovery. CPC services will be provided through traditional MCR services in a targeted effort of offering least restrictive, trauma-informed alternatives for individuals experiencing a behavioral health crisis. The MCR teams' utilization of CPCs will enhance services to individuals by offering their lived experiences, modeling recovery, and intervening in the crisis situations to avoid arrest, re-arrest, incarceration, hospitalization, or involuntary detainment.

Overall enhancements have included:

- Increasing team staffing
- Redefining personnel roles
- Expanding established work hours
- Providing coordinated services with tribal services
- Developing or maintaining active communication with law enforcement offices and co-responders' divisions

Additionally, each region developed and implemented specific enhancements to include:

Spokane region
MCR services are contracted through the Spokane BHASO. The contracted agencies are Frontier Behavioral Health and Adams County Integrated Health Care Services.

- Frontier Behavioral Health is developing and implementing a Trueblood-centered segment of its mobile crisis service designed and trained to work with individuals who are identified as either class members or potential class members. FBH reports a long history of providing crisis intervention services, operation of the regional crisis line, and is currently piloting a co-deployment team with the Washington Association of Sheriffs and Police Chiefs to respond to individuals presenting with mental health distress.

Frontier Behavioral Health's MCR services are in operation 8 a.m. to-5 p.m. and 2 p.m. to-11 p.m. Monday through Friday. This coverage has been going well and staff are providing same-day outreach support during these hours of operation; however, due to some recent changes in staffing, there may be times when the team is not able to respond on the same day.

- Frontier Behavioral Health also has expanded its MCR services outside of Spokane County to assist with and to address the needs of neighboring rural counties.

- Adams County Integrated Health Care Services is creating a linkage to requested/necessary resources in the community for family and individuals while shoring up its frontline assessment services. Adams County, recognizing its multicultural needs, enrichened its staffing by hiring a Spanish-speaking mental health professional to meet the needs of its Spanish-speaking residents.

- Both Frontier Behavioral Health and Adams County continue to coordinate with co-responders and law enforcement. Frontier Behavioral Health MCR continues to provide follow up to all police reports provided and 911 caller/crime check caller reports. Frontier Behavioral Health staff have been communicating with the Co-Responder Program supervisor and the Co-Responder sergeant frequently, regarding referrals to MCR. Additionally, Frontier Behavioral Health MCR staff and the Co-Responder Program continue to discuss ways to improve coordination efforts across these teams. In June, the Frontier Behavioral Health MCR team met with the Behavioral Health Unit to discuss ways to increase the efficiency of triage through 911 caller reports and to improve communication regarding outcomes between the Behavioral Health Unit and the MCR services.

Pierce region

MCR services are contracted through Beacon in Pierce County. These services are provided by Multicare Behavioral Health's mobile outreach crisis team.

- Providing a more rapid response time for interaction with law enforcement and co-responders by expanding coverage area and creating two service bases to cover the region. After being fully staffed in Q1 2021, the team experienced several staffing changes in the second quarter including the resignation of the supervisor. The supervisor position was filled in June. One of the care coordinators resigned to pursue her master's degree and the other care coordinator moved to an open crisis position in the MOCT, leaving both care coordinator positions open. MOCT is actively recruiting to fill open positions.

- Coordinated communication with tribal and law enforcement partners. MOCT continues to meet regularly with law enforcement, community hospitals, E&Ts, and local providers.

The team attends the Pierce monthly Crisis Collaborative and provides updates on the progress of the Enhanced Mobile Crisis Team. The meetings consist of general information about the mobile crisis team, referral processes, ways to increase coordination of individuals into the crisis system rather than legal system when appropriate, any new changes and outreach efforts.

- MOCT continues to provide follow-up services to many of the individuals they encounter in crisis. This includes checking in with them and their family as well as getting them connected with appropriate services for mental health, substance use, primary care, or specialty care. The MCR team continues to work closely with co-responders to receive follow-up referrals. The team has made great efforts to reduce response times and they are focused on capturing and reporting more accurate data related to response times.

Southwest region

MCR services are contracted through Beacon. The community providers are Sea Mar Adult Mobile Crisis Intervention in Clark County, Comprehensive HealthCare in Klickitat County, and Skamania County Community Health in Skamania County.

- Sea Mar AMCI increased its coverage pool, from six mental health providers and one 2nd for Safety/non-mental health provider staff, to 10 mental health providers and two 2nd for Safety/non-mental health provider staff. This on-call staffing has been retained successfully. Additionally, an RN with mental health provider status began with AMCI on April 26, 2021, and a full-time CPC started with AMCI on July 20, 2021. Sea Mar is in the process of hiring an additional part-time mental health provider as well as a part-time CPC who are expected to begin in the next three-to-four weeks (one is an internal transfer). Sea Mar successfully met the goal of expanding AMCI hours to midnight on June 1, 2021 (one month earlier than initially proposed), which has been a significant enhancement in services to the larger community. A stipend was added for mental health providers who work until midnight, which seemed to buffer the effect of expansion upon staff and led to an overall boost in morale. Sea Mar will continue to explore financial incentives to assist with staff retention.

- Comprehensive HealthCare continues to provide outreach services in the community to increase awareness of their mobile crisis team. Staff continue to conduct ongoing outreach and education to community hospitals on how to access the program. Comprehensive HealthCare reports that they recently hired a second crisis case manager to assist furthering the implementation of the mobile crisis program. Other community outreaches include meeting with adult and juvenile probation and court-appointed Special Advocates to discuss the mobile crisis program, developing professional working relationships, and to gather feedback on ways the program can be of greater assistance.

- Skamania County Community Health reports that its behavioral health post-crisis follow-up service pilot program had five referrals for this reporting period, up from one in the last reporting cycle. Their primary referral partners for this program are law enforcement and Emergency Management Services. Skamania reports that law enforcement has made 100 percent of the referrals, so increased communication and education is needed to increase referrals from EMS. Considering the often disconnect with first responders when referring for services, Skamania is looking to revamp its referral form to require more individual contact information. Skamania County Community Health reports regular participation in local and regional collaboration meetings, and coordination with law enforcement, EMS, probation, and prosecutor's office on programing and identifying community needs.

Areas of Concern

In consultation with HCA and DSHS staff, regional representatives from the crisis response systems, and local rural law enforcement representatives, stated that they struggled with managing the need for providing secure transportation for people who needed to be brought to metropolitan areas for treatment. These trips take the already limited number of officers offline during transport, which can take hours depending on the distance traveled. Another concern was that in the most rural areas, despite having funding to hire staff, qualified candidates simply do not apply to work in these remote regions. Additionally, some regions possess very limited health care or behavioral health care treatment options.

The review and assessment of the MCR enhancement plans from the three regions must take into consideration the local needs and challenges the BHASOs encounter when improving MCR services.

Recommendations to Address Concerns

HCA, the Accountable Communities of Health, and WASPC have been in conversation about strategies to address transporting individuals from rural areas who are experiencing a mental health crisis. HCA, through its Misdemeanor Diversion funds, has provided WASPC funding for rural regions for safe/secure transportation of individuals in a mental health crisis to crisis triage/stabilization facilities, evaluation and treatment facilities, and secure withdrawal management facilities.

A regional approach to enhancing MCR services must be flexible to meet the needs of each specific region. In reviewing BHASO contracted service delivery standards, a one-size-fits-all approach will not work. The needs of each community, albeit urban or rural must be taken into consideration. Regional MCR services must be flexible in considering settings where crisis intervention can occur, the methods utilized, and the ways to address staffing shortages by employing a variety of service provider types.

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

Data from the contracted MCR providers was submitted to HCA's Behavioral Health Data System by January 31, 2021. DSHS and HCA have been reviewing data submitted from the providers contracted to provide the expanded MCR services. This is the first collection and review of data associated with this program. Unfortunately, the initial processing of this data has revealed several major deficiencies in the data. Some of the deficiencies include:

- Community providers submitting incomplete or incorrect data about MCR encounters.
- Updated data entries sometimes result in duplicative entries for the same encounter, or unintended modification of the response time data associated with that MCR encounter.
- The current data fields being collected do not provide all of the data necessary for a sufficient analysis.
- Some encounters outside of the Phase 1 area are mistakenly included in reporting, because the data-system is a statewide resource used by all providers.

Efforts are underway to identify solutions and implement fixes to improve data collection. These efforts include consideration of a corrective action plan to address past reporting, but also efforts to ensure future reporting does not suffer from the same problems. Because these services are embedded in the larger community mental health delivery system, data collection occurs through a much larger data system that is used by all providers across the whole state. The initial changes to the system to collect this data required a substantial lead time. The necessary modifications to improve the data system, and introduce error checks to prevent future reporting of erroneous data by providers, will likely have a similarly long lead time.

When data are of sufficient quality, the number of interventions, individual characteristics of those served, and average response time will be reported through the Trueblood Quarterly Dashboard (see Table 2). The Washington Association of Sheriffs and Police Chiefs is responsible for co-responder's data.

TABLE 2. **PRELIMINARY EXAMPLE**

Mobile Crisis Response Interventions and Client Characteristics

QUARTER

	TOTAL - ALL REGIONS	
	NUMBER	PERCENT
TOTAL POPULATION		
Individuals Served (unduplicated)	888	88%
Among Served Individuals…		
GENDER		
Female	888	88%
Male	888	88%
AGE GROUP		
18-29	888	88%
30-49	888	88%
50+	888	88%
RACE/ETHNICITY		
Non-Hispanic White	888	88%
Minority	888	88%
RESPONSE TIME/DURATION		
Average Response Time (hours)	888	88%
Average Duration (minutes)	888	88%

DATA SOURCE: Washington State Health Care Authority (HCA) Behavioral Health Data System (BHDS)[8].

[8] Table 2 above does not include data from WASPC. Per the *Trueblood* implementation plan, WASPC independently collects data on co-responders.

Crisis Triage and Diversion – FPATH

As part of the Trueblood Agreement, the state is funding enhanced outreach and engagement to connect identified individuals with behavioral health services using a federal model called Projects for Assistance in Transitions from Homelessness. In the Settlement Agreement, this program is called Intensive Case Management for High Utilizers. HCA, in partnership with DSHS' RDA, created a referral list to identify individuals who are at risk of repeat court orders for competency evaluations. RDA identified individuals with two or more competency evaluation orders in the last two years who are at higher risk of future intersection with the criminal court system. FPATH is focusing outreach and engagement efforts to individuals on that list who are predominately homeless or have had multiple competency evaluations.

FPATH teams, within community behavioral health agencies, will include enhanced certified peer counselors who have experience working with individuals who may be experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years. Using a model similar to the PATH, teams will seek out people, assertively engage and assist them in getting connected to community supports including housing, transportation, and health care and behavioral health services. People court-ordered for forensic navigator/outpatient competency restoration may also utilize FPATH for case management services.

Current Status and Areas of Positive Impact

FPATH teams have been providing targeted outreach and engagement to people identified on the referral list since March 2020. Using a model similar to the federal PATH program, teams have been reaching out to eligible individuals with an emphasis on homeless or unstably housed individuals. The goal is to connect people with community resources and services by building relationships and rapport. While most of the eligible individuals are homeless or unstably housed, some are not. In all instances, teams seek out the individual "where they are at."

All FPATH teams are located within a community behavioral health agency that has a history of providing outreach and engagement services, which allows for warm handoffs to other needed services to include certified peer counselors who have experience working with individuals who may be experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years.

Teams continue to prioritize their outreach and engagement efforts to individuals prioritized by the following criteria: individuals living in rural areas, individuals who have had four or more referrals for competency evaluation in the past 24 months regardless of housing status, and/or individuals experiencing homelessness. The intent behind prioritization is to assist in connecting those most at risk of additional referrals for competency evaluations to services in hopes of diverting them away from further justice involvement.

FPATH teams have increased their referrals and coordination with the FHARPS program for housing supports. Eligible persons interested in seeking housing assistance are referred to FHARPS. This information is currently being tracked by FHARPS. HCA is working with FPATH providers to better track referrals to FHARPS on their monthly data submissions.

FPATH teams have participated in trainings on SSI/SSDI Outreach, Access, and Recovery and Cultural Humility training provided by tribal agencies. The team at Frontier Behavioral Health completed additional diversity, equity, and inclusion training specific to individuals who are court involved.

FPATH teams from across the state participated in the value stream mapping exercise. As a result of this process, it was decided that there was some need for further guidelines or "best practices" must be developed around outreach, engagement, enrollment, and program exit. Teams and the FPATH program administrator will work over the next several months to develop them.

Areas of Concern

Due to the lag time between FDS and RDA's generation of the referral list, some individuals referred by the forensic navigators are not appearing on the referral list. While the list does not ultimately control eligibility, this lag can sometimes make it more difficult to quickly identify eligible individuals. HCA and DSHS are working closely to identify a solution to this challenge, and while initially this looked like an area of concern, recent improvements made to the referral lists as well as to the referral process from the forensic navigators to the FPATH teams, appear to have resolved this concern.

Another area of concern being addressed is improving the quality of data that teams are providing. HCA is in the process of creating an automated data validation system to provide more error-free data to RDA.

Recommendations to Address Concerns

FPATH, in collaboration with RDA, DSHS, and HCA IT, is working to come up with a permanent solution to address the issue of the referral list that would eliminate the lag that is causing concern. Until this solution is identified and implemented, the interim remedy is to ensure that the appropriate referrals are being made even when an individual is not immediately found on the referral list. When a referral from a forensic navigator is not on the FPATH-eligible list, teams are accepting the referral as if the individual is eligible for FPATH services.

Technical support was being provided to teams by HCA IT Business Analysist on an almost weekly basis as HCA prepared for go-live of the automated data validation in August 2021.

Data – Crisis Triage and Diversion – FPATH

FPATH data in the current report are from the Homeless Management Information System, as well as monthly Excel trackers submitted by FPATH providers in the Phase 1 regions. Program eligibility is based on a referral list (formerly the "high utilizer list") of individuals with two or more competency evaluation referrals in the past 24 months.

The FPATH program began March 1, 2020. Between March 1 and June 30, 2021, 1,067 individuals within the Phase 1 regions were referred to the program (Appendix F, Table 1). HCA has asked providers to focus outreach efforts on a subset of these individuals based on housing status (prioritizing unstably housed and homeless), number of referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 434.

Of all individuals on the referral list, FPATH providers attempted to contact 514 (48%), and successfully contacted 315 (30%). Initial data indicate that a total of 164 individuals (15% of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Of these, the majority were male (80%) and between 30 and 49 years old (56%). More than half of enrollees (54%) were homeless, while 26 percent were unstably housed, indicating that providers are focused on enrolling those in the priority population. The Southwest region enrolled the largest portion of those on their referral list (30%).

FPATH operations and data collection methods are complex, and practices continue to evolve. Additional information on program services and referrals will be available as data from providers stabilize. Data should be considered preliminary as the program and data collection are still evolving.

Education and Training – Crisis Intervention Training

Crisis Intervention Training is designed to provide tools and resources to certified peace officers, corrections officers, and telecom/911 dispatchers in order to respond effectively to individuals who may be experiencing an emotional, mental, physical, behavioral, or chemical dependency crisis, distress, or problem. The training provides skills that are designed to increase the safety of both the emergency response personnel and individuals in crisis. Law enforcement agencies are already familiar with CIT training and several corrections agencies have begun training in the last couple of years.

Current Status and Areas of Positive Impact

To date, the Criminal Justice Training Commission has completed seven 40-hour courses for law enforcement and trained 244 certified peace officers. Within these classes CJTC has trained a total of 344 attendees who consisted of law enforcement officers, mental health professionals, dispatchers, emergency responders, security officers, and corrections officers. There are 162 officers left to train to reach the 25 percent goal in the Phase 1 regions. Please note, this does not account for state patrol and the Washington State Department of Fish and Wildlife as CJTC is determining the exact numbers in those districts. CJTC's database tracks WSP and Fish and Wildlife as a whole, not by district. Since June, CJTC completed two classes and has two more scheduled in the Spokane region. Likewise, CJTC completed one course and has a second course scheduled for the Southwest region and six courses scheduled in the Pierce region to be completed by June 30, 2022.

CJTC developed and deployed a webinar-style course to meet the needs of correctional agencies during the pandemic. CJTC conducted 24 of these classes in the first half of 2021 training 483 officers. In addition to the earlier traditional courses and the addition of Clark County's 40-hour program, 555 corrections officers have received the eight-hour CIT for Corrections training. The Lincoln and Skamania county sheriffs' departments cross train all of their corrections officers as 911 dispatchers. Those officers took the eight-hour 911 CIT training. There are an estimated 168 correctional officers left to train in the Phase 1 areas.

Phase 1 regions are now eligible to receive all 40 hours of cost coverage backfill dollars as a result of the Trueblood funding provided by the legislature. Not all agencies have availed themselves of this benefit. The CJTC team is continuing to provide significant outreach and education and has seen improvement using this available resource to remove barriers to participation.

CJTC collaborated with the state 911 office for delivery of the eight-hour CIT course for dispatchers. The telecom/911 training was reformatted to a hybrid course compromised of four hours of static online training and a follow-up four-hour webinar course. It was also found that several telecom training programs already included the eight-hour CIT materials. Several of

these programs applied and were granted equivalency status. To date, 388 dispatchers have received the eight-hour training. This brings the total of 98 percent of dispatchers in the Phase 1 regions having completed the training. Only seven dispatchers in two agencies remain.

Areas of Concern

An area for concern regarding implementation is the affects that COVID-19 had on implementing the training either in person or online. Many of those obstacles were overcome as webinar and other online training formats were developed and deployed. Low staffing levels at police agencies, which were a problem earlier, have become a greater problem. Another area of concern that has been discussed is low staffing levels in most county jails. Even with backfill and overtime provided, there are insufficient personnel to cover the shifts to allow officers to attend training. One commander stated they are already mandating corrections officers work 16 hours of mandatory overtime every two weeks, which is the maximum permitted by the relevant labor agreement. Another concern primarily impacts smaller law enforcement agencies: allowing an officer to leave the jurisdiction for a week of training. While smaller agencies have only a few officers to train, one officer represents a significant percentage of the overall police force. The loss of one officer to attend a 40-hour training course is extremely difficult to absorb within existing resources, even with the available backfill funding.

Recommendations to Address Concerns

CJTC deployed an eight-hour corrections course that is being offered via webinar. This training was offered 24 times since January 1, 2021, and had a significant positive impact on the numbers of corrections officers completing this training. With the reduction in pandemic closures, CJTC has been able to gradually increase offerings of the 40-hour course. CJTC has scheduled 10 trainings in the Phase 1 areas for the remainder of the fiscal year and has also increased backfill/overtime funding from 16 hours to the full 40 hours within the present budget. Agencies located more than 50 miles from their regional training sites are also eligible for lodging and per diem reimbursement. CJTC has increased outreach and communication to small agencies working with them to overcome coverage and financial barriers.

Data – Education and Training – CIT

CJTC monitors law enforcement training completion rates through a Learning Management System. Per the Agreement, 25 percent of patrol officers in each law enforcement agency were required to complete 40 hours of enhanced CIT by June 30, 2021. Trainings began July 1, 2019. Figure 4 displays training completion rates for each individual law enforcement agency in the Phase 1 regions. As of June 30, 2021, 18 of the 51 law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies had higher training completion rates than small agencies in all three regions.

As of June 30, 2021, 14 percent of officers were trained in the Pierce region, compared to 52 percent in the Southwest region, and 42 percent in the Spokane region (Table 3). Previously, these rates were 18 percent, 48 percent, and 41 percent, respectively (see September 2020 Semi-Annual Report). Statewide, Washington State Patrol units have demonstrated a training rate of 16 percent. Due to the impact of COVID-19, in-person trainings continue to be impacted throughout the state.

The Settlement Agreement also states the 25 percent training target should prioritize agencies that serve areas with higher population densities. As of June 30, 2021, large agencies serving the areas of greater population density within the Southwest and Spokane regions have higher rates of training completion (Southwest 61% and Spokane 53%) than the Pierce region (14%, Table 4 below). Similar rates were observed in the March 2021 semi-annual report.

The Agreement also requires all 911 dispatchers and correctional officers complete an eight-hour CIT course by June 30, 2021. As of June 30, 2021, nearly all 911 dispatchers had completed CIT training, with completion rates of 100 percent in the Pierce region, 99 percent in the Spokane region, and 100 percent in the Southwest region (Table 5). In addition, approximately 80 percent of correctional officers in Phase 1 regions completed CIT training, ranging from 79 percent in the Pierce region to 82 percent in the Southwest region (Table 6).

TABLE 3.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Region

JUNE 30, 2021

Region	# of Officers	# of Officers Trained	% Trained
Pierce Region	973	140	14.4%
Southwest Region	482	252	52.3%
Spokane Region	731	306	41.9%
Statewide - Fish & Wildlife	11	3	27.3%
Statewide - WA State Patrol	270	42	15.6%

DATA SOURCE: Washington State Criminal Justice Training Commission.

TABLE 4.

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

JUNE 30, 2021

Region	Pierce Region			Southwest Region			Spokane Region			Statewide - Fish & Wildlife			Statewide - WA State Patrol			TOTAL - ALL REGIONS		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained
Large	641	91	14.2%	342	208	60.8%	537	285	53.1%				110	6	5.5%	1630	590	36.2%
Medium	283	45	15.9%	119	31	26.1%	153	15	9.8%				160	36	22.5%	715	127	17.8%
Small	49	4	8.2%	21	13	61.9%	41	6	14.6%	11	3	27.3%				122	26	21.3%

DATA SOURCE: Washington State Criminal Justice Training Commission.

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington state. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1 regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course.

TABLE 5.

Crisis Intervention Training (CIT) Program Measures
Number of 911 Dispatchers Trained, by Region

JUNE 30, 2021

Region	# of Dispatchers	# of Dispatchers Trained (Total)	# of Dispatchers Trained post-2019 (including LE/Military)	% Trained (Total)
Spokane Region	174	172	124	98.9%
Southwest Region	81	81	81	100.0%
Pierce Region	135	135	4	100.0%
Statewide - WA State Patrol	55	54		98.2%

DATA SOURCE: Washington State Criminal Justice Training Commission.

TABLE 6.

Crisis Intervention Training (CIT) Program Measures
Number of Correctional Officers Trained, by Region

JUNE 30, 2021

Region	# of Officers	# of Officers Trained	% Trained
Southwest Region	148	122	82.4%
Spokane Region	269	216	80.3%
Pierce Region	292	231	79.1%

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington state. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1 regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers. The number of correctional officers in the Spokane Region was incorrectly reported in the March 2021 Semi-Annual Report. Previous reporting included dispatchers for Fire/EMS, which are excluded in the current report.

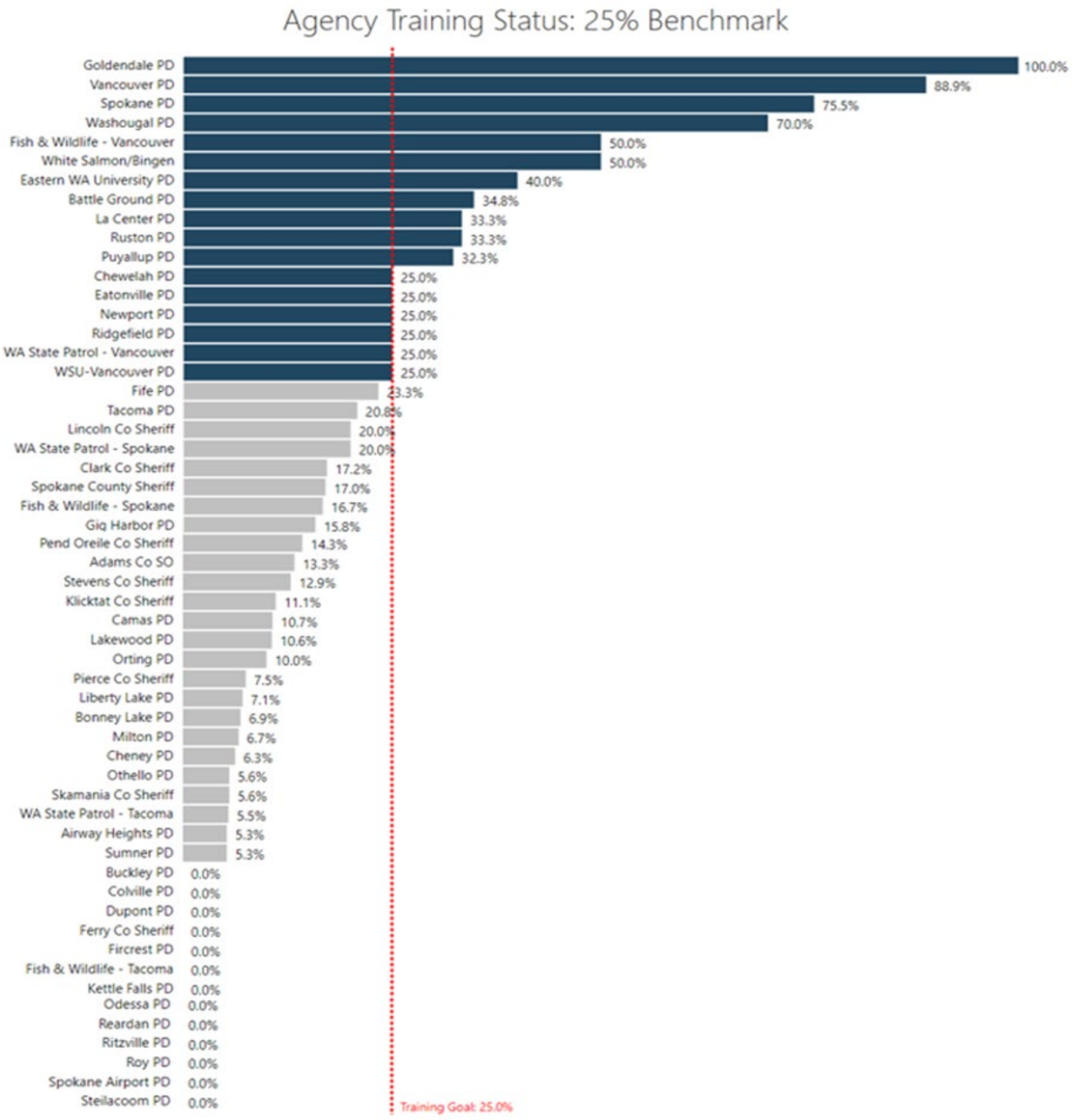
DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 4 displays training completion rates for each law enforcement agency in Phase 1 regions. Eighteen law enforcement agencies in the Phase 1 regions are meeting or exceeding the 25 percent benchmark.

FIGURE 4.

Crisis Intervention Training (CIT)
Individual Agency Compliance Metrics: Phase 1 Regions

JUNE 30, 2021



*Percent of officers who have received 40 hours of Crisis Intervention Training.
View TABLE 4 above for clarifying details on FIGURE 4.

Education and Training – Technical Assistance for Jails

The Jail Technical Assistance team has been working in collaboration with a number of entities to create a guidebook of best practices for behavioral health services in a jail setting. The initial workgroup convened on May 24, 2019 and included representation from Disability Rights Washington, WASPC, and the Washington State Office of the Attorney General. The workgroup met monthly and as needed to progress toward the guidebook's completion. Numerous revisions were made in collaboration with the workgroup. The membership grew to include the HCA's enhanced peer services program administrator and representatives from city and county jails both within and without Phase 1 regions.

The guidebook addresses the topics of pre- and post-booking diversion, identification of need and access to treatment, administration of involuntary medication, transition planning and continuity of care, and use of segregation as well as additional subject matter. The guidebook was completed on May 14, 2020, prior to the June 1, 2020 deadline. It is now available on the JTA website[9] and has served as a support document for trainings on the topics it covers.

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plan have been delivered. Webinar-based trainings continue on a monthly basis, and the schedule for these trainings has been established through December 2021. Several of the topics scheduled for delivery were identified by input from the field, including those attending prior trainings and providing feedback on additional trainings that would be useful. Other topics are extensions of prior trainings to provide greater depth of coverage than was possible in the initial training session.

Efforts are underway to extend the reach of JTA trainings and improve audience engagement. As part of this effort, the team collaborates with a BHA communications consultant to improve content and user interface of our public-facing website. JTA recently purchased licenses for a suite of authoring tools intended to create more engaging and interactive online learning experiences. During the summer of 2021, JTA staff engaged with psychology and nursing leadership within the King County Jail to identify training topics of particular interest for jail staff. JTA staff are now following up by designing a training series that will be piloted with King County Jail staff, further honed based on feedback from that group, and then made available to jail staff statewide. A central focus of this JTA training will be to increase jail staff's understanding of competency to stand trial, and how competency evaluations, competency restoration treatment and associated court activities interface with their daily work.

There has been a significant increase in the use of videoconferencing software to conduct forensic evaluations remotely. The use of videoconferencing has been an effective adaptation to

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

the limitations imposed by COVID-19 on in-person evaluations. It has also helped improve the efficiency with which competency evaluations can be completed. Members of the JTA team have been centrally involved in providing guidance and technical assistance statewide in support of this transition to increased online forensic evaluations at jails throughout the state. DSHS continues to provide support for jail-based competency evaluations to be completed via video teleconferencing. A total of 24 jails (including county, city and tribal jails) are now using video conferencing to complete approximately 150 competency evaluations per month via video teleconferencing.

Areas of Concern

A continuing area of concern is regional awareness of the JTA program. Although the foundation of the program has been established and a communication plan created, program awareness, as well as attendance (by jail staff, etc.) at trainings offered by the JTA team could be enhanced. To address this, beginning July 2021, the JTA team implemented a method of tracking the number of participants in each JTA monthly webinar. The team is also consulting with DSHS information technology staff to seek more ways of tracking the number of visits to materials on the JTA website. By gathering this information, the team aims to identify opportunities for expanding the reach of our training and technical assistance efforts.

Another area of concern is determining how the JTA program can be most effective in the delivery of training and other forms of assistance. One of the primary challenges is that jails have several common obstacles to receiving training (e.g., budget, staffing, technology), which may be a factor in the modest training attendance numbers. Beginning in July 2021, JTA staff began including a survey during each monthly JTA webinar, in hopes of learning more about how to effectively deliver training to jail staff.

Recommendations to Address Concerns

JTA had arranged to staff a booth at the spring 2020 WASPC conference and planned to deliver an awareness campaign as well as to solicit additional information regarding JTA needs. Unfortunately, this important outreach opportunity was canceled due to the COVID-19 pandemic. However, we continue to see the WASPC conferences as a major opportunity for us to expand awareness of our services. JTA staff are currently pursuing an opportunity to present at the November 2021 WASPC conference and thereby expand awareness of our training and technical assistance resources.

Data – Jail Technical Assistance

Effective July 1, 2021, the Jail Technical Assistance team implemented a method to accurately track participation in the monthly JTA training webinars.

Enhanced Peer Support

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

HCA, in partnership with OFMHS, developed a continuing education training that provides a foundational overview of the forensic mental health system. This training will be utilized to educate certified peer counselors who work on Trueblood-related services as well as other professionals who work in the forensic mental health system. This training will be co-presented by peers and OFMHS.

Current Status and Areas of Positive Impact

The Intersection of Behavioral Health and the Law curriculum was created and the training developed. Peers will learn about the components of the legal system and how they intersect with the behavioral health system. Professionals in the legal and forensic mental health systems will learn about the successful impacts and effectiveness of peer services.

All in-person continuing education trainings have been postponed due to COVID-19 and the continued need for physical distancing. HCA and OFMHS created pre-recorded overviews of the training modules to meet the May 1, 2020 deadline. These overview modules are posted on the HCA's Peer Support webpage and are available to all CPCs employed on Trueblood-related service teams, as well as CPCs in the state and other professionals who support individuals who are involved in the criminal court system.

Due to COVID-19 and the continued need for physical distancing for the foreseeable future, the Enhanced Peer Services program administrator is working on transitioning the interactive in-person training to a virtual format. Transitioning this written curriculum to a virtual format has entailed several steps and has required in-depth review by numerous parties. The virtual format is also undergoing layers testing to ensure that the content is engaging for learners, provides an interactive learning experience, and is Section 508 compliant and therefore accessible to all learners within the Learning Management System that is being utilized. Section 508 of the Rehabilitation Act of 1973 ensures those with disabilities have equal access to government information contained on information and communications technology, thereby ensuring access to government employment programs and services to which all citizens are entitled. While these additional review and testing points and the complexities of developing this online training will keep us from meeting the previous goal for project completion in summer 2021, the virtual version of the training will be completed and ready for learners by the Trueblood Contempt Settlement Agreement deadline of January 31, 2022.

The development of additional diversity, equity, and inclusion continuing education modules was funded by the legislature. Contracting for this project is currently underway. This project will be completed and ready for learners by the Settlement Agreement deadline of February 28, 2022.

On August 4, 2021, certified peer counselors on Trueblood program teams and court-funded diversion programs were invited to come together for the inaugural quarterly Trueblood CPC Learning Community meeting. Twenty-three CPCs representing teams across the state were in attendance, including CPCs working in the King region. CPCs in attendance were informed of the status of the transition of the *Intersection of Behavioral Health and the Law* curriculum to a virtual format and the link to the currently available overview modules for this curriculum were provided. The learning community focus is technical assistance, resourcing, and networking for CPCs on Trueblood program teams and court-funded diversion programs throughout Washington state.

Traditionally, people with criminal court involvement have been reluctant to move forward to become certified peer counselors because of the possibility they would not be employable. However, changes to RCW 43.43.842 decreased restrictions for certified peer counselors to access the Agency Affiliated Counselor Credential through the Department of Health. These changes are projected to expand the workforce opportunities for individuals with lived criminal court and behavioral health experiences to work in the field.

Even with the changes to RCW 43.43.842, background checks continue to provide employment challenges with behavioral health employers. These checks typically examine an applicant's criminal or substance use history, with the goal of preventing risk to vulnerable patient populations, but they may also present unnecessary barriers to employment of needed behavioral health professionals. Any changes in policy regarding the use of background checks for behavioral health workers needs to balance safety, workforce availability, and equity. There have been concerns about the availability of appropriate workforce members, some whom may have a criminal or substance use history, who can help address behavioral health care needs. For example, a CPC's primary function on behavioral health treatment teams is using their lived experience to identify with and draw support for people in recovery. CPCs are a valued part of community behavioral healthcare teams in agencies across the state: they act as guides and role models for those undergoing behavioral health treatment, and provide hope that recovery is possible. However, this lived experience may also include criminal court involvement, which can put a CPC at risk for failure to pass background checks required for employment or credentialing. When background checks are used to unnecessarily exclude individuals from providing behavioral health services due to a criminal or substance use record, the result may reduce access to behavioral health care. In 2018, the past president of Oregon's Addiction Counselor Certification Board reported that, "one-in-five behavioral health workers with a criminal history have been denied employment because of that history," despite high demand for such workers.

The Washington State Behavioral Workforce completed an 18-month, two phase project focused on the behavioral health workforce. Phase 1 of this project culminated in November 2016 with a report of initial findings regarding barriers and short-term solutions to ensure a comprehensive and effective behavioral health workforce. In the Phase 1 report, the challenges to ensuring adequate access to behavioral healthcare are complex. Making certain that Washington's behavioral health workforce can meet the state's needs will require more than just "turning on the spigot" at education programs across the state. Because the health care system is rapidly changing, workforce planning requires that attention be paid to the underlying systemic, structural, and perception challenges that affect the ability to recruit, educate, train, credential, and retain a sufficiently large and adequately skilled workforce to provide needed behavioral health services. The Phase 2 report identifies various specific issues that affect the availability and effective functioning of behavioral health occupations. These included issues related to education, regulation, and practice. Phase 2 focused on assembling more detailed information to describe the Washington behavioral health workforce and refining and updating Phase 1 recommendations as healthcare providers gained knowledge and experience regarding behavioral and physical health care integration.

The Proviso 40 Criminal Background Task Force was created as a result of the December 2020 *Washington's Behavioral Health Workforce Barriers and Solutions Phase 2 Report and Recommendations*. This report provided four recommendations related to criminal background checks. One of these recommendations, "Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks," has brought together a task force to "examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce, while maintaining patient safety measures." The Enhanced Peer Services program administrator is participating on this Proviso 40 task force as findings on background checks have proven to impact employability of CPCs, especially CPCs with forensic backgrounds, and has created a shortage of peers with the desired lived experience to fill the Trueblood-related service teams.

Areas of Concern

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

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails. There have been recent reports from certified peer counselors working with class members, in which they have had success in entering the jails by working directly with the sergeant on duty. The Enhanced Peer Services Program administrator is working with certified peer counselors who have successfully entered the jails to seek a way to operationalize certified peer counselors entering the jails. It is of note that HCA is currently undergoing a pilot, Peer Pathfinders Transition from Incarceration, in which CPCs will be added to Jail Transition Services teams. This pilot has identified contracted Peer Pathfinder agencies that have an established agreement with local jails. The Enhanced Peer Services Program administrator is included on the team that is working on this pilot and will use knowledge gained from this project to inform the operationalizing of CPCs entering jails.

Data – Enhanced Peer Support

Between March 2020 and August 2021, 26 certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 regions completed the overview modules. One additional program staff also completed the overview.

Workforce Development

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

Current Status and Areas of Positive Impact

The WFD team has been involved in a range of initiatives. In previous reports we described progress on a comprehensive training plan to provide guidance in the scope, process, and focus of training provided by WFD. In January 2021, OFMHS finalized the *Forensic Workforce Development and Jail Technical Assistance Training Plan*. This document helps define the parameters of the WFD team's functions with the broader workforce development system in the state of Washington. It is intended to serve as a strategic document in defining the work of the WFD team and be useful as a means of communicating the team's functions to key stakeholders.

Other documents developed in support of the training plan include a series of brochures illustrating the career pathways for key work positions within the forensic mental health system. These are intended as an outreach and education tool for potential members of the workforce, to be used to increase awareness of and to stimulate interest in the field, as well as to provide information about the training and qualifications required. These brochures also provide a graphic illustration of the developmental pathway for each position, and they can be used to identify key points of engagement with potential workers to steer them toward positions in the forensic mental health workforce. Six brochures were finalized in March 2021. These "Career Pathway" brochures illustrate the educational pathways for forensic behavioral health careers in psychology, social work, peer counseling, mental health counseling, nursing, and psychiatry. These brochures were designed to generate interest in forensic fields by informing prospective degree candidates of various career options and the distinct educational pathways to achieve them.

WFD team members are delivering training in support of a recently implemented New Employee Orientation program for OFMHS staff. In June 2020, OFMHS New Employee Orientation (NEO) was created to help orient new hires statewide to varied aspects of the forensic mental health system, including an overview of the *Trueblood* lawsuit. In August 2020, the Workforce Development team began to deliver trainings as part of NEO which included Philosophy of Care, Suicide Awareness, and Characteristics of Clients Served. As NEO training developed, the team also began to provide training on the Breaking Barriers curriculum for competency restoration, the Social Learning Program, and OFMHS Quality Assurance. These trainings are delivered monthly.

Workforce Development staff have also developed training in an updated version of the Breaking Barriers curriculum for competency restoration, designed to train staff at the Residential Treatment Facilities.

In June 2021, WFD staff delivered the second annual workforce development report to the legislature regarding forensic mental health workforce needs. In addition, OFMHS developed a survey to further assess training needs in the identified functional areas by February 1, 2020. On February 14, 2020, OFMHS sent the surveys to approximately 80 entities in each of the workforce development functional areas: community mental health provider organizations, inpatient facilities, and law enforcement and corrections agencies. After receiving the surveys back, OFMHS evaluated the results and incorporated the analysis in the workforce report, *The Washington State Forensic Mental Health Workforce: Assessing the Need and Target Areas for Training, Certification, and Possible Degree Programs*. This report was completed and distributed to the executive committee and to key and interested legislators in June 2021. These workforce reports analyzed the need and target areas for additional training, certification, and degree programs; examined the availability of those programs in and outside of Washington; assessed the statewide workforce needs of the Trueblood programs over the next 10 years; and included recommendations detailed by high, medium, and low cost and by long, medium, and short-term recommendations for future action.

Efforts to establish relationships and opportunities for collaboration within post-secondary education have resulted in dialogues with Shoreline Community College and the University of Washington. These discussions were deepened during 2021 as Workforce Development staff conducted structured interviews with educational partners as part of our work to prepare the report mentioned above. These conversations revealed a number of existing strengths and potential collaborations. For instance, Shoreline Community College has a series of courses in forensic topics, and consultation has begun to explore ways in which this may serve the needs of expanding the workforce required to serve the Trueblood class members. The University of Washington recently established The UW Center for Mental Health, Policy and the Law. This group has expressed interest in building partnerships. An introductory meeting was held on September 3, 2020. A follow up meeting took place March 5, 2021. Eastern Washington University's master's in social work program expressed interest in expanding its options to expose students to the field of forensic mental health. WFD will continue to build on these budding partnerships and opportunities for collaboration.

Areas of Concern

The WFD team is on track to complete all required element tasks on time or ahead of schedule. One area of concern continues to be the short- and medium-term impacts of COVID-19. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. However, we and our partners have found ways to interact online via videoconferencing

and other available means as we work to provide education and training to prepare people to enter and successfully work in this field.

Recommendations to Address Concerns

The primary focus to address the identified concerns is to expand the reach and improve the effectiveness of online methods to reach the necessary audiences. Improvement of existing websites, enhancement of online and distance learning offerings, and presentations at virtual conferences and online classes are being pursued as potential ways to more effectively reach our audiences. Towards that end, WFD purchased three licenses for the presentation software called Articulate. This format enables the creation of online trainings that are more interactive and multidimensional than PowerPoint. The WFD team has already used Articulate to deliver trainings on Abuse and Neglect, and on Social Learning Programs for DSHS staff. We are currently developing other trainings within Articulate as we have indeed found this format to be a more engaging way of presenting trainings.

Workforce Development also delivered a presentation at the Co-Occurring Disorder and Treatment Conference on October 5, 2020, titled *Forensic Workforce Development in Washington*. It explored the role of Workforce Development in building an adequate forensic mental health workforce in Washington, the goals of the team, and its place in the broader statewide system.

The Intersection of Behavioral Health and the Law manual was co-developed by OFMHS and HCA and completed in May 2020. This manual serves as a workforce training resource that addresses the history, rules, laws, services, and practices pertaining to forensic mental health settings. An overview training detailing each of the 12 modules in the manual was created, recorded, and made available online on April 29, 2020.

OFMHS Workforce Development and HCA peer support program staff co-presented a Behavioral Health and the Law workshop based on the enhanced peer curriculum at the 2020 Peer Pathways conference on August 20, 2020.

Data – Workforce Development

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

Conclusions

Behavioral health transformation is well underway in Washington state. Several new programs began operations during spring and summer 2020, and the next several months promise to be a time of immense change and progress toward continued implementation of the Settlement Agreement as these programs ramp up toward full enrollment. Noteworthy is the recent completion of the first more than 125 required tasks and deadlines as part of the Settlement Agreement's implementation plan. Accomplishment of this milestone shows significant progress since the final implementation plan's submission to the Court on June 27, 2019.

Excitement over recent progress is tempered, however, by the challenging reality continuing to face the United States and a many other countries throughout the world as of summer 2021. Throughout spring and summer 2021, COVID-19 impacts intensified as much of the United States, Washington state included, suffered the fifth – and to date most severe – wave of the pandemic. The COVID-19 pandemic continued to place significant constraints on daily life and normal operations of the state's behavioral health system. COVID-19-related impacts to Trueblood initiatives are ongoing, and additional impacts could emerge, efforts to mitigate the effects notwithstanding.

By the next semi-annual report, to be published in late March 2022, HCA and the department expect they will be in the midst of implementing Phase 2 programming in the King County region. Phase 2 began on July 1, 2021. Plans and early activities to implement services in King County are underway. Additionally, the governor recently mandated all state employees to be vaccinated against COVID-19 or face separation from state employment. The deadline for vaccine verification is mid-October, and the potential for staffing challenges to affect Trueblood implementation will become better understood at that time and in the coming months.

The state remains committed to implementing the elements of the Settlement Agreement, and continuing to improve those elements that have already been established in Phase 1. Phase 1 programs continue to gain experience serving their clients, while the state continues collaboration with Phase 2 stakeholders in preparing for successful implementations across King County.

Appendix A – Related Resources

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

State Agency Resources:

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

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

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

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

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

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

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

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

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

Trueblood *August 2021 Progress Report for the Court Monitor and Appendices A-L:* August | Appendix A-H | Appendix I | Appendix J | Appendix K | Appendix L

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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

Appendix B – OCRP Dashboard

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

The program objective of the Outpatient Competency Restoration Program (OCRP) is to provide timely and effective outpatient competency restoration services to individuals determined by the court as a) not competent to stand trial and b) appropriate for community treatment. The intent of the OCRP is to reduce the number of people waiting to receive competency restoration, to provide the services in a safe and cost effective environment, and to provide the most appropriate level of care to the individual. OCRP services began July 1, 2020.

REPORTING PERIOD

Cumulative: July 1, 2020 to to June 30, 2021

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

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Contents

TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: JULY 1, 2020 - JUNE 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	32	100.0%						
Among Enrolled Clients…								
RESTORATION ORDER TYPE (unduplicated)								
Felony	29	90.6%						
Misdemeanor	3	9.4%						
GENDER								
Female	3	9.4%						
Male	29	90.6%						
AGE GROUP								
18-29 yrs	14	43.8%						
30-49 yrs	12	37.5%						
50+ yrs	6	18.8%						
RACE/ETHNICITY								
Non-Hispanic White	21	65.6%						
Black, Indigenous, and People of Color	11	34.4%						
HOUSING STATUS AT PROGRAM ENROLLMENT								
Stably Housed	6	18.8%						
Unstably Housed	18	56.3%						
Homeless	7	21.9%						
Unknown	1	3.1%						

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

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Greyed out areas suppressed due to small n's.

TABLE 2.

OCRP Discharges

CUMULATIVE: JULY 1, 2020 - JUNE 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
CLIENT STATUS (on last day of reporting period)								
Enrolled	32	100.0%						
Active	10	31.3%						
Discharged	22	68.8%						
Among Discharged Clients…								
DISCHARGE REASON								
Charges Dismissed	3	13.6%						
Opined Competent	8	36.4%						
Opined Not Competent	2	9.1%						
Opined Not Restorable	0	0.0%						
Returned to Jail	1	4.5%						
Inpatient Medical Care	0	0.0%						
Inpatient Civil Psychiatry Care	0	0.0%						
Revoked Conditional Release	8	36.4%						
Death	0	0.0%						
DISCHARGE LOCATION								
Community	15	68.2%						
Residential Treatment Facility	1	4.5%						
State Hospital	4	18.1%						
Jail	2	9.1%						

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

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Greyed out areas suppressed due to small n's.

OCRP Definitions

Variable name	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase One Regions: Pierce, Southwest, Spokane.
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Individuals assessed and enrolled into OCRP during the reporting period.
Restoration Order Type	Restoration order type, based on most serious charge of first competency period orders (including concurrent orders). An individual with both a misdemeanor and felony competency restoration order is counted as a felony restoration order.
Misdemeanor	Restoration order with one or more misdemeanor charges as specified in RCW 9a.20.
Felony	Restoration order with one or more felony charges as specified in RCW 9a.20.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Minority categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was unreported.
Housing Status at Program Enrollment	Self-reported housing status at time of program enrollment.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
Client Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Discharge Reason	Reason the program ended for participant. Providers are limited to one dropdown option. Table reflects this selection.
Charges Dismissed	Participant charges were dismissed by court order; program has no legal authority to retain participant in the program.
Opined Competent	Evaluator opined the participant competent to stand trial.

Opined Not Competent	Evaluator opined the participant not competent to stand trial but possibly restorable.
Opined Not Restorable	Evaluator opined the participant not competent to stand trial and not restorable.
Returned to Jail	Participant returned to jail and there is no expectation that they would return to the program. Used if 'returned to jail' was the only reason for program end.
Inpatient Medical Care	Participant admitted to a medical hospital due to a serious medical condition (e.g., liver transplant) and there is no expectation the participant will return, or participant did not return from a Leave of Absence for inpatient medical care.
Inpatient Civil Psychiatry Care	Participant admitted voluntarily or involuntarily to an inpatient psychiatric facility (community or state hospital) due to grave disability and/or danger to self or others (e.g., participant is at risk of suicide or homicide) with no expection the participant will return, or participant did not return from a Leave of Absence for inpatient psychiatric care.
Revoked Conditional Release	Court revoked conditional release order.
Death	Participant passed away while in the program.
Discharge Location	Location of participant at time of program end.
Community	Participant was not in a facility at the time of discharge. Some participants may be pending inpatient treatment.
Residential Treatment Facility	Maple Lane, Yakima, and Fort Steilacoom competency restoration facilities.
State Hospital	Western and Eastern State Hospitals.
Jail	County, city, or tribal jail facility.
Unknown	Discharge location unknown.

Appendix C – Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health Administration Forensic Navigator Program

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2021

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

Forensic Navigator Enrollment and Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Total Population (unduplicated)								
Referred	1,017	100%	462	100%	213	100%	342	100%
Forensic Navigator Assigned	1,009	99%	459	99%	211	99%	339	99%
Among Clients Assigned a Forensic Navigator…								
Client Status (on last day of reporting period)								
Active	139	14%	43	9%	23	11%	59	17%
Pre-Competency Hearing	125	12%	43	9%	23	11%	59	17%
OCRP Enrolled	10	1%	--	--	--	--	--	--
Post-OCRP (Coordinated Transition)	4	0%	--	--	--	--	--	--
Discharged	870	86%	409	89%	185	88%	276	81%
Gender								
Female	212	21%	105	23%	39	18%	68	20%
Male	757	75%	337	73%	162	77%	258	76%
Unknown	40	4%	17	4%	--	--	--	--
Age Group								
18-29	261	26%	124	27%	54	26%	83	24%
30-49	549	54%	247	54%	112	53%	190	56%
50+	199	20%	88	19%	45	21%	66	19%
Race/Ethnicity								
Non-Hispanic White	618	61%	250	54%	142	67%	226	67%
Black, Indigenous, and People of Color	246	24%	177	39%	42	20%	27	8%
Unknown	145	14%	32	7%	27	13%	86	25%
Most Serious Current Criminal Charge								
Felony	591	59%	255	56%	120	57%	216	64%
Misdemeanor	418	41%	204	44%	91	43%	123	36%
Housing Status at Program Intake								
Stably Housed	233	23%	97	21%	61	29%	75	22%
Unstably Housed	133	13%	77	17%	26	12%	30	9%
Homeless	271	27%	92	20%	84	40%	95	28%
Unknown	372	37%	193	42%	40	19%	139	41%

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

NOTE: All individuals in Phase One regions with a competency evaluation order are referred to the Forensic Navigator program. A small number of individuals referred had not yet been assigned a navigator because their order was received at the end of the reporting period. The program is working to improve data collection for gender, race and ethnicity. The number of individuals with "unknown" demographic data is expected to improve in future reports. For more details on housing status at program intake and those with an "unknown" housing status see definitions. Counts and percentages may not sum due to unreported data and/or rounding.

--Cells suppressed due to small n's.

TABLE 2.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population								
Active Clients (at any point during the reporting period)	1,009	100%	459	100%	211	100%	339	100%
Average Daily Forensic Navigator Caseload		13.2		13.7		12.0		13.4
Among Active Clients (at any point during the reporting period)								
Forensic Navigator Services								
Assisting Clients with Attending Classes and Appointments	20	2%	12	3%	--	--	--	--
Attending Competency Hearing	393	39%	161	35%	136	64%	96	28%
Client Meeting, Interview, and/or Observation	632	63%	286	62%	141	67%	205	60%
Client Support-Network Interactions	96	10%	48	10%	--	--	--	--
Completed Recommended Services Plan	664	66%	289	63%	154	73%	221	65%
OCRP Compliance Monitoring	32	3%	13	3%	--	--	--	--
Contact with Client's Attorney or Prosecutor	799	79%	389	85%	150	71%	260	77%
Coordination of Care	409	41%	95	21%	124	59%	190	56%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	163	16%	44	10%	68	32%	51	15%
Information Gathering	1,002	99%	454	99%	211	100%	337	99%
Medication Monitoring	27	3%	--	--	--	--	--	--
Outreach Services - Attempted Contact	244	24%	64	14%	55	26%	125	37%
Outreach Services - Client Contact	147	15%	25	5%	40	19%	82	24%
Post-OCRP Client Check-in (up to 60 days)	7	1%	--	--	--	--	--	--
Post-OCRP Coordinated Transitions	5	0%	--	--	--	--	--	--
Referral to Services	273	27%	108	24%	52	25%	113	33%
Referrals								
Adult Protective Services (APS)	1	0%	--	--	--	--	--	--
Community Outpatient Mental Health Services	40	4%	--	--	--	--	21	6%
Designated Crisis Responder (DCR) Referral	0	0%	--	--	--	--	--	--
EBT/ABD (Food/Cash Benefits)	11	1%	--	--	--	--	--	--
Educational Services	2	0%	--	--	--	--	--	--
Employment Assistance	6	1%	--	--	--	--	--	--
Forensic HARPS Services	137	14%	81	18%	20	9%	36	11%
Forensic PATH Services	188	19%	76	17%	40	19%	72	21%
Home and Community Services	14	1%	--	--	--	--	12	4%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Housing Services (Non-HARPS)	21	2%	--	--	--	--	18	5%
Job Training	1	0%	--	--	--	--	--	--
Medical Insurance Services	5	0%	--	--	--	--	--	--
Other Community Based Resource	26	3%	--	--	--	--	13	4%
Primary Health Care/Dental Care	4	0%	--	--	--	--	--	--
SSI/SSDI	5	0%	--	--	--	--	--	--
Substance Use Disorder Treatment	25	2%	--	--	--	--	19	6%
Supported Employment	2	0%	--	--	--	--	--	--
VA Benefits	1	0%	--	--	--	--	--	--

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

--Cells suppressed due to small n's.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Clients Discharged								
Clients discharged during the reporting period	870	100%	409	100%	185	100%	276	100%
Clients discharged w/ warm hand-off to provider or jail staff	342	39%	127	31%	45	24%	170	62%
Discharge Reason								
Charges Dismissed	76	9%	39	10%	18	10%	19	7%
Civil Conversion - Removal from OCRP	3	0%	--	--	--	--	--	--
Client Death	3	0%	--	--	--	--	--	--
Client Determined Competent	298	34%	149	36%	73	39%	76	28%
Dismiss & Refer (to DCR)	63	7%	39	10%	--	--	--	--
Diversion Program(s)	0	0%	0	0%	0	0%	0	0%
Felony (72-Hour) Civil Conversion	9	1%	--	--	--	--	--	--
Inpatient Restoration	226	26%	128	31%	51	28%	47	17%
Not Restorable - Developmental Disability	2	0%	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	1	0%	--	--	--	--	--	--
Order Canceled or Withdrawn	15	2%	--	--	--	--	--	--
Re-arrest	2	0%	--	--	--	--	--	--
Refused Forensic Navigator Services	30	3%	--	--	--	--	14	5%
Released from Jail on Personal Recognizance (PR)	131	15%	--	--	--	--	97	35%
Successful OCRP Completion - Coordinated transition completed	6	1%	--	--	--	--	--	--
Successful OCRP Completion - Summary of treatment completed	0	0%	0	0%	0	0%	0	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	5	1%	--	--	--	--	--	--
	NUMBER	AVERAGE	NUMBER	AVERAGE	NUMBER	AVERAGE	NUMBER	AVERAGE
Length of Stay								
Average Length of Stay in Forensic Navigator Program (days)	870	36.0	409	36.5	185	36.8	276	34.7

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

--Cells suppressed due to small n's.

Forensic Navigator Program Definitions

Variable Name	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase One Regions: Pierce, Southwest, Spokane.
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
ENROLLMENT TABLES	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred or enrolled more than once in Forensic Navigator services during the reporting period, the most recent information is included.
Referred	All individuals with an outpatient competency evaluation order are referred to the Forensic Navigator Program.
Forensic Navigator Assigned	Individuals assigned to a Forensic Navigator during the reporting period.
Client Status (on last day of reporting period)	Program enrollment status on the last day of the reporting period, among those assigned to a Navigator.
Active	Individuals assigned a navigator, who have not yet been discharged from the program as of the last day of the reporting period.
Pre-Competency Hearing Clients	Individuals in the pre-competency hearing phase of Forensic Navigator services. These individuals have not yet had a competency hearing.
OCRP Enrolled	Individuals in the Outpatient Competency Restoration Program (OCRP) phase of Forensic Navigator services. These individuals have been found not competency to stand trial and ordered by the court to participate in outpatient (community-based) competency restoration treatment.
Post-OCRP (Coordinated Transition)	Individuals who have successfully completed the Outpatient Competency Restoration Program and are in the coordinated transition phase of Forensic Navigator services, meaning the Navigator is attempting to ensure the client is connected to community behavioral health services.
Discharged	Clients who were discharged from Forensic Navigator services during the reporting period.
Gender	Client's gender based on either self report or administrative records.
Age Group	Age at enrollment, based on date of birth and date the navigator was assigned.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. Non-Hispanic White and Minority categories are mutually exclusive.
Non-Hispanic White	Individuals who identify as White and non-Hispanic, or are recorded as such in administrative data.
Black, Indigenous, and People of Color	Individuals who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino, or are recorded as such in administrative data.
Unknown	Individuals for whom race/ethnicity information was unreported.
Most Serious Criminal Charge	The most serious criminal charge (Felony/Misdemeanor) associated with the competency evaluation order that initiated forensic navigator services.
Housing Status at Forensic Navigator Intake	Self-reported housing status at time of intake; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission. Forensic navigators attempt to capture housing status at the initial meeting with a client. Housing status is reported as "unknown" when the navigator is unable to meet with the client or when the client is not able to report their housing status.

Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing status is unknown. Housing situation indeterminate at time of initial meeting between Forensic Navigator and client or from the information gathered at time of FN assignment.
SERVICES TABLE	
Average Daily Forensic Navigator Caseload	The average daily caseload per Forensic Navigator during the reporting period.
Forensic Navigator Services	Forensic Navigator Services provided to active clients at any point during the reporting period. Number represents the number of individuals receiving the service at any point during the reporting period. Percent represents the percentage of active clients who received the service.
Assisting Clients with Attending Classes and Appointments	Forensic Navigator provided assistance including facilitating transportation of a client to attend OCRP classes or appointments in the community. This includes setting up transport assistance, such as Hopelink, coordinating transportation through FHARPS, FPATH, or OCRP, or providing direct transportation.
Attending Competency Hearing	Forensic Navigator attended the client's competency hearing in-person, by phone, or virtually.
Client Meeting, Interview, and/or Observation	Forensic Navigator met with, interviewed, and observed the client.
Client Support-Network Interaction	Forensic Navigator communicated (via phone, email, in-person) with family and/or friends of a client in order to coordinate care.
Completed Recommended Services Plan	Forensic Navigator completed (or updated) and submitted a Recommended Services Plan to the court, or uploaded the service plan to the Navigator Case Management System (NCM).
OCRP Compliance Monitoring	Forensic Navigator engaged in communication (phone, email, in-person) with OCRP providers, probation officer, legal counsel, and/or client to ensure client's compliance with conditions of release.
Contact with Client's Attorney or Prosecutor	Forensic Navigator called, emailed, met with, or in any other way either communicated with OR sent communication to client's defense attorney, the prosecuting attorney, or the defense/prosecution attorney of record for the case.
Coordination of Care	Forensic Navigator synchronized the delivery of a client's care between multiple providers and/or specialists to ensure care from disparate providers is not delivered in silos.
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	Forensic Navigator provided written or oral report on client's progress to the court per the court's request, on a periodic basis, or at the time of hearing. Written reports may be provided by email, and oral reporting by phone.
Medication Monitoring	Forensic Navigator engaged in any form of communication (phone, email, in person) with OCRP providers, the client, or others to assure the client's adherence to prescribed medication(s). This also include assisting clients with obtaining medication.
Outreach Services - Attempted Contact	Forensic Navigator attempted to locate and engage client in the community, but was unable to make contact with the client.
Outreach Services - Client Contact	Forensic Navigator attempted to locate and engage client in the community, and successfully contacted the client.
Post-OCRP Client Check-in (up to 60 days)	After a client successfully completes OCRP, Forensic Navigator attempted to follows-up with the client and/or community provider (via phone, email, or in person) to determine whether the client is receiving community mental health services.
Post-OCRP Coordinated Transitions	Forensic Navigator engaged in any form of communication (phone, email, in-person) with community providers to establish on-going behavioral health care for a client after OCRP discharge.
Information Gathering	Forensic Navigator gathered one or more documents, or other reported information relevant to the client, prior to the competency evaluation hearing. Includes, but not limited to, behavioral health, educational, and/or law enforcement agency records.

Referral to Services	Forensic Navigator referred a client to a specific outpatient service (substance use, mental health treatment, employment, etc.). Active Forensic Navigator support on behalf of or in conjunction with a client to connect them to another provider, agency or organization for services.
Referrals	Referrals made by the Forensic Navigator on behalf of a client. Among active clients (at any point during the reporting period).
Adult Protective Services (APS)	Forensic Navigator referred client to Adult Protective Services.
Community Outpatient Mental Health Services	Forensic Navigator referred client to Community Outpatient Mental Health Services.
Designated Crisis Responder (DCR) Referral	Forensic Navigator referred client to the Designated Crisis Responders (DCRs).
EBT/ABD (Food/Cash Benefits)	Forensic Navigator aided the client in applying for or reestablishing EBT/ABD (Food/Cash Benefits).
Educational Services	Forensic Navigator aided the client in obtaining educational services (e.g. classes, school, technical).
Employment Assistance	Forensic Navigator aided the client in obtaining employment/vocational services.
Forensic HARPS Services	Forensic Navigator referred client to Forensic HARPPS Services.
Forensic Path Services	Forensic Navigator referred client to Forensic PATH Services.
Home and Community Services	Forensic Navigator referred client to Home and Community Services.
Housing Services (Non-HARPS)	Forensic Navigator aided the client in applying for or reestablish Housing Services (Non-HARPS).
Job Training	Forensic Navigator aided the client in obtaining job training (e.g. classes, school, technical).
Medical Insurance Services	Forensic Navigator referred client to Medical Insurance Services.
Other Community Based Resource	Forensic Navigator referred client to Other Community Based Resource.
Primary Health Care/Dental Care	Forensic Navigator aided client is establishing or reestablishing Primary Health Care/Dental Care.
SSI/SSDI	Forensic Navigator aided the client in applying for SSI/SSDI.
Substance Use Disorder Treatment	Forensic Navigator aided the client in establishing or reestablishing Substance Use Disorder Treatment.
Supported Employment	Forensic Navigator aided the client in obtaining supported employment (e.g. classes, school, technical).
VA Benefits	Forensic Navigator aided the client in obtaining Veterans Services and/or benefits.
DISCHARGE TABLE	
Discharged with warm hand-off to provider or jail staff	When a Forensic Navigator interacts with service providers or correctional staff to move a client from the Forensic Navigator Program to a jail, community mental health agency, hospital, Residential Treatment Facility, or other forensic service. Occurs if client had a Forensic Navigator assigned, a competency hearing took place, and that client is not ordered to the OCRP.
Discharge Reasons	The reason Forensic Navigator services ended and the individual was discharged from the program.
Charges Dismissed	The criminal charges associated with the order for competency services were dismissed.
Client Death	Client deceased.
Client Determined Competent	Client found competent by the court.
Dismiss and Refer (to DCR)	Charges were dismissed and the client was referred by the court to the Designated Crisis Responders for evaluation.
Diversion Program(s)	Client ordered by court into diversion program (e.g. prosecutorial diversion program)
Felony (72-Hour) Civil Conversion	The court ordered a forensic to civil conversion commitment (72 Hour Felony) at the initial competency hearing.
Civil Conversion - Removal from OCRP	The court ordered a forensic to civil conversion commitment (72 Hour Felony/Misdemeanor Evaluation) after the client had been ordered to OCRP.
Inpatient Restoration	Client ordered by court into state psychiatric hospital for inpatient restoration services.
Not Restorable - Developmental Disability	Navigator services ended because the level of the client's disability indicated to the court that the client could not be restored.
Not Restorable - Pre-Hearing/OCRP	Navigator services ended at the pre-hearing stage because prior findings of not restorable indicated to the court that the client could not be restored. Or the client was evaluated for competency to stand trial while in OCRP and was determined by the court to be not restorable.

Order Canceled or Withdrawn	The court order for competency services was canceled or withdrawn.
Re-arrest	Individual re-arrested and unable to continue Forensic Navigator Program services.
Refused Forensic Navigator Services	Individual refused Forensic Navigator Program services prior to the initial competency hearing.
Released from Jail on Personal Recognizance (PR)	Individual released from jail at, before or after the initial competency evaluation order, but prior to the initial competency hearing or finding.
Successful OCRP Completion - Coordinated transition completed	Individual ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator completed a coordinated transition for the client from OCRP to community behavioral health services.
Successful OCRP Completion - Summary of treatment completed	Individual was ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator did not complete a coordinated transition for the client from OCRP to community behavioral health services, but did complete a summary of treatment.
Violation of OCRP Conditions of Participation/Court Ordered CR	Individual violated OCRP conditions of participation and/or conditions of release, and was removed from OCRP.
Length of Stay	
Average Length of Stay in Program (days)	The average number of days from the date the Forensic Navigator was assigned to the date the individual was discharged from the program.

Appendix D – Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Voucher Disbursals by Crisis Triage and Stabilization Facilities

CUMULATIVE UPDATE

Beginning December 2019, Washington State Health Care Authority (HCA) contracted funds for select crisis triage and stabilization facilities to provide short-term housing vouchers for persons leaving the facility without housing. Individuals are also referred for additional housing supports to mitigate the potential negative impacts of housing instability on behavioral health.

REPORTING PERIOD

Cumulative: December 1, 2019 to June 30, 2021

Prepared by Washington State Department of Social and Health Services
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TABLE 1.

Crisis Triage and Stabilization Facility Housing Vouchers

CUMULATIVE: December 1, 2019 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Vouchers Disbursed	197	100%	31	16%	**52**	26%	114	58%
Recipients (unduplicated)	143	100%	31	22%	46	32%	66	46%
Total Amount Disbursed	$195,044	N/A	$32,837	N/A	$61,717	N/A	$100,490	N/A
Average Amount Per Recipient	$1,364	N/A	$1,059	N/A	$1,342	N/A	$1,523	N/A
FACILITY REFERRAL SOURCE								
Crisis Call Center	2	1%						
Family/Friend	3	2%						
Hospital	67	47%						
Mobile Crisis Response	10	7%						
Designated Crisis Responder	7	5%						
Tribe or Indian Healthcare Provider	0	0%						
Emergency Responder	1	1%						
Other Healthcare Provider	14	10%						
Law Enforcement (Police, Co-Responders)	13	9%						
Court/Criminal Justice Referred	0	0%						
Self	24	17%						
Other	2	1%						
GENDER								
Female	43	30%						
Male	95	66%						
Other/Unknown	5	3%						
AGE GROUP								
18-29	22	15%						
30-49	86	60%						
50+	34	24%						
Unknown	1	1%						
RACE/ETHNICITY								
Non-Hispanic White	91	64%	16	*52%*	32	*70%*	43	*65%*
Black, Indigenous, and People of Color	49	34%	15	*48%*	14	*30%*	20	*30%*
Unknown	3	2%	--	--	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Voucher Recipients…								
FORENSIC HARPS (FHARPS) STATUS*								
Referred to FHARPS	92	64%	22	71%	22	48%	48	73%
Contacted by FHARPS staff	86	60%	22	71%	17	37%	47	71%
Enrolled in FHARPS	85	59%	22	71%	17	37%	46	70%
Housed or sheltered by FHARPS	72	50%	18	58%	14	30%	40	61%
Among Individuals Housed or Sheltered by FHARPS…								
FIRST FHARPS HOUSING TYPE*								
Permanent	2	3%						
Transitional	5	7%						
Shelter/emergency	64	89%						
Other	1	1%						

DATA SOURCES: Excel trackers submitted by each contracted crisis triage and stabilization facilty and Forensic HARPS team to the Washington State Health Care Authority (HCA).

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Greyed out areas or cells with '--' are suppressed due to small n's.

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

Crisis Triage and Stabilization Facility Housing Voucher Definitions

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

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

Appendix E – FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

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

REPORTING PERIOD
Cumulative: March 1, 2020 to June 30, 2021

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

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Contents

TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Referred	760	100%	331	100%	162	100%	267	100%
Contacted	461	61%	205	62%	138	85%	118	44%
Enrolled	418	55%	190	57%	115	71%	113	42%
Among Referred Individuals…								
REFERRAL SOURCE								
Trueblood partner programs	379	50%	161	*49%*	58	*36%*	160	*60%*
Forensic Navigator	*105*	*14%*	*47*	*14%*	*19*	*12%*	*39*	*15%*
Forensic PATH	*116*	*15%*	*63*	*19%*	--	--	--	--
OCRP	*1*	*0%*	--	--	--	--	--	--
Crisis Stabilization Center	*136*	*18%*	*43*	*13%*	*31*	*19%*	*62*	*23%*
Mobile Crisis Response	*1*	*0%*	--	--	--	--	--	--
Co-Response Team	*20*	*3%*	--	--	--	--	*12*	*4%*
Behavioral Health Facility - Outpatient	153	20%	37	11%	82	51%	34	13%
Inpatient Facility	38	5%	18	5%	--	--	--	--
Family/Self	42	6%	27	8%	--	--	--	--
Other	148	19%	88	27%	15	9%	45	17%
Among Contacted Individuals…								
LOCATION OF INITIAL CONTACT								
Phone	327	71%	157	77%	136	99%	34	29%
Court	0	0%	0	0%	0	0%	0	0%
Hotel/Motel	5	1%	--	--	--	--	--	--
Jail	24	5%	12	6%	--	--	--	--
Crisis Stabilization Center	57	12%	11	5%	0	0%	46	39%
Behavioral Health Facility - Outpatient	8	2%	--	--	--	--	--	--
Inpatient Facilty	9	2%	--	--	--	--	--	--
Shelter	3	1%	--	--	--	--	--	--
Street/encampment	1	0%	--	--	--	--	--	--
Temporary Residence	4	1%	--	--	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Other	23	5%	13	6%	0	0%	10	8%
Among Enrolled Individuals…								
PARTICIPANT STATUS (on last day of reporting period)								
Active	150	36%	59	31%	37	32%	54	48%
Discharged	268	64%	131	69%	78	68%	59	52%
GENDER								
Female	136	33%	66	35%	35	30%	35	31%
Male	275	66%	120	63%	80	70%	75	66%
Other/Unknown	7	2%	--	--	--	--	--	--
AGE GROUP								
18-29	97	23%	48	25%	31	27%	18	16%
30-49	237	57%	93	49%	71	62%	73	65%
50+	84	20%	49	26%	13	11%	22	19%
RACE/ETHNICITY								
Non-Hispanic White	229	55%	78	41%	71	62%	80	71%
Black, Indigenous, and People of Color	170	41%	94	49%	44	38%	32	28%
Unknown	19	5%	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT								
Unstably Housed	100	24%	38	20%	37	32%	25	22%
Homeless	318	76%	152	80%	78	68%	88	78%

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

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

-- Cells suppressed due to small n's.

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	418	100%	190	100%	115	100%	113	100%
Housed or Sheltered	358	86%	176	93%	92	80%	90	80%
Among Enrolled Individuals…								
SERVICES PARTICIPANT AGREED TO								
Subsidies only	9	2%	--	--	--	--	--	--
Support Services and Subsidies	409	98%	188	99%	115	100%	106	94%
Among Housed/Sheltered Individuals…								
FIRST HOUSING TYPE								
Permanent	24	7%	11	6%	--	--	--	--
Transitional	80	22%	41	23%	27	29%	12	13%
Shelter/emergency	244	68%	115	65%	58	63%	71	79%
Other	10	3%	--	--	--	--	--	--

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

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

-- Cells suppressed due to small n's.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - June 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)								
Enrolled	418	100%	190	100%	115	100%	113	100%
Active on last day of reporting period	150	36%	59	31%	37	32%	54	48%
Discharged during reporting period	268	64%	131	69%	78	68%	59	52%
Among Individuals Discharged…								
SUBSIDY								
Average total subsidy since enrollment	$5,095	N/A	$5,151	N/A	$5,880	N/A	$3,883	N/A
DISCHARGE REASON								
Transitioned to other housing support	40	15%	33	20%	--	--	--	--
Received maximum subsidy	*13*	*5%*	--	--	--	--	--	--
Did not receive maximum subsidy	*27*	*10%*	26	20%	--	--	--	--
Transitioned to self-support	34	13%	16	12%	--	--	--	--
Admitted to a facility	14	5%	--	--	--	--	--	--
Received maximum assistance (no transition)	39	15%	18	14%	--	--	--	--
Withdrew	26	10%	11	8%	--	--	--	--
Loss of contact	92	34%	35	27%	42	54%	15	25%
Served by another FHARPS team	0	0%	0	0%	0	0%	0	0%
Other	23	9%	12	9%	--	--	--	--
LENGTH OF SUPPORT								
Average Length of Stay in Program (days)	155	N/A	142	N/A	183	N/A	144	N/A
HOUSING STATUS AT DISCHARGE								
Stably Housed	83	31%	57	44%	14	31%	12	20%
Unstably Housed	13	5%	--	--	--	--	--	--
Homeless	49	18%	28	21%	--	--	--	--
In a facility	25	9%	--	--	--	--	15	25%
Unknown	98	37%	32	24%	47	37%	19	32%

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

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

-- Cells suppressed due to small n's.

FHARPS Definitions

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

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

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

Appendix F – FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

Formerly referred to as Intensive Case Management, the Forensic PATH program offers enhanced engagement and connection to services for individuals identified as most at risk of being referred for a competency evaluation within the next six months. Teams within behavioral health agencies will connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The Forensic PATH program began on March 1, 2020.

REPORTING PERIOD
Cumulative: March 1, 2020 to June 30, 2021

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

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: MARCH 1, 2020 - JUNE 30, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Number on Referral List	1,067	100%	631	100%	174	100%	262	100%
Attempted Contacts	514	48%	211	33%	122	70%	181	69%
Contacted	315	30%	120	19%	65	37%	130	50%
Enrolled	164	15%	62	10%	53	30%	49	19%
PRIORITIZED POPULATION								
Prioritized Referral List	434	41%	253	40%	54	31%	127	48%
Attempted Contacts	250	58%	122	48%	36	67%	92	72%
Contacted	155	36%	66	26%	24	44%	65	51%
Enrolled	88	20%	39	15%	19	35%	30	24%
Among All Enrolled Individuals…								
Client Status								
Active (on last day of reporting period)	118	72%	36	58%	40	75%	42	86%
Discharged	46	28%	26	42%	--	--	--	--
Average Length of Stay in Program (days)	184.0	N/A	153	N/A	234	N/A	208	N/A
Gender								
Female	33	20%	--	--	--	--	12	24%
Male	129	80%	50	82%	42	81%	37	76%
Unknown	2	1%	--	--	--	--	--	--
Age Group								
18-29	54	33%	25	40%	16	30%	13	27%
30-49	92	56%	27	44%	32	60%	33	67%
50+	18	11%	--	--	--	--	--	--
Race/Ethnicity								
Non-Hispanic White	71	43%	21	34%	28	53%	22	45%
Black, Indigenous, and People of Color	60	37%	32	52%	--	--	--	--
Unknown	33	20%	--	--	--	--	19	39%
Housing Status at Program Enrollment								
Stably Housed	20	12%	--	--	--	--	--	--
Unstably Housed	42	26%	--	--	15	28%	17	35%
Homeless	89	54%	38	61%	29	55%	22	45%
Unknown	13	8%	--	--	--	--	--	--

Housing Status at Program Exit								
Stably Housed	--	--	--	--	--	--	--	--
Unstably Housed	0	0%	0	0%	0	0%	0	0%
Homeless	13	28%	13	50%	0	0%	0	0%
In a Facility	--	--	--	--	--	--	--	--
Unknown	21	46%	--	--	13	100%	--	--

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

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

FPATH Definitions

Variable name	DEFINITION
Total - All Regions	**Includes all Phase One Regions: Pierce, Southwest, Spokane.**
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
ENROLLMENT TABLES , Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Number on Referral List	Number of individuals who appeared on the Forensic PATH eligibility list during the reporting period. Eligibility criteria include having two or more competency evaluation referrals in the past 24 months.
Number on Prioritized Referral List	Number of individuals who appeared on the prioritized Forensic PATH eligibility list during the reporting period. Eligibility is prioritized based on meeting any of the following criteria: (1) having 4 or more competency evaluation referrals in the previous 24 months; (2) residing in a rural county; or (3) having any of the following housing statuses: City/County Jail, Emergency Housing/Shelter, Homeless, Unstably Housed, or living in an institution. Housing status is based on available administrative data at the time of the referral. For some individuals housing status is unknown at referral.
Attempted Contacts	Individuals with an attempted (unsuccessful) contact during the reporting period.
Contacted	Individuals successfully contacted by the program during the reporting period.
Enrolled	Individuals who have agreed to formally accept Forensic PATH services and referrals, and were enrolled into the program during the reporting period.
Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Minority categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was unreported.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.

Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
Housing Status at Program Exit	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program end.