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

Semi-Annual Report 9

March 29, 2024

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Criminal Justice Training Commission Washington

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List of Abbreviations in this Document

AAG-assistant attorney general

AHAB-Affordable Housing Advisory Board

ASO-administrative service organization

ASPD-antisocial personality disorder

BHA-Behavioral Health Administration, part of DSHS

BHASO-behavioral health administrative service organization

BPD-borderline personality disorder

CIT-Crisis Intervention Training

CJTC-Criminal Justice Training Commission

CMS-Centers for Medicare and Medicaid Services

CPC-certified peer counselor

CS/CT-crisis stabilization/crisis triage

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

DCR-designated crisis responder

DSHS-Department of Social and Health Services

DOH-Department of Health

DRW-Disability Rights Washington

ESH-Eastern State Hospital

ETP-exception to policy

FDS-Forensic Data System

FRA-forensic risk assessment

HARPS-Housing and Recovery through Peer Services

HCA-Health Care Authority

MCR-mobile crisis response

MOCT-mobile outreach crisis team

MOU-memorandum of understanding

NGRI-Not Guilty by Reason of Insanity

OCRP-Outpatient Competency Restoration Program

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

PATH-Projects for Assistance in Transition from Homelessness

PHS-Pioneer Human Services

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

Preamble

Each March and September, a semi-annual report is published to review the implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress during July through December 2023. The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new Trueblood programs initially launched during the Phase 1 implementation of the Settlement Agreement and those operations are ongoing. Work to implement Phase 2 programming of the Settlement Agreement is arriving at completion. Phase 3 of the Settlement Agreement became effective on July 1, 2023. Initial pre-implementation and implementation work in the five counties of the two Phase 3 regions is ongoing as of Dec. 31, 2023.

Ultimately, a major focus of this report is to provide relevant data that demonstrates program use and outcomes, where possible. Most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. As programs continue their operations and mature, this report will expand over time to include more data and reporting elements. For this SAR, the forensic navigator program data comes from the new publicly-available Power BI dashboard, which includes trend data. Additional programs will be moving to dashboard reporting as data and resources allow; more data collection changes will be provided in the individual program sections. Additional details on OCRP participants are also provided due to the increase in people served, as less suppression is required for privacy purposes. With a few exceptions noted in the report, the data is current through Dec. 31, 2023. Data from new regions will typically be included in the SAR following at least two calendar quarters of operation, assuming sufficient counts to preserve confidentiality.

Background

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

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

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

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

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

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

Definitions

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

Agreement: Trueblood Contempt Settlement Agreement or Settlement Agreement

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

CJTC or the Commission: Washington State Criminal Justice Training Commission

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

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

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

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

Forensic Housing and Recovery through Peer Services or FHARPS: Staff teams with lived experience with behavioral health challenges that provide unstably housed and recently forensically involved people 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. People identified on a referral list generated by Research and Data Analysis have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those people most vulnerable to access housing, treatment and resources in an effort to divert them from future intersections with law enforcement. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

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

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

Health Care Authority or HCA: Washington State Health Care Authority

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

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

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

Residential Treatment Facilities or RTFs: (1) DSHS usage refers to an inpatient facility that treats either forensic or civil 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; as part of the department's ongoing efforts to establish additional civil RTFs during the next several years, the existing facilities were re-named to better align for current and future needs systemwide. The Maple Lane Competency Restoration Program or MLCRP as it has been known is part of a growing campus of programs hosted at Maple Lane. The new campus name is DSHS Behavioral Health & Treatment Center – Maple Lane Campus and MLCRP will be known as Cascade Unit. Cascade is the building that houses the forensic RTF. Similarly, the forensic RTF housed on Western State Hospital's campus has updated its name as well. It will now be known as DSHS Behavioral Health & Treatment Center – Steilacoom Unit (formerly Building 27/Fort Steilacoom) or Steilacoom Unit for short.

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

COVID-19 Procedures Update for Q3 & Q4 2023

Washington state officially re-opened from pandemic-related closures on June 30, 2021, subject to limited restrictions, and the Governor's COVID-19 State of Emergency ended on Oct. 31, 2022. As of December 2023, BHA's Western State Hospital, Eastern State Hospital, DSHS Behavioral Health & Treatment Center – Steilacoom Unit (formerly Building 27/Fort Steilacoom) Fort Steilacoom Competency Restoration Program, and DSHS Behavioral Health & Treatment Center – Maple Lane Campus are operating without any COVID-19 related admissions restrictions.

COVID-19 Cases All BHA Facilities

Clients and Staff

- As of March 21, 2024, there were 1,861 cumulative cases of COVID-19 in BHA clients and 2,861 cumulative cases in BHA staff across all facilities.

- COVID-19 continues to impact facility operations. Between Sept. 27, 2023 and March 21, 2024, there were 368 covid cases among clients in BHA facilities and 380 cases among staff.

Data Source: BHA Case Snapshot by Facility: BHA 24/7 Facilities – Clients-Staff.

Note: "All facilities" includes several BHA facilities that do not serve Trueblood clients. However, as of March 21, 2024, more than 86 percent of all COVID-19 staff cases and 89 percent of all COVID-19 client cases involve the state hospitals or RTFs.

Impacts of Civil Conversion Cases on the Inpatient Forensic Bed Supply

Court-ordered civil conversion cases have grown rapidly and substantially in the past few years, which led to increased demand for state hospital beds, also necessary for Trueblood class members. Civil conversion cases increased 18 percent from 2019-2020, 8.2 percent from 2020-2021, and 39 percent from 2021-2022, before decreasing by 9.9 percent from 2022-2023. This is a cumulative 59 percent increase between 2019-2023 after peaking at a 77 percent increase in 2022[1].

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

The Department opened 74 new beds for class members in 2023. Thirty additional new beds were delayed until February 2024. A detailed list of recently opened facilities and currently projected opening dates follows:

- DSHS Behavioral Health & Treatment Center – Maple Lane Campus
    - Oak Unit opened 16 beds to civil patients in April 2023.
    - Columbia Unit, a newly remodeled 30-bed facility for not guilty by reason of insanity patients from WSH. Columbia Unit began accepting patients on Feb. 21, 2024.
- Two new 29-bed forensic competency restoration wards opened at WSH in May 2023.
- In summer 2023, DSHS purchased a private mental health hospital in Tukwila to re-open as Olympic Heritage Behavioral Health and use initially for civil conversion patients. Beds that open at Olympic Heritage will free up space for Trueblood Class Members at WSH. These beds are not included in the new bed totals listed above.

Gaining at least 74 new beds in calendar year 2023 did not immediately solve the admissions crisis outright; however, these additional beds allow OFMHS and the state hospitals greater flexibility with new types of facilities coming online to provide a more diverse and responsive care environment to better meet the needs of each patient. As civil and NGRI patients can shift to these new facilities, new bed space opens for Trueblood class members at WSH and ESH. Critically, this allows the department to better serve civil patients as well as forensic class members. It provides additional approaches to treating various patient types, and it begins a period of realizing the governor's vision for significant growth in inpatient restoration capacity around the state, as additional, similar facilities and hundreds of new beds are brought online

[1] Sources: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated by Research and Data Analysis March 2024; and

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

from 2023 until approximately 2028. This ultimately allows patients the potential to receive restoration treatment closer to their home communities, enabling access to family support and critical community resources that are vital for successful restoration and return to the community.

Breach Motion

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

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

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

The department filed its response to the Plaintiff's motion on Jan. 11, 2023, and the Plaintiff's filed their counter-response on January 16. The judge issued her initial ruling on July 7. As part of the Court's July 7 order, the State and the Plaintiffs met and conferred on various aspects of the order and jointly proposed modified language. A hearing on the modification language was held on August 7 and the court issued a second order on August 14. This order of August 14 clarified the original July 7 order in certain respects. Notably, the August 14 order specifically excludes defendants charged with non-violent criminal acts from being admitted into either state hospital on a civil conversion commitment order. The state filed notice of appeal to the Ninth Circuit Court of Appeals, and the case awaits further proceedings in mid-2024.

Workforce Challenges-Recruitment and Retention

Competing for staff talent with the private sector in the context of the well-publicized post-pandemic workforce challenges has left many positions, especially at our treatment facilities, chronically unfilled. BHA has identified and implemented creative solutions within our existing authority and partnered with executive leadership, state human resources, labor, and other partners to develop and implement innovative approaches to recruiting and retaining critical staff positions. In spring and summer 2022, DSHS completed several steps to alleviate staffing challenges. Steps taken included hiring more contractors and travel nurses, adding hiring recruitment resources to both WSH and ESH, especially to hire nurses, partnering with the Washington State Office of Financial Management to adjust pay ranges for certain positions, expanding our successful forensic evaluator training and recruitment post-doctoral program from three to five interns, and engaging a successful demand to bargain with labor partners to allow for contract evaluations to take place until vacancies can be filled. Implementing new policies and practices to attract and retain passionate, talented staff remains critical to success, and BHA has continued this critical focus throughout 2022 and 2023. Even with these successful actions, BHA continues to face high vacancy rates in several critical patient-centered job classes. As of early January 2024, vacancies in these classes now range between 36-43 percent. The ability to maintain current restoration capacity is a challenge, and staffing new facilities' capacity is also very challenging.

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

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

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

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

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

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

- Enacted targeted wage scale adjustments for critical positions.

- Extra duty pay for forensic evaluators and psychiatric social workers

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

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

Evaluation and Monitoring Overview

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

Project Monitoring

The department provides ongoing project monitoring analyses through monthly and semi-annual reporting. Monthly monitoring reports provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness goals and slowing the rate of growth in competency evaluation referral volume. Most commonly, this information is available as part of the monthly reports to the court-appointed monitor and can be found on DSHS' Trueblood website[2]. Semi-annual reporting on implementation elements (e.g., FPATH and the Forensic Navigator Program) provides timely information on client engagement in implementation programs. Monitoring measures include:

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

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

For programs using Excel data trackers, HCA replaced data trackers with a centralized data collection called the Program Data Acquisition Management and Storage system (PDAMS) for FHARPS in August 2023 and crisis housing vouchers in November 2023. FPATH is expected to move to PDAMS before the next report. Some data anomalies are expected as providers transition to the new platform. HCA and RDA continue to collaborate on how to minimize errors and merge sources to track people and events accurately across data platforms.

There are now three Power BI dashboards available for public use that provide dynamic data views:

- Crisis Intervention Training

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

- Forensic Dashboard
- Misdemeanor Restoration Orders by Fiscal Year

Similar Power BI dashboards are under development for the crisis housing voucher and FHARPS programs, both of which will merge excel data tracker and PDAMS data. Upon completion, OCRP and FPATH Power BI dashboards will follow.

In all public reports, client-level data is aggregated and suppressed when necessary to protect individual confidentiality, both in the semi-annual report tables and the dynamic dashboards for public use. Additional data will be provided over time as data quality improves and the numbers served increase.

Longer-term Impact Analyses

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

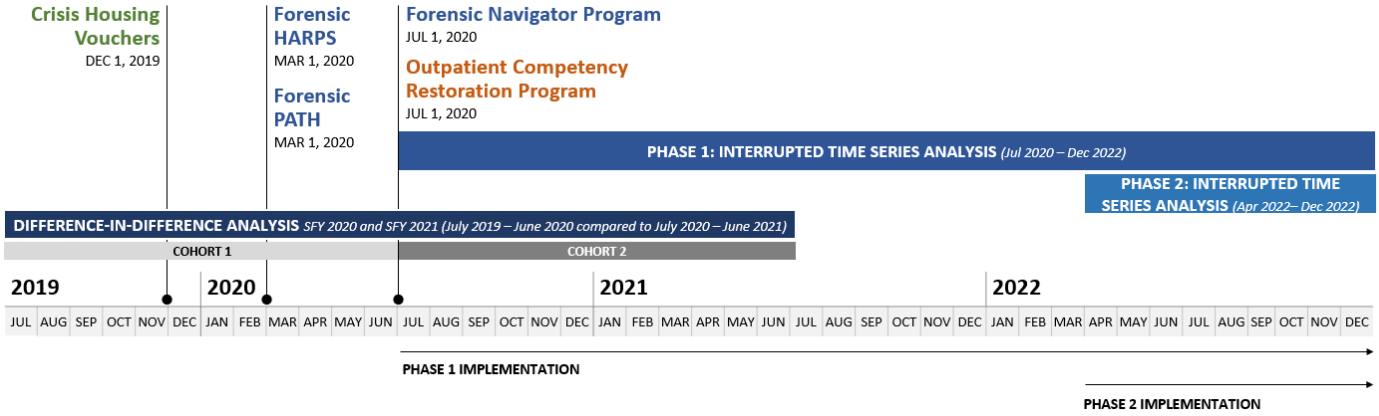
- Use of mental health and substance use disorder treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

Evaluations include assessments of the overall phased regional impact of Settlement Agreement components on outcomes through two methods: (1) an interrupted time series analysis to assess the impact of the Trueblood implementation programs on the number of competency referrals; and (2) a difference-in-difference analysis to assess impacts on behavioral health access and social outcome metrics. The interrupted time series is being updated in Spring 2024; the findings for the prior three analysis periods are included in this report. The difference-in-difference analysis will be updated as resources allow. Figure 1 shows the reference periods for the analysis previously reported, and the following sections outline the method and findings from each approach.

FIGURE 1.

Trueblood Evaluation Reference Periods

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



Interrupted Time Series Analysis

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

Three iterations of the interrupted time series analysis have been completed, the most recent of which was in Spring 2023. Findings from each analysis are summarized below. The next analysis will occur in Spring 2024.

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

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

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

- Competency Evaluations – There was a decrease in the rate of competency evaluation orders in Phase 1 regions of 1.6 per 100,000 residents relative to the expected rate. This was significant at p<.05.[3]

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

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

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

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

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

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

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

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

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

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

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

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

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

Early findings for Phase 2 King region showed no impact on competency orders and a significant decrease in restoration orders. The next analysis is in Spring 2024.

Difference-in-Difference Analysis

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

- Mental Health Treatment: There was a significant increase in the rate of mental health treatment among people with at least one competency evaluation order in Phase 1 regions compared to the balance of the state at p<.0001.[4]

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

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

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

Forthcoming: Individual Program Evaluation(s)

In the research plan drafted in January 2020, RDA estimated the first Settlement Agreement program evaluation utilizing a propensity-score matching method would be available no earlier

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

than March 2022. This assumed sufficient study populations, with a minimum six-months of data in the follow-up period, seven months for data maturity, and at least two months for data integration, analysis, and reporting.

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

Implementation Plan Elements

The sections that follow detail the current status of the 14 elements included in the Phases 1, 2, and 3 Settlement Agreement Final Implementation Plans.

Each element's report considers the following five items as they relate to the element specifically and to the Settlement Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) available data pertaining to the element. Data tables included in this report reflect data through Dec. 31, 2023, with exceptions noted.

Competency Evaluation-Additional Evaluators

The Settlement Agreement required hiring 18 additional forensic evaluators over two years for Phase 1. Phases 2 and 3 did not have any requirements to hire additional staff; rather, the focus is on the amount of referral data and whether enough evaluators are hired to support this demand. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines for in-jail competency evaluations, evaluators can also be assigned to address the need of completing non-Trueblood forensic assessments (such as specialized forensic risk assessments for the NGRI population in forensic beds, not guilty by reason of insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state. Furthermore, with up-to-date forensic risk assessments, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity.

Current Status and Areas of Positive Impact

For fiscal year 2024 and 2025, OFMHS received funding for an additional 19 positions (11 for fiscal year 2024 and eight for 2025). With staff movement naturally occurring, as of Dec. 31, 2023, 68 of the 86 positions are filled. Recruitment continues to fill the remaining vacancies with an emphasis on filling positions located in the east and north of the state. OFMHS has implemented the following measures to improve recruitment: 1) continue to offer hybrid work schedules emphasizing ability to work from home, 2) nationwide recruitment, 3) creating seven out-of-state remote telehealth positions, 4) attending conferences/workshops to recruit, 5) adding more administrative support staff to assist evaluators, and 6) leveraged technology to assist with data tracking/scheduling. WSH continues to staff clinical psychologists that complete civil commitment treatment reports for the court, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations).

During the July-December 2023 reporting period, 59 FRAs were completed at WSH. Now that there is no longer any backlog of forensic risk assessments to complete at WSH, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. Additionally, OFMHS is working with ESH to have all forensic risk assessments caught up and on the same evaluation schedule as WSH. ESH completed 17 FRAs during the July-December 2023 reporting period. However, due to staffing challenges, the department is currently recruiting contractors to help have the new system in place as currently each patient has an FRA. The next phase, where annual updates will be completed, is now underway. This is in addition to continuing to recruit to fill vacant positions and the addition of two post-doctoral positions in the eastern region. While completion of risk assessments for the NGRI population at the state hospitals assists in vacating forensic beds that can be occupied by those in need of inpatient competency restoration services, completion of competency

evaluations for class members remains prioritized over other types of evaluations, including forensic risk assessments.

Areas of Concern

For all phases, the continued increase in competency evaluations continues to be a concern. In Fiscal Year 2023, Washington state had its highest number of referrals for all competency evaluations (6,794[5]). Compared to FY22, referral levels increased by an additional 302 orders and 4.7 percent, which is a significant slowdown in growth compared to the FY21 to FY22 39 percent year-over-year increase for all competency evaluation orders. This growth came despite the original 12 fine-funded[6] diversion programs six of which continue to contract with HCA for a second year of funding in FY24, three state-funded prosecutorial diversion programs that have continued operating under contract with BHA, and the statistically significant impact of Trueblood interventions demonstrated in the Phase 1 regions. Without these programs, demand for evaluations likely would have increased even more in the past.

Recommendations to Address Concerns

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

To date, OFMHS has reached out to all county jails in the state as well as tribal and municipal jails to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). Currently, jails with telehealth capacity on the west side of the state include the Nisqually Indian Tribe's Nisqually Corrections Center as well as city jails in Aberdeen, Enumclaw, Forks, Hoquiam, Issaquah, Kent, and Puyallup, SCORE in Des Moines (contracted with several cities and towns in King County and elsewhere in the state for local-level inmates), and county jails in Clallam, Cowlitz, Grays Harbor, Jefferson, King (King County Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and SCORE in Des Moines for county-level inmates), Kitsap, Pacific, San Juan (holding facility), Thurston, Wahkiakum, and Whatcom counties. Jails on the east side with telehealth capacity now include

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

those in Benton, Ferry, Franklin, Grant, Okanogan, Spokane, Stevens, Walla Walla, Whitman, and Yakima counties as well as the City of Sunnyside jail, and Yakima city jail. In addition, Airway Heights Corrections and the Colville Tribal Jail now have telehealth capabilities.

Data-Competency Evaluation-Additional Evaluators

DSHS continues to use data from FDS to determine whether the evaluator capacity (current and funded increase) maintains substantial compliance with the injunction with respect to in-jail competency evaluations. Timeliness metrics are shown in Figure 2. Overall, compliance rates for jail-based evaluations remain high. As of March 26, 2024, data reflects that in December 2023, a total of 77 percent of evaluation orders were completed within court-ordered time limits, with 76 percent of orders in the WSH catchment area and 83 percent of orders in the ESH catchment area completed within court-ordered time limits. Note, these numbers may continue to evolve as the good cause extensions are recomputed based upon the court's order entered on Sept. 7, 2023. During summer 2022, the compliance rate at ESH declined. The reasons for the decline in compliance on the east side were threefold: (1) near-record high numbers of evaluation referrals; (2) staff vacancies; and (3) scheduling issues that involved new processes and working out telehealth connectivity disruptions.

To address vacancies, robust recruitment has continued through fall 2022. While vacancies remain an issue, several new evaluators and other staff began positions throughout fall 2022, and evaluators assigned to westside evaluations have taken on extra work to help complete eastside evaluations, when possible. The recently bargained allowance for forensic contractors to assist in completing evaluations has allowed OFMHS to begin contracting as well. Furthermore, the scheduling issues have been addressed and are monitored to ensure disruptions to the evaluation process are minimized or a good cause exception is submitted. Improvements in these areas resulted in substantial improvement in ESH's evaluation timeliness rate during fall 2022. ESH improved from 24 percent completed within court-order time limits in September 2022 to 83 percent in December 2023.

For the FY2024-FY2025 budget cycle, the department examined the number of orders filed by the courts between July 2018 and June 2023 and projected the number of evaluation orders through June 2027 using an exponential smoothing forecast model[7]. Data over the 12-month period corresponding to the start of the COVID-19 pandemic (March 2020-March 2021) was interpolated to account for pandemic-related effects. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood Agreement and Engrossed Substitute Senate Bill 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

Projections indicate that the number of Trueblood competency evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 86.0 FTE in the FY2024 budget

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

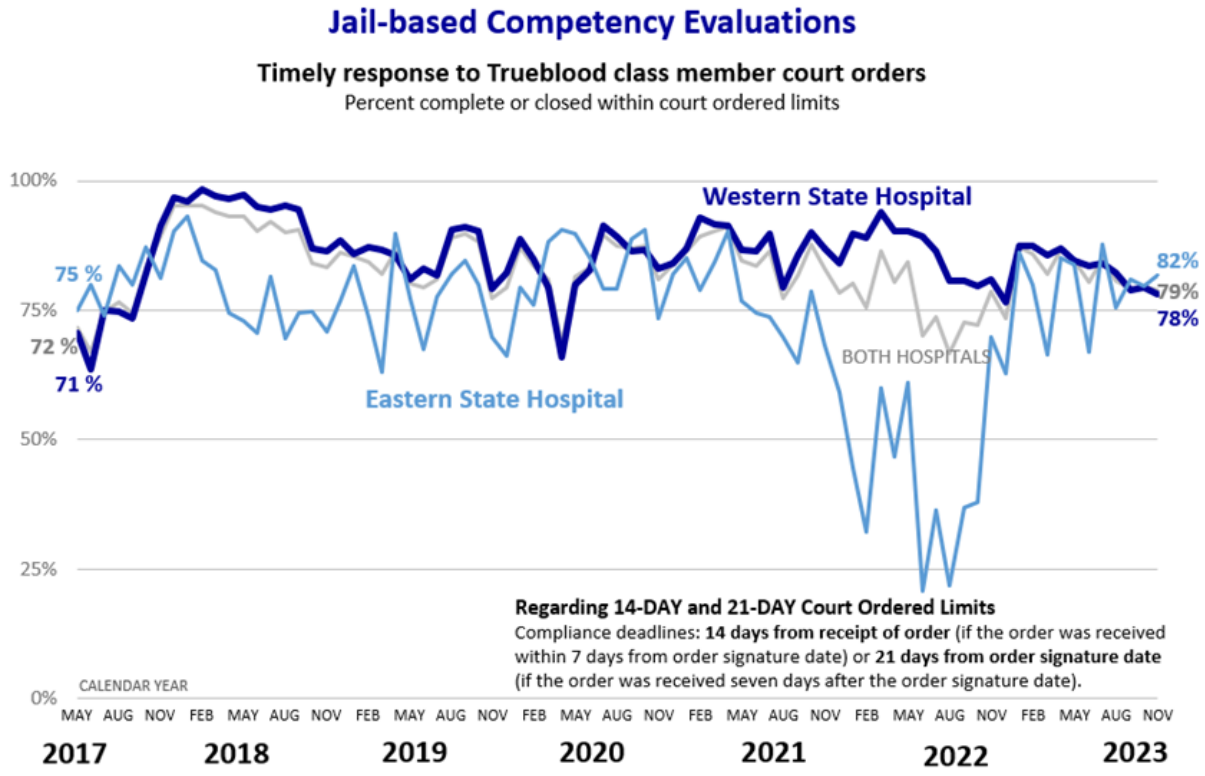
and 96.0 FTE in the FY2025 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, which may present evaluation capacity challenges in peak months. The department continues to monitor caseloads regularly, and during periods of increased demand, OFMHS management/staff prioritize jail-based cases. These calculations do not account for evaluations for forensic risk assessments (both initial evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks. The department will continue to update the projection analysis in line with the legislative budget cycle and will have an updated forecast in the next semi-annual report for the FY2025-FY2027 budget cycle.

FIGURE 2.

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

Percent complete or closed within court-ordered limits

DECEMBER 2023



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

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

Data-Competency Restoration-Misdemeanor Restoration Orders

As part of the Settlement Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supports legislation toward this goal. ESSB 5444 was signed into law by the governor on May 9, 2019, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. These changes went into effect July 28, 2019. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on

June 11, 2020. The department continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088).

The department has recently developed a dynamic Power BI report to show the average number of misdemeanor restoration orders made by courts each month, organized by fiscal year. Figure 3 displays the data from July 2017 through December 2023. In the two fiscal year period prior to the law change (FY2018-FY2019), courts issued an average of 23 misdemeanor restoration orders. In the two fiscal year period after the law change (FY2020-FY2021), the average number of misdemeanor restoration orders decreased to 14. However, the average number of misdemeanor restoration orders has increased to a level similar to the period before the 2019 law change with an average of 21 misdemeanor restoration orders between FY2022-FY2023. Because this data is updated monthly, the average number of misdemeanor restoration orders in the most recent two fiscal year periods (FY2024-FY2025) is not complete but as of December 2023 shows an average of 18 misdemeanor restoration orders in FY2024 year-to-date. Most recently, in December 2023 there were 16 misdemeanor restoration orders. This chart and data are updated online in Power BI monthly and can be found on the DSHS Trueblood website, here*. Due to these monthly updates, data will likely be updated beyond what is described above.

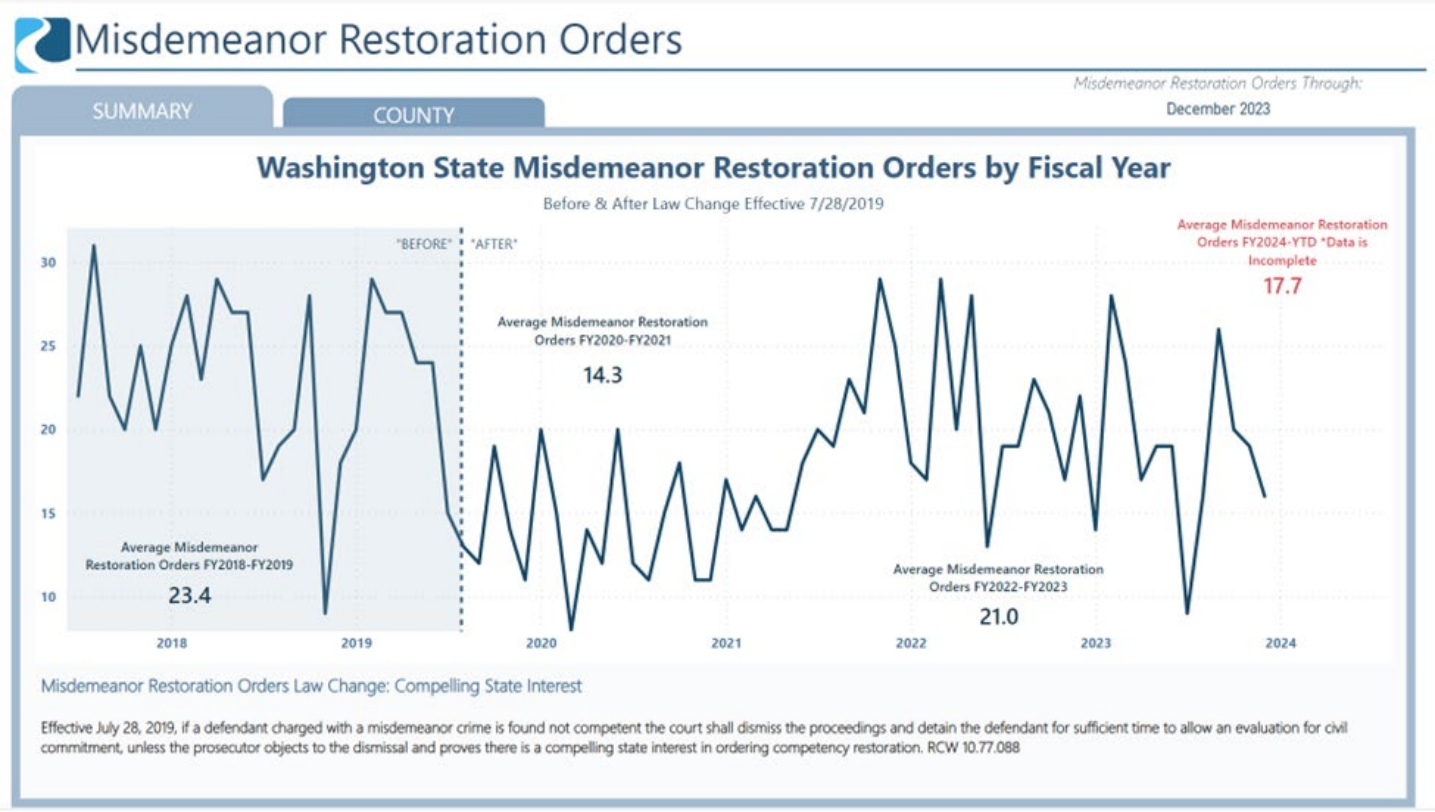
Additionally, the online Power BI report displays the number of misdemeanor restoration orders per county in each fiscal year. For this county-level view, data is suppressed in counties where there are less than 11 misdemeanor restoration orders to maintain client confidentiality.

The department continues its efforts to conduct outreach to the courts that refer the highest number of misdemeanor restoration orders and remains engaged in ongoing discussions with the Court Monitor and Plaintiff's counsel about how to reduce these referrals.

Note that in 2023, RCW 10.77.088 was amended by E2SSB 5440 (signed into law May 15, 2023, and effective July 23, 2023) to require the court to consider "all available and appropriate alternatives to inpatient competency restoration." This includes developing a diversion program for defendants charged with nonfelony crimes. The department will continue to monitor the impacts of this amendment on misdemeanor restoration orders, but there are currently no further updates to report.

FIGURE 3.

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



***FULL DASHBOARD**: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/misdemeanor-competency-restoration
DATA SOURCE: Forensic Data System.

Competency Restoration-Community Outpatient Services

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

Current Status and Areas of Positive Impact

Phase 2 OCRP services began Oct. 31, 2022, in the King region. OCRP contractors in Phases 1 and 2 are accepting outpatient restoration orders from courts in their regions and working with DSHS to communicate and certify when adequate space is available in each of the separate programs. Despite workforce hiring challenges leading to some contractors experiencing vacancies in program staffing, these programs are still meeting the needs of those enrolled in the OCR program.

HCA is working with all four contractors (Lifeline Connections, Greater Lakes Mental Health, Frontier Behavioral Health, and Community House) on ways to address their program's staff vacancies. As an example, HCA added additional funding for more competitive salaries for existing staff on July 1, 2023, and is continuing to review and revise education and experience requirements where appropriate.

HCA is in the process of finalizing contracts with two additional providers in the Phase 3 region. Olympic Health and Recovery Services will provide an OCR program in the Thurston-Mason region, and Kitsap Mental Health Services will provide an OCR program in the Salish region. They are slated to begin OCRP services no later than April 30, 2024.

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

- A transition plan that aids the OCRP, FHARPS, and FPATH teams who may be working with enrolled participants to provide information related to OCRP groups, the element program providers' contact information, and applicable housing plans.
- DSHS and HCA continue to meet to review the findings and identify best practices.
- At a minimum, monthly case staffing events occur between Settlement Agreement elements to ensure communication and program coordination for people enrolled in multiple Trueblood programs.

- OCRP staff complete weekly meetings with forensic navigators and other Settlement Agreement elements, as applicable to review all people enrolled in OCRP services.

- The OCRP administrator, in conjunction with DSHS, has provided examples of how the Breaking Barriers Competency Restoration Program curriculum could be amended to be more culturally aware.

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

OCRP contractors in Phases 1 and 2 have housing units they can use specifically for people enrolled in OCRP. In October, the OCRP contractor in Phase 2 opened an OCRP-specific transitional supportive housing global lease house, where they are providing an on-site Breaking Barriers curriculum to up to six OCRP participants. The Phase 2 OCRP provider plans to open an additional global leased property in early 2024.

Areas of Concern

In Phase 1, the Spokane region had several months of no OCRP enrollments for the months of August through December 2023. The Forensic Navigators noted a decline of 10.77 orders and caseloads during this period and noted that a large portion of their caseload was people in the community waiting for a competency evaluation. The Trueblood Class members who were still in custody were not being assessed as eligible or suitable for OCRP.

In Phase 2, on the other hand, King County courts have been more willing to order OCRP; however, there have been challenges in building out the King County behavioral health provider network necessary to meet this demand.

Recommendations to Address Concerns

In Phase 1, HCA, DSHS, and the Spokane OCRP provider met and created a plan for the OCRP staff and the Forensic Navigators to outreach Trueblood Class members in jail together and attempt to reduce potential barriers to their suitability for OCRP. Since that time, there have been 2 new OCRP enrollments in Spokane.

In Phase 2, HCA is working to build the provider network in King County to meet the demand for OCRP services. HCA increased the contracted staffing with the King County OCRP provider and is working with all OCRP providers to reduce barriers to workforce challenges. HCA is working to respond to the strong interest in ordering people into OCRP in the King region.

Data-Competency Restoration-Community Outpatient Services

OCRP services began in Phase 1 regions on July 1, 2020, and the Phase 2 King region on Oct. 31, 2022. Between July 1, 2020, and Dec. 31, 2023, 192 clients were enrolled in OCRP Phase 1 and 2 regions: 56 in Pierce, 68 in Southwest, 38 in Spokane, and 30 in King (Appendix B, Table 1). This is an increase of 40 people (26 percent) since June 30, 2023. Additional data by region are provided for this period and will be expanded as regions serve more participants. Across regions, most enrollments were for felony restoration orders (82 percent) and participants were mostly male (69 percent), 30-49 years old (52 percent), non-Hispanic white (61 percent), and unstably housed or homeless (a combined 75 percent).

Of the 166 participants discharged, (Appendix B, Table 2), 41 percent were opined competent, 28 percent had their conditional release revoked, and 12 percent had their charges dismissed. About 6 in 10 (63 percent) were discharged to the community, 19 percent were admitted to inpatient services at either a state hospital or a residential treatment facility, and 10 percent were in jail. Among those discharged, the average length of stay in OCRP was 73 days, ranging from 60 days in King region to 83 days in Pierce region. The average length of stay includes misdemeanor and felony orders and all discharge types (e.g., those who completed the program and were opined competent, and those who were returned to jail or whose conditional release was revoked).

Forensic Navigators

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

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

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

Current Status and Areas of Positive Impact

Forensic navigators remain in close contact with attorneys and outpatient competency restoration programs. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators facilitate eligible clients' connections to housing and recovery programs as well as to forensic peer services and case management supports even when class members are not ordered into outpatient restoration, and after the forensic navigator is no longer actively assigned to the client. New staff have been added to Southwest Region (Clark, Klickitat, Skamania on Nov. 1, 2023) and Spokane Region (on Oct. 16, 2023). As mentioned above, forensic navigators have also connected with both OCRP and RTFs to pilot a program that re-assesses clients on a second 90-day inpatient restoration order, who may be suitable for community restoration. This pilot is in process of being extended to Western State Hospital as another phase to the program.

The Phase 2 navigators became fully staffed in July 2023 and continue making every effort to advocate for Trueblood class members in King County. The Phase 2 supervisor has done an excellent job leading the staff, which has allowed the team to increase communication with courts and attorneys. The phase is also adding more staff to ensure that caseloads remain sustainable, allowing navigators to effectively advocate for Trueblood service members. OCRP continues to increase its capacity in the region, which has allowed navigators to transition more clients into diversion options. The program staff has been essential in furthering refinement of program practices.

Phase 3 implementation is on track to begin engagement with the Trueblood suite of services in the Salish and Thurston/Mason Regions. Phase 3 has hired a former Pierce County Navigator as supervisor. Phase 3 has also hired seven navigators across all three regions, some of whom have worked as navigators in other phases to extend the understanding of the role in the new areas. The Phase 3 team has recently begun program outreach in the regions. The team has three hires outstanding: two more navigators and an administrative assistant.

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

As of February 2024, this team has hired a supervisor, Carlita Boyd, and has worked with her administrative assistant to establish a rollout process for the team. Diversion staff have been hired in the Southwest region, Pierce County, Spokane, King County, Thurston/Mason, and Salish (Kitsap, Clallam, Jefferson) areas. Southwest staff have been the first to engage and access jail/court systems to initiate practice to support Trueblood class members and begin the diversion process. Diversion staff are finalizing education resources with the communications team that should be shared in March 2024.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one that primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not necessarily extend to a larger group of people for whom competency to stand trial has been raised, particularly those for whom a competency evaluation is ordered at or after their release from jail. Additional stakeholder frustration appears to be focused on availability of other non-navigator resources and diversion options. With the additions to our program roles included in House Bill 5440, the attention increases on how both components of the navigators will function within the court system.

Program staff continue to engage and inform prosecution, defense, and judges to develop a shared understanding of this new program. Meetings and discussions continue with prosecutors, defense, and courts in all three Phase 1 regions in partnership with HCA. While the program grows and awareness increases, outreach remains a necessity to enhance the referral process. Phase 2 outreach and engagement have been more consistent after learning from Phase 1 interactions. While courts, jails, and many attorneys have been understanding partners, because the program is in its infancy, defense attorneys have allowed minimal client contact across the county. The lack of access to clients in this region continues to be an issue. Although space continues to increase in the region, access to clients has not. The team has yet to find a solution to obtain more interaction with clients.

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

Recommendations to Address Concerns

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

Data-Forensic Navigators

The department has recently published a dynamic Power BI report to track program data and illustrate trends. The new report provides both quarterly and cumulative data that can be broken down by region to enhance reporting capabilities. The data presented below and in Appendix C represents selected figures and tables from the new Power BI report. The full report can be accessed online here*

There were 381 people active in the Forensic Navigator program at the end of Q4 2023 (Appendix C, Figure 1). Twenty-three of them were enrolled in OCRP as of the last day of the reporting period (Appendix C, Figure 2). This number is slightly fewer than previous 2023 quarter's enrollment but still represents a trending increase in OCRP enrollment since the program's inception. As can be seen in the full Power BI report, the King region had the highest number of people enrolled in OCRP in Q4 2023 and the Spokane region did not have any enrolled

in OCRP in this most recent quarter. OCRP enrollment data for the Southwest and Pierce regions is suppressed in the full report due to numbers less than 11. Note that suppressing region-level numbers less than 11 occurs throughout the full Power BI report to protect client confidentiality.

Cumulatively, a total of 6,036 people were assigned a forensic navigator between July 1, 2020 (program start) and Dec. 31, 2023 (Appendix C, Figure 1). As can be seen in the online Power BI report, this includes 2,767 people in King County, where forensic navigator services began in January 2022. Just under half (46 percent) were charged with a felony, and 54 percent were charged with a misdemeanor (Appendix C, Figure 1). This shift from a majority of felony cases to misdemeanors is attributed to the addition of cases from the King region when Phase 2 began, where 7 in 10 people served by forensic navigators had a misdemeanor offense.

More than half of the people assigned a navigator since the program's start were male (62 percent) and were between the ages of 30 to 49 (56 percent). Slightly less than half (47 percent) were non-Hispanic white (Appendix C, Table 1). These patterns are consistent across regions. Note that for gender reporting, due to a small number of people identifying as a gender other than male or female, that category is combined with "unknown" to protect client confidentiality and preserve anonymity. As the program grows, the department continues to monitor if it is possible to break out these categories accordingly. The program additionally continues to make improvements to data collection and data quality.

Across all regions, forensic navigators had an average of 21 clients in their caseload (Appendix C, Figure 1). This has remained stable for the past year. However, caseload did differ by region. Since Q3 2022, the Southwest region has consistently had the highest average daily caseload, with quarterly numbers shown in pink to represent a caseload exceeding the program standard of 25 (Appendix C, Figure 3). In Q4 2023, the Southwest region had the highest average daily caseload (34), and the Spokane region had the lowest average caseload (11). Forensic navigators worked to gather information for the courts for nearly all people assigned a navigator during the reporting period (99 percent, Appendix C, Figure 4). This is the most common service provided for people since the program's start. Client meetings, interviews, or observations were conducted with 46 percent of people assigned a navigator. A recommended service plan was completed for 77 percent of people. The percentage of clients receiving a completed recommended service plan has increased by nine percent since Q1 2023 (Appendix C, Figure 4), and the full online Power BI report* presents changes in time of additional selected services as well. Navigators provided coordination of care for 37 percent of clients overall, and a higher rate in Southwest (74 percent) and Spokane (52 percent), compared to Pierce (45 percent) and King (18 percent) can be seen in the online report. Nearly one in three (32 percent) received a referral to other community services. Forensic navigator services in King County started prior to other Trueblood programs in the region. Navigator services and referrals are expected to increase as OCRP services expand and the program matures.

The most common types of referrals were for other Trueblood partner programs: 19 percent received a referral to the FPATH program and 18 percent received a referral to FHARPS (Appendix C, Figure 5).

A total of 5,655 people were discharged during the reporting period, with an average length of stay in the program of 39.7 days, ranging from 35.4 days in King region to 59.4 days in Southwest region as can be seen in the online report. About one-third (31 percent) of those were discharged with a warm handoff to providers or jail staff. Thirty percent of cases were closed because the person was determined competent, and 20 percent of cases were closed because the person was ordered by the court to receive inpatient restoration (Appendix C, Table 2). Twenty percent of cases were closed when people were released from jail on personal recognizance and 16 percent were discharged due to charges being dismissed (Appendix C, Table 2). This did vary by region, for example, the full online report shows the Southwest region had a smaller number of discharges due to release from jail on PR (6 percent) and the Spokane region had a higher number due to PR (32 percent).

The program and data collection continue to evolve. Data for the program is collected through the Navigator Case Management System and will continue to be updated and made available in Power BI on a quarterly basis. Due to these monthly updates, data in the online report will likely be updated beyond what is described above.

***FULL ONLINE POWER BI DASHBOARD:** https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program-0

Competency Restoration-Ramp Down of Maple Lane Forensic RTF

DSHS opened two forensic RTFs for Trueblood Class Members to provide additional inpatient competency restoration services in 2016, the Yakima Competency Restoration Program and Maple Lane's Competency Restoration Program (as Maple Lane's campus has begun to grow, MLCRP is now known as Cascade Unit, and the entire campus is known as DSHS Behavioral Health & Treatment Center – Maple Lane Campus.). In 2019 the department opened a third RTF, DSHS Behavioral Health & Treatment Center – Steilacoom Unit (formerly Building 27/Fort Steilacoom Competency Restoration Program). The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order.

Both YCRP and Cascade Unit were scheduled to close as part of the overall integrated system changes contemplated in the Settlement Agreement. Yakima was scheduled to close by Dec. 31, 2021, but closed on Aug. 14, 2021, due to difficulty recruiting and retaining staff through December 2021. The last patient transferred out on July 26, 2021. Cascade Unit has a hard closure date of July 1, 2024. The DSHS positions at Cascade Unit converted to permanent status on Dec. 16, 2021, providing the staff who stay until closure layoff rights. During the 2023 Legislature session, funding was secured to keep the building that houses Cascade Unit open permanently. Competency restoration services will end on June 30, 2024, along with the contract with WellPath. On July 1, 2024, Cascade Unit will be re-purposed for Not Guilty by Reason of Insanity residents transferring from both state hospitals. Cascade Unit's ramp down plan timeline was updated due to this change.

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 Cascade Unit. As stated above, the timelines were modified due to the DSHS positions being converted to permanent. A meeting held on June 28, 2022, clarified the changes that needed to occur. Additional information on that meeting's outcomes will be reported in the future. Based on the closure of YCRP, the current plans may be adjusted to reflect lessons learned from that recent closure. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

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

Recommendations to Address Concerns

DSHS continuously monitors turnover, morale, and other factors, and actively takes steps to neutralize negative affects at Maple Lane's Cascade Unit now that Yakima has closed. Given the potential variability in closure dates due to agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient discharges. Additionally, our contract oversight of the contractor at the Cascade Unit will focus on the contract requirements to ensure sufficient staffing.

The residential services manager works closely with the director of residential treatment facilities on staffing challenges for the DSHS side of operations at the Cascade Unit. As of late fall 2022, two changes have been made: recruiters have expanded where open positions are advertised, and all DSHS positions have been made permanent. The director of RTFs is currently working on reallocating the staff to be consistent with the two other DSHS programs opening on the Maple Lane campus starting in December 2022. In January 2023, Cascade Unit entered a contract with Centralia College to offer a practicum for its students in the college's Behavioral Health program. Staff from Cascade Unit attended a job fair in early January 2023 and received a few applicants from the event.

Data-Competency Restoration-Ramp Down of Maple Lane RTF

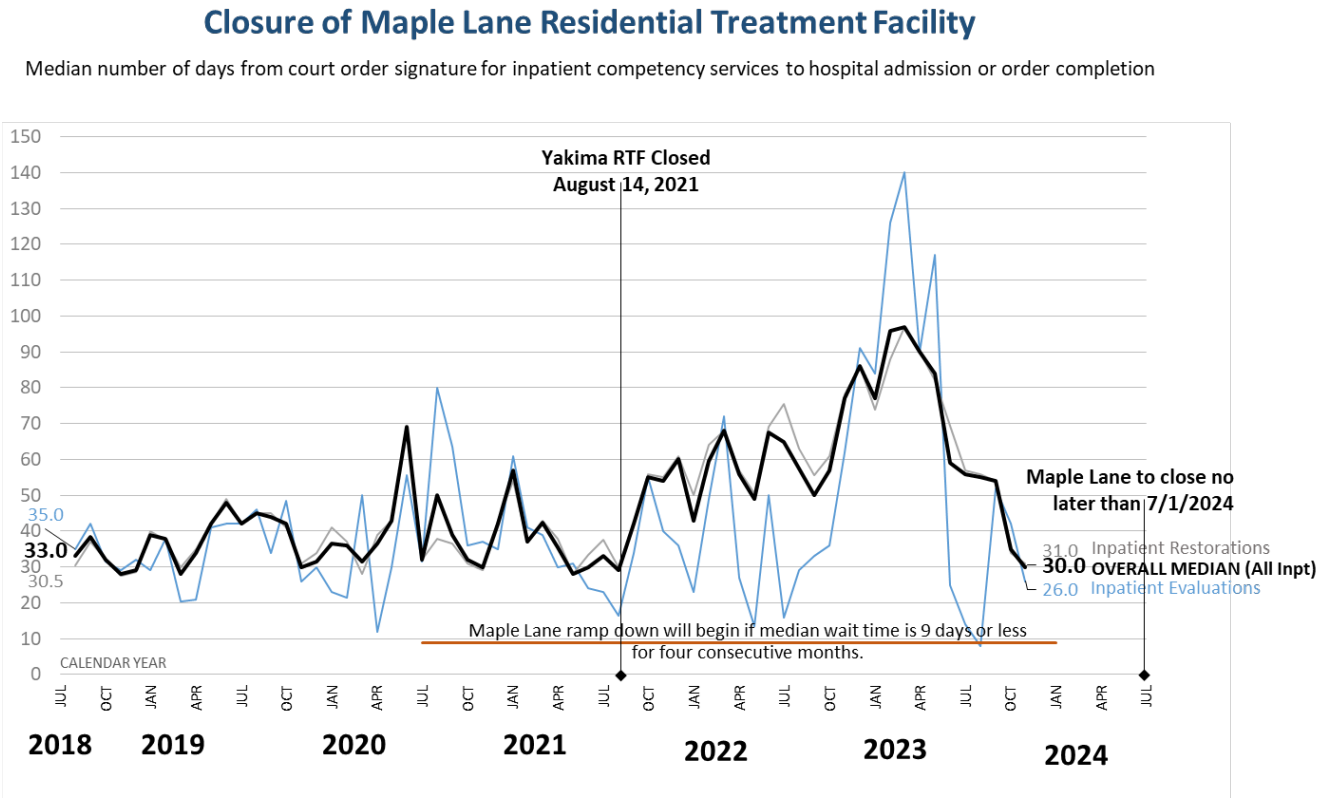
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services monthly (Figure 4). As of January 2024, the median wait time for inpatient competency services in December 2023 was 30.0 days. The ramp down of Maple Lane's Cascade Unit will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 4.

Closure of Maple Lane Residential Treatment Facility

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

JANUARY 2024



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 people waiting for services in jail. The order is completed when the individual is admitted for inpatient services, or when the order is dismissed, withdrawn or when the individual is physically released from jail (e.g., on personal recognizance or work release). Includes admissions to WSH, ESH, Maple Lane's Cascade Unit, and Yakima Residential Treatment Facilities.

Crisis Triage and Diversion-Additional Beds and Enhancements

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

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

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

In Phase 3, once HCA receives the fiscal budget for FY2025, HCA will coordinate with the Department of Commerce to begin the RFP process to add 16 crisis stabilization beds in the Thurston-Mason region. The Salish region has existing sufficient crisis stabilization bed capacity.

Current Status and Areas of Positive Impact

Additional Crisis Beds – Spokane Phase 1

Spokane Regional Stabilization Center was designed to provide alternative options for law enforcement and other first responders when interacting with people demonstrating a behavioral health crisis whose behaviors did not meet the threshold of arrest and would benefit from behavioral health support.

SRSC has steadily increased their collaboration with local law enforcement agencies and first responders to continue to provide support and diversion for people brought to the SRSC by police hold or drop-off. SRSC maintains regular coordination meetings with a diverse group of community stakeholders, including the Spokane Police Department, Spokane County Sheriff, the Spokane Regional Law and Justice Council, and the Spokane County Regional Interlocal Leadership Structure.

Additional Crisis Beds – King Phase 2

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

The Department of Commerce entered into a contract with Recovery Innovations International RII on June 30, 2022, for one of the two King County crisis stabilization facilities. Additionally, ConnectionsWA is now under contract with the Department of Commerce. ConnectionsWA has been under construction since June 2023. ConnectionsWA has successfully navigated the process of obtaining permitting and licensure to maintain the construction timeline. ConnectionsWA is on target to open the crisis stabilization facility by June or July 2024.

Areas of Concern

The implementation plan required that two crisis stabilization facilities be under contract with the Department of Commerce by June 30, 2022, and that they begin their construction in King County by December 2022. RII has been under contract with the Department of Commerce but did not start construction by the deadline of December 2022.

RII identified a capital construction funding gap of 1.6M and requested a direct appropriation form the legislature. They were directly appropriated 1.9M in capital funds for their Trueblood funded crisis stabilization facility in July 2023. Commerce has not added these funds into contract with this award because of the ongoing hesitancy of RII. RII continues to raise concerns regarding the future sustainability of the project due to future investments into the crisis system in King County. RII reports that if they are not awarded the RFP for south King County Crisis Care Center, then their project would not be sustainable. King County intends to open a competitive procurement for these new facilities in late Spring 2024. RII has stated that they will not be moving forward with construction of this 16-bed Trueblood funded crisis stabilization facility until they know if they are awarded King County's procurement.

HCA has received broad concerns from crisis stabilization providers that current reimbursement rates pose difficulties in sustaining facility operations across the state.

Recommendations to Address Concerns

To address the concerns indicated above, HCA and DSHS in coordination with the Department of Commerce have:

- Met with RII on an on-going basis until November 2023 to address their concerns regarding the capitol funds, the rate of reimbursement, and the King County procurement. The meetings stopped on Nov. 2, 2023 because RII stated that they will not be moving forward with the construction unless they are awarded the King County funding for the South King County Crisis Care Center.

- Met with King County to learn more about their procurement process and their interactions with RII.

- HCA is assessing how reimbursement rates affect the sustainability of crisis stabilization facilities to better support providers like ConnectionsWA and RII.

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 1

As of Sept. 30, 2023, Lifeline Connections served 2,231 people. Of the people that were served, Lifeline Connections successfully discharge 53 percent with some sort of community behavioral health support, 14 percent of people served were discharged directly into substance use residential treatment, and only eight percent of people served were discharged into homelessness. The Lifeline Connections case management team continues to build strong relationships with community partners in order to connect people to services upon discharge. Lifeline Connections also hired two full-time mental health professionals to support with 24/7 intakes.

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

Current Status and Areas of Positive Impact

Crisis Enhancements – Phase 2

The total number of people served increased during this reporting period. King County BHASO reports that the SUD supervisor and the Crisis Diversion Facility Program Manager have hired SUD frontline staff positions. King County also had improvements with retaining staff at the Crisis Solutions Center after recent wage increases. King County BHASO also reports continued success in providing crisis diversion services as an alternative to arrest for law enforcement.

Areas of Concern

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

Both Spokane and King County BHASOs report continued workforce shortages reports continued obstacles in hiring and retaining staff, particularly registered nurses, mental health professionals, and behavioral health clinicians.

Recommendations to Address Concerns

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

Data-Crisis Triage and Diversion-Additional Beds and Enhancements

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

Crisis Triage and Diversion-Residential Supports

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

Current Status and Areas of Positive Impact

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

HCA allowed FHARPS providers to request exemptions to policy when participants are clinically unique, are engaged in the program, and might otherwise re-enter the criminal court or forensic systems if no exception is granted. These extensions allow people to access more housing voucher funds and continue to receive housing supports for longer than an initial six-month period. FHARPS providers reported to HCA that the majority of FHARPS program participants are remaining in the program for longer than the initial six-month duration in order to increase their likelihood of obtaining permanent housing. FHARPS teams consider all housing interventions in order to be responsive to individual needs and preference of program participants.

FHARPS providers are engaged in multiple global leasing projects with most dedicated units existing in Pierce County through Comprehensive Life Resources. While CLR has access to over 60 units, workforce challenges limit their ability to fill every unit. HCA is working with CLR to ensure best practices regarding caseload sizes while they maintain a high number of FHARPS participants.

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

Emergency Housing Vouchers

Because there are no licensed crisis stabilization facilities currently located in the King region, HCA and the King County BHASO have made crisis housing vouchers available to programs that

provide hourly crisis services. King County BHASO reported the vouchers are available through Downtown Emergency Services Center's Community Outreach and Advocacy Team program, Navos' Adult Crisis Services, and Valley Cities' Adult Crisis Services and Assisted Outpatient Services teams. DESC, COAT, and Valley Cities Assisted Outpatient Services are currently the only programs that have used the vouchers. King County BHASO held support meetings with each provider to identify more ways to support the teams in utilizing this resource.

In Phase 3, crisis housing vouchers were added to the Thurston-Mason BHASO contract because there are no licensed crisis stabilization facilities currently located in that region. HCA executed direct contracts with the two agencies in the Salish Region that operate the region's crisis stabilization facilities, Kitsap Mental Health Services and Peninsula Behavioral Health Services, to make crisis housing vouchers available to people needing emergency housing upon discharge from those facilities.

Carelon has expressed interest in receiving the short-term crisis housing vouchers in the Pierce Region and is interested in increasing utilization and diversifying voucher distribution.

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

Areas of Concern

Housing remains the primary need for Trueblood Class members. HCA is working with the FHARPS programs to identify current gaps in the FHARPS program model. These include the issues surrounding time-limited, transitional housing for Trueblood Class members. As reflected in the data, many of the FHARPS program participants discharge from the program within an unknown status. This is unfortunately a common occurrence in time-limited, transitional housing programs. FHARPS programs are continuously trying to identify and connect participants to permanent housing options, but these are extremely limited resources especially for Trueblood Class members. The FHARPS programs are continuing to extend the length of stay for program participants to prevent discharge to homelessness while working towards connecting participants to permanent housing. However, permanent housing options are not available to the majority of program participants while they are enrolled in FHARPS programs. This has created unsustainable caseloads for many of the programs.

Recommendations to Address Concerns

HCA has and will continue to strategize how to increase permanent housing options for Trueblood Class members. HCA is working with the FHARPS programs to address the workforce issues and the barriers related to time-limited housing interventions without adequate permanent housing options available. In order for Trueblood Class members to sustain housing beyond FHARPS, we must have a robust housing continuum that includes indefinite, permanent housing options. Since adequate permanent supportive housing is not readily available to Trueblood Class members, HCA is working with the FHARPS providers to provide sustained housing as best as possible within these constraints.

Hourly crisis teams that have short-term crisis housing vouchers available assess people who are currently experiencing behavioral health crises and show decreased use of crisis housing vouchers in an outpatient setting, while inpatient facilities use crisis housing vouchers after a period of treatment and stabilization. HCA is relying on regional experts at the BHASOs to determine how to best utilize these vouchers.

Data-Crisis Triage and Diversion-Residential Supports

Residential supports are provided through two mechanisms: (1) crisis housing vouchers provided by crisis triage and stabilization facilities; and (2) the FHARPS program. The collections continue in Excel tracker workbooks while HCA works to implement the alternative forms-based collection. The FHARPS program was the first to transition to this system in August 2023. Data processes will be updated to report data from both sources in the next semi-annual report.

Vouchers Data

The crisis stabilization and triage facilities and provider teams contracted with HCA to provide housing vouchers distributed 728 vouchers to 551 people between Dec. 1, 2019, and Dec. 31, 2023 (Appendix D, Table 1).[8] Vouchers were available in the Phase 2 King region beginning July 2022.

Southwest (accounting for 36 percent of vouchers) distributed the greatest number of vouchers and served the largest portion of people receiving vouchers (197, or 36 percent). The total amount disbursed across Phase 1 and 2 regions was $705,935 and the average amount per recipient was $1,271. Due to vouchers being distributed both by CS/CT facilities and within the community, 'referral source' can mean either how the individual was referred to the CS/CT facility or to the community entity distributing housing vouchers. Self-referrals and hospitals accounted for 6 in 10 referrals among those receiving vouchers (34 percent and 27 percent, respectively).

[8] Crisis housing vouchers transitioned to HCA's PDAMS in November 2023. Pierce Region data are incomplete due to one provider, RI International, not submitting the final excel tracker following the data collection transition to PDAMS. which may include up to four weeks of data in October. HCA will continue efforts to obtain this data.

Most voucher recipients were male (67 percent), between 30 and 39 years old (54 percent), and non-Hispanic white (62 percent).

Based on matching crisis housing voucher recipients to those within the FHARPS program data, 22 percent of voucher recipients were referred to FHARPS, 20 percent were contacted and enrolled, and 17 percent were housed or sheltered by FHARPS. Most initial housing placements through FHARPS were shelter/emergency placements (83 percent), which included motels.[9]

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

FHARPS Data

The FHARPS program expanded to the Phase 2 King region in April 2022. A total of 1,840 people were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to Dec. 31, 2023 (Appendix E, Table 1).[10] Of these referrals, 1,292 (70 percent) were contacted[11] and 1,096 (60 percent) were enrolled.

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

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 63 percent of recorded referrals. Forensic navigators made the most referrals, 39 percent overall, and comprised 99 percent of referrals in the King region. FPATH referred 15 percent, and crisis stabilization and triage facilities referred 8 percent.

Most initial contacts were made by phone (34 percent), down from 74 percent in yearend 2020 when outreach methods were limited due to COVID-19 protocols. Contacts in jail increased to 32 percent, largely due to King region conducting 99 percent of contacts in jail.

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[9] Linking individuals became more complex when CHV and FHARPS transitioned to using the Program Data Acquisition, Management, and Storage system for data collection since the last report. RDA and HCA will continue to collaborate on how to improve person and event tracking across sources.

[10] FHARPS data collection transitioned to PDAMS in August 2023. Data are subject to change due to challenges tracking people across Excel trackers and PDAMS data. RDA and HCA will collaborate on improvements.

[11] 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.

More than two-thirds of people (69 percent) enrolled in FHARPS were male, 57 percent were between 30 and 49 years old, and 49 percent were non-Hispanic white. Nearly one-quarter of participants (24 percent) identified as Black or African American and 10 percent as Hispanic or Latino. People can identify as more than one race or ethnicity. Most people were homeless at the time of enrollment (56 percent).

Of those enrolled, 76 percent were housed or sheltered at least once since their enrollment (Appendix E, Table 2). About 51 percent of first housing types were emergency/shelter placements, which included motels. This is down from 68 percent at year-end 2021. There was simultaneously an increase in transitional housing from 23 percent at year-end 2021 to 40 percent as of Dec. 31, 2023, due in part to an increase in the use of master leasing options and King region utilizing mainly transitional housing placements.

The King region had a lower rate of people housed or sheltered compared to other regions. This is likely due to enrollments in jail and that the King region mostly uses transitional housing rather than emergency placements. Those enrolled could still be incarcerated, may transfer to inpatient treatment, may be released into the community and fail to reconnect with the program, or may be awaiting placement in transitional housing through the program.

About two-thirds (65 percent) of participants enrolled between March 2020 and December 2023 were discharged as of Dec. 31, 2023, with an average length of support of 207 days, ranging from 42 days in King region to 232 days in Spokane region (Appendix E, Table 3). The average total subsidy support received by those discharged was $6,469.

Data indicates that providers are not closing cases as requested. Some are leaving cases open longer than 60 days or with no subsidies or contacts, which would increase length of stay. Others are re-opening previously closed cases instead of starting a new enrollment, which would result in longer lengths of stay and higher average subsidies. RDA and HCA are working together on how to ensure consistent data entry.

Among people discharged, 28 percent of cases were closed due to loss of contact, 15 percent transitioned to other housing support, 13 percent transitioned to self-support, and 14 percent withdrew. Another 9 percent received the maximum assistance and were discharged without transition to other services. At the time of discharge, about one-third (33 percent) were stably housed, 12 percent were homeless, and 11 percent were in a facility. Housing status at program discharge was unknown for 35 percent of people (slightly higher than the loss of contact rate).

Crisis Triage and Diversion-Co-Responders

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

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

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

Current Status and Positive Impacts

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

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

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

The enhancements in the three Phase 1 regions were funded to provide a more timely response for people in the community who were experiencing a crisis and to work collaboratively with law enforcement, co-responders, and other first responder teams to accept referrals and thereby

divert from arrest. Trueblood-funded MCR enhancements during the Phase 1 schedule have included:

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

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

- Frontier Behavioral Health utilized MCR enhancements to expand MCR services outside of Spokane County to better assist with and address the needs of neighboring rural counties. FBH continues to actively work to provide community outreach and education to promote awareness for the MCR program in Spokane County.
- Adams County reports that enhanced MCR services have assisted the needs of their rural communities by providing a more efficient way of dealing with crisis and with people that meet criteria by meeting them where they are, in community settings. They report that being able to provide this level of services in this way addresses crises with more resources that can aide people in their current situations.

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

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

- Reduce response times
- Expand services to increase in-person response to rural areas

- Increase follow up services
- Provide community training and education.

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

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

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

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

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

Areas of Concern
There are no areas of concern that this time.

Recommendations to Address Concerns
As a result of the Phase 3 negotiations, it was agreed upon by all parties that the mobile crisis response element be removed from the Settlement Agreement. There have been significant investments into mobile crisis response statewide. This work has moved from the Trueblood team to the Adult Services and Involuntary Treatment section within HCA and is funded within the maintenance budget.

Data-Crisis Triage and Diversion-Co-responders

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

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

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

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

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

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

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

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

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

Crisis Triage and Diversion-FPATH

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

Current Status and Areas of Positive Impact

FPATH teams across the state are reporting an increased number of referrals coming from forensic navigators and have been adjusting their services to meet the increased need. HCA continues to facilitate learning opportunities for FPATH providers as needs increase.

FPATH is currently preparing for Phase 3 and expanding to Thurston County, Mason County, and the Salish region (Clallam, Jefferson, and Kitsap Counties). Contracts are expected to be finalized no later than Feb. 29, 2024, and programs running near full capacity by April 30, 2024. HCA will be contracting with Olympia Health and Recovery, Kitsap Mental Health Services and Peninsula Behavioral Health. HCA is connecting the new Phase 3 FPATH teams to C4 Innovations for trainings related to person-centered case management, trauma informed care, assertive outreach practices, and equity and inclusion.

Areas of Concern

In the King region, FPATH teams struggled with utilization of Homeless Management Information System (HMIS) for data recording. HMIS is not the appropriate data capture system and the FPATH programs have experienced barriers to entering data and capturing FPATH related services in HMIS.

FPATH teams have identified and are working to reduce challenges with outreaching and providing services to people in rural parts of Washington. FPATH teams are trying to identify the most effective ways of locating and engaging FPATH eligible people.

Recommendations to Address Concerns

Since program inception, FPATH programs have been utilizing HMIS and Excel trackers as data capture tools. HCA has acquired a new program data acquisition and storage (PDAMS) system for all of the HCA Trueblood element programs. FPATH data will officially transition to PDAMS in March 2024. The PDAMS data capture system is being designed for the HCA Trueblood element programs and will enhance data entry, program oversight, and allow HCA to make data-informed decisions.

Data-Crisis Triage and Diversion-FPATH

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

The FPATH program began March 1, 2020 in Phase 1 regions, and April 1, 2022 in the Phase 2 region. Between March 1, 2020 and Dec. 31, 2023, 3,280 people were referred to the program across all regions (Appendix F, Table 1). HCA continues to encourage providers to focus outreach efforts on a subset of these people based on housing status (prioritizing unstably housed and homeless), number of referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 1,635, which was 50 percent of the total referral list.

Of all people on the referral list, FPATH providers attempted to contact 1,257 (38 percent) and successfully contacted 1,087 (33 percent). As of Dec. 31, 2023, a total of 621 people (19 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Similarly, enrollments among the prioritized population were also 19 percent of the prioritized list.

Of the Phase 1 regions, Southwest had the smallest referral list and continued to enroll the largest proportion (38 percent, Appendix F, Table 1). The Pierce region had the largest referral list and enrolled 20 percent. The Phase 2 King region has had 171 enrollees since the program started in April 2022, which was 13 percent of its referral list. Of these, 64 were from the prioritized population.

Among enrolled people, the majority were male (69 percent overall) and between 30 and 49 years old (62 percent). Nearly two-thirds of enrollees (62 percent) were homeless at program enrollment, while 19 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among all people discharged from the FPATH program through Dec. 31, 2023, the average length of stay in the program was 290 days. People in the Pierce region had the longest length of stay at 341 days, while the King region had the shortest at 167 days. (Appendix F, Table 1). Loss of contact was the most common reason for FPATH discharge throughout all four regions (45 percent overall).

Services

There have been 12,131 service encounters between FPATH providers and participants over the duration of the program, with an average of 2.2 services per participant, per month (Appendix F, Table 2). Averages ranged from 2.0 services per month in the King region to 2.5 in the Southwest region. Across all FPATH regions, the most common service encounter was case management

(1.2 per person, per month, on average), followed by outreach services (0.3 per person, per month) (Appendix F, Table 2).

Referrals

Of the 621 FPATH enrollees, 219 (35 percent) had received at least one referral through December 2023 (Appendix F, Table 2). The Spokane region provided the most referrals, with 64 percent of participants having at least one, followed by 41 percent in the Southwest region and 37 percent in the Pierce region. In the Phase 2 King region, 8 percent of enrollees had received at least one referral.

The most common referral throughout all four regions was to FHARPS housing, with 16 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Approximately 11 percent of enrollees received at least one community mental health referral. Due to low enrollment numbers, and to protect participant confidentiality, detailed referral information for Phase 2 FPATH enrollees is not available as of Dec. 31, 2023.

Education and Training – Crisis Intervention Training

For all the phased regions through Dec. 31, 2023, the Criminal Justice Training Commission has completed 39 40-hour courses for certified peace officers. Within these classes, CJTC has trained law enforcement officers, mental health professionals, dispatchers, co-responders, military police, and corrections officers. As of Dec. 31, 2023, 2,814 law enforcement officers have completed this training. As of June 30, 2023, every agency in the Phase 2 region had met the goal of 25 percent of certified peace officers completing the 40-hour CIT training. Phase 1 and 2 regions continue to conduct 40-hour CIT training on a regular basis.

CJTC has developed and deployed a webinar-style eight-hour course, specifically to meet the needs of correctional agencies. Corrections classes were put on hold for the last six months while the focus was set on developing and deploying the 40-hour regional Law Enforcement classes. These will begin to be scheduled both virtually and in person in the coming six months. Through the combination of the earlier traditional courses and the addition of Clark County's 40-hour program, 1,091corrections officers have received at least the minimum eight-hour CIT for corrections training. Lincoln and Skamania counties sheriff's departments cross-train their corrections officers as 911 dispatchers. Those officers took the eight-hour 911 CIT training.

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

CJTC collaborated with the state 911 office to provide the eight-hour CIT course for dispatchers. The telecom/911 training was reformatted to a hybrid course comprised of four hours of self-paced online training and a follow-up four-hour instructor-led webinar course. It was also found that several telecom training programs already included the eight-hour CIT materials. Several of these programs applied and were granted equivalency status. To date, 1,003 dispatchers have received the full eight hours of training.

For Phase 2, the King region continues running a robust 40-hour CIT program. Because of this, of the 3,160 certified peace officers in the King region, 1,558 have completed the training (49 percent). By June 30, 2023, every police agency in King County (Phase 2) had met or exceeded the mandate of 25 percent of not just officers assigned to patrol but of certified officers assigned to their individual agencies. The King region completed five of the 40-hour CIT courses in the second half of 2023.

The King region has six correctional agencies encompassing 576 correctional officers. To date, 562 officers (98 percent) have completed the required eight-hour CIT for corrections training. These courses have been offered exclusively in an interactive webinar format.

The King region has 446 telecom/911 dispatchers. Of these, 427 (97 percent) have completed either the hybrid four-hour static/four-hour webinar or equivalent training. At least two webinar courses are scheduled each month, and the static course can be taken at any time as the prerequisite.

Areas of Concern

The current training environment is improving slowly. The pandemic and resulting vaccine requirements had a significant impact on staffing levels across the board. The CJTC has more than doubled the number of basic law enforcement academies, and there is a six-month wait for entry. Every law enforcement, corrections, and telecom agency are working short-staffed. Some are staffed as much as 20 percent below their allotted positions. When an agency cannot cover their own active shifts, it is difficult to encourage them to create a larger deficit by sending an officer to 40 hours of training. This trend continues to turn around, and we are seeing improvements in staffing levels at more and more agencies.

Recommendations to Address Concerns

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

Data-Education and Training-CIT

Phase 1

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

Appendix G, Figure 1 displays training completion rates for each individual law enforcement agency in Phase 1. As of Dec. 31, 2023, 38 (70 percent) law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies continued to achieve higher training completion rates (49 percent overall) than small agencies (36 percent) in all three regions (Appendix G, Table 1). It should be noted that the CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022. Training rates will continue to shift, however, as the number of officers in each agency fluctuates over time.

As shown in Appendix G, Table 1, the overall training completion rate for all law enforcement agencies in Phase 1 was 39 percent as of Dec. 31, 2023. In the Pierce region, 26 percent of officers were trained, compared to 55 percent in the Southwest region, and 51 percent in the Spokane region. Washington State Patrol units in the Phase 1 regions have achieved a training rate of 25 percent.

The Settlement Agreement also requires 911 dispatchers and correctional officers in the Trueblood Phase 1 regions to complete an eight-hour CIT course. In June 2022, the CIT program achieved 100 percent compliance with the 911 dispatchers training requirement in the Phase 1 regions. As of Dec. 31, 2023, 96 percent of Phase 1 911 dispatchers had completed CIT training, with the Pierce region remaining 100 percent compliant (Appendix G, Table 3). In addition, 94 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 65 percent in the Southwest region to 97 percent in the Pierce region (Appendix G, Table 2).

Phase 2

Appendix G, Figure 2 displays the training completion rates for the law enforcement agencies in Phase 2, which began July 1, 2021. As of Dec. 31, 2023, all 28 (100 percent) law enforcement agencies continued to exceed the 25 percent benchmark, with an overall training completion rate of 49 percent (Appendix G, Table 1). Washington State Patrol units in Phase 2 had a training completion rate of 37 percent. Unlike Phase 1, small law enforcement agencies in King County had the highest overall training rate (54 percent) while medium-sized agencies had a lower overall rate of 38 percent.

Nearly all (98 percent) correctional officers in King County had completed the eight-hour CIT course by Dec. 31, 2023 (Appendix G, Table 2), as well as 96 percent of 911 dispatchers (Appendix G, Table 3). Dispatchers and correctional officers in the Phase 2 region had until June 30, 2023, to meet the 100 percent training requirement.

Phase 3

Appendix G, Figure 3 displays the training completion rates for the law enforcement agencies in Phase 3, which began on July 1, 2023. As of Dec. 31, 2023, 12 (55 percent) law enforcement agencies had met or exceeded the 25 percent training requirement, with an overall training rate of 35 percent. Large law enforcement agencies had higher training rates than small agencies (42 percent and 26 percent, respectively), and Washington State Patrol units had a training completion rate of 28 percent (Appendix G, Table 1).

Nineteen percent of correctional officers in the Phase 3 regions had completed the eight-hour CIT course by Dec. 31, 2023 (Appendix G, Table 2), as well as 77 percent of 911 dispatchers (Appendix G, Table 3). Dispatchers and correctional officers in the Phase 3 region have until June 30, 2025, to meet the 100 percent training requirement.

The Settlement Agreement states that the 25 percent training target should prioritize law enforcement agencies that serve areas with higher population densities. As of Dec. 31, 2023, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (62 percent and 60 percent, respectively; Appendix G, Table 1) than the Pierce region (24 percent,). This pattern was not observed in the Pierce or King regions, however, where large agencies with higher population densities had lower training completion rates than small agencies with lower population densities. In the Phase 3 regions, large agencies had a higher training completion rate than small agencies (42 percent and 26 percent, respectively; Appendix G, Table 1).

Education and Training – Technical Assistance for Jails

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

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

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

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

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

- Initial Screening
- Assessment and Treatment Planning
- Service Delivery
- Continuity of Care/Release Planning

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plans have been delivered and are available on the JTA website. These webinar-based learning events continue monthly with robust participation. Many of the training topics are the direct result of information gained through jail visits and through input from participants attending prior events and providing feedback on topics of interest to jails. The learning events presented from July 1, 2023 through Dec. 31, 2023 were:

- July: Department of Corrections' Approach to the State Opioid Response Grant
- August: Jail Standards & Oversight in Washington State Past and Present
- September: SSB5440 New Law Implementation and its Impact on Jails
- October: Forensic Navigators; The Role they Play with Competency Restoration and How Their Duties are Being Expanded
- November: Managing Substance Withdrawals in Jails
- December: No learning event

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

Outreach efforts and a regular presence at the WASPC conference also helped foster relationships which led to three significant workgroup invitations: the Washington Jail Commander meetings, the Legislative Joint Jail Standards and Accountability Taskforce meetings, and the Washington State University Rural Jail Project meetings. The Washington Jail Commander meetings occur twice a month and are facilitated by the Washington Association of Sheriffs and Police Chiefs. Representatives from jail leadership and other stakeholders discuss ongoing issues and topics with potential impacts to jails. JTA staff attend to provide updates, keep current on relevant issues, maintain relationships, and gather input on future learning event topics. The Jail Standards and Accountability Taskforce was established to determine if there should be statewide standards and oversight of Washington jails. JTA staff attend the task force meeting as an observer but have been added to a task force subgroup responsible for developing recommendations based on jail survey data. The WSU Rural Jail Project is based on a grant from the Vera Institute of Corrections and involves graduate students and professors

working with rural jails to identify challenges and assist with making positive changes. JTA staff meet with this group quarterly to discuss progress and share information.

Areas of Concern

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

Recommendations to Address Concerns

To resolve the necessary updates and review of trainings and publications, JTA staff has developed a review and update plan for the *Best Practices for Behavioral Health Services in Jail Settings* manual and should continue with the process. The revised manual should then be posted online with a communication sent out to all partners. A review and update plan for the current trainings posted online is in process and once determinations are made relating to updates the review process should be initiated.

Data-Jail Technical Assistance

In July 2021, JTA staff began tracking the number of participants in each JTA Monthly Learning Event. For the six-month period from July 2021-December 2021, average attendance was 5.5 persons per event. During calendar year 2022, the average number of participants was 16 people per event. From January 2023 to June 2023 the average number of participants per event was 13. The average number of attendees for the second half of 2023 was 26, which is double that of the first half of the year.

Enhanced Peer Support

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

Current Status and Areas of Positive Impact

HCA, in partnership with OFMHS, developed a continuing education training titled *The Intersection of Behavioral Health and the Law* that provides a foundational overview of the forensic mental health system. This training was developed for certified peer counselors who work on Trueblood-related services as well as other professionals who work within the forensic mental health system. There have been 537 people who have completed the training, with more than 400 currently in the process.

Enhancing Your Cultural Intelligence is a training that adds content to IBHL, and is centered on topics and considerations around diversity, equity, and inclusion. HCA contracted with a national diversity, equity, and inclusion subject matter expert to create this continuing education offering. Topics covered include cultural intelligence and safety; diversity, identity, and intersectionality; understanding microaggressions; achieving health equity through the lens of social justice; and reducing the effects of systemic inequities on 2SLGBTQIA+ communities. This training is also currently available to learners through a learning management system. To date there have been 751 people to complete this training, and more than 600 in the process.

Through conversations with stakeholders, it was clear that additional curriculum development on diversity, equity, and inclusion would be helpful to CPCs working with Trueblood class members. HCA has initiated the creation of a diversity, equity, and inclusion curriculum titled, *Cultural Inclusion in Peer Support: Compassion in Action.* This curriculum will be made available in an online Learning Management System (LMS). This will be a complement to the original *Enhancing Your Cultural Intelligence* training. This training is expected to be completed and shared with the certified peer network in summer 2024.

In October 2023 the Enhanced Peer Support Program Administrator resigned from her position. Because the HCA/DBHR has an entire section of staff dedicated to the licensure, training, and support of Certified Peer Specialists across the state, the HCA Trueblood team took this as an opportunity to reevaluate the needs of our team. In conjunction with the Trueblood AAG team and DRW, the decision has been made to repurpose this position to a Trueblood Data Program Manager. This position will work with all our Trueblood element leads to interpret, analyze, and make data-informed programmatic decisions about OCRP, FPATH, and FHARPS. This position will be out for recruitment in early 2024.

Areas of Concern

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

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails. Our Trueblood element leads will continue the work of jail access for their teams in each of the phased regions.

Data-Enhanced Peer Support

Beginning February 2022, data collection around completion of the online trainings offered by the Enhanced Peer Support program has been captured by a learning management system that registers individual users and tracks each user's completion of trainings.

Between July 1 and Dec. 31, 2023, 183 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions, have completed *The Intersection of Behavioral Health and the Law* online training. Between July and December 2023, 265 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions have completed *Enhancing Your Cultural Intelligence* online training.

Workforce Development

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

In previous reports, WFD described the development of a series of brochures illustrating the career pathways for key work positions within the forensic mental health system. These are intended as an outreach and education tool for potential members of the workforce, to increase awareness of and stimulate interest in the field and to provide information about the training and qualifications required. These six "Career Pathway" brochures illustrate the educational pathways for forensic behavioral health careers in psychology, social work, peer counseling, mental health counseling, nursing, and psychiatry. In early 2022, the workforce development team worked with Washington state K-12 school districts and skill centers to distribute these career pathway brochures. These brochures were updated in December 2023.

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

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

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

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

Current Status and Areas of Positive Impact

Expanding on the information gathered during the survey of legal partners, the workforce development team procured a contract with Groundswell Services Inc. to conduct follow-up focus groups and interviews with attorneys and judges to collect information regarding the forensic mental health system from their perspective, to discover potential strategies, and to disseminate information about current and future OFMHS initiatives to improve the competency system. Groundswell has substantial expertise related to forensic mental health services, particularly forensic evaluation, competency restoration services, forensic mental health systems, workforce development, and training. They have previously served as consultants for Washington's forensic mental health system and were the lead consultants and an expert witness in the Trueblood vs. Washington State Department of Social and Health Services federal class action lawsuit. Groundswell conducted the focus group and interviews in May 2022, collecting robust information about challenges and recommendations to Washington's competency services system. After gathering the input provided by the legal system partners, Groundswell analyzed the information and compiled material pertaining to promising practices and programs throughout the county. They issued a report on their findings and included four recommendations. These recommendations suggested looking at opportunities for greater collaboration among a cross-section of public agencies, additional options for restoration, innovations from other states, and working with decision-makers to find solutions. Workforce development has convened a group that meets regularly to move these recommendations forward and submitted a proposal to the March 2023 American Psychology Law Society conference to present information on this survey and focus group. The proposal was accepted and will be part of a larger presentation, *Trueblood v. Washington State: The Continued Impact of the Competency Crisis on State Psychiatric Services and Program Development.*

In June 2023 recruitment began for the workforce development administrator position due to the administrator retiring. At the beginning of July, the position was filled. This action resulted in a vacancy in the workforce development team that was filled in October. A second vacancy then occurred on the team in September and the position was filled in November. The administrator oversees both the JTA and WFD elements.

Workforce development staff continue to lead the Behavioral Health Administration's trauma-informed care workforce development subcommittee, in an intensive effort to embed trauma-informed principles into all DSHS forensic mental health facilities, starting with a pilot project at Western State Hospital. In December 2023, this subcommittee submitted its deliverables to leadership for their review. The deliverables included identifying TIC core competencies, developing a master list of trainings in support of TIC implementation, building out a training

schedule, developing evaluation and coaching tools, audit tools, and developing recommendations for employee wellness and recognition.

Workforce development staff also continue to be centrally involved in providing guidance and technical assistance statewide in a leadership role with the BHA telehealth committee. This committee has three subcommittees, which focus on telehealth policy, telehealth key performance indicators, expanding the use of telehealth for competency evaluations, and providing ongoing support for relevant facilities. The BHA telehealth committee has been successful in creating a community of knowledgeable practitioners and subject matter experts to facilitate the use of technology and the inherent benefits for forensic evaluations.

In Q1 2023, the Cisco-based video conferencing technology solution that BHA had used reached its end-of-life and was decommissioned. In anticipation of this event, IT staff developed a small profile turnkey solution operating in kiosk mode to offer interested jails and BHA facilities. The first unit was installed at Yakima County Jail in the spring of 2023. While IT staff continued to make refinements to this initial placement, exceptions to policy were put in place to mitigate issues in completing telehealth evaluations for the other counties using the Cisco technology. Workforce development staff are working with IT to extend these exceptions until alternate solutions can be deployed. During this time frame, the telehealth committee continued to work with the King and Snohomish County jails to establish a robust telehealth setup. During this reporting period, staff worked with King County to establish a secure connection and to initiate testing with two evaluators. Testing remains in progress. Also, during this reporting period staff worked with Snohomish County to install a WAN connection in preparation for setting up two telehealth kiosks. After testing of the connection is complete state IT staff will travel to Snohomish to install and test the telehealth equipment in partnership with Snohomish County IT staff. Telehealth committee and state IT staff continue to work with county partners as they troubleshoot various aspects of technology-related issues pertinent to telehealth implementation and sustainment.

Due to the limitations imposed by COVID-19, videoconferencing became an effective adaptation to counteract severe restrictions on in-person evaluations. The use of this technology for evaluations increased significantly. It has also helped improve the efficiency with which competency evaluations can be completed. DSHS continues to provide support to complete jail-based competency evaluations via videoconferencing. More than 30 locations statewide are now using videoconferencing to regularly complete telehealth evaluations. During the period covered by this semi-annual report, July 1-Dec. 31, 2023, on average, OFMHS evaluators completed 224 telehealth evaluations per month.[12] This is a decline from the previous six- month period, Jan. 1-June 30, 2023, where on upward revision after further data maturity, evaluators completed 251 telehealth evaluations per month, on average.

[12] Data are current as of March 19, 2024. Telehealth data matures more slowly than other data. November and December 2023 telehealth figures will continue to mature following this report's publication date in late March 2024.

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

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

Workforce development team members continue to lead the delivery of training in support of the New Employee Orientation program for OFMHS staff and are continuing to offer NEO on the first and sixteenth of every month. This ensures minimal time between an employee's first day and OFMHS orientation. This effort is designed to aid in staff retention by welcoming and preparing staff for their new position and orienting new hires statewide to varied aspects of the forensic mental health system, including an overview of the Contempt Settlement Agreement. Workforce development has also designed and deployed NEO surveys which are delivered to new employees on their 30-day, 90-day, six-month and eleven-month anniversaries. These surveys will assist in determining if new staff are well supported in their first year of employment and will identify any gaps or issues for OFMHS to address.

The workforce development team has updated the *Hiring and Onboarding Manual* and companion checklist to assist hiring managers in implementing a standardized set of protocols following policy and procedure established by DSHS human resources. This manual serves as OFMHS policy for the hiring and onboarding process. OFMHS workforce development staff have developed and provided training to orient managers to this new policy and its procedures. Workforce development has also established a hiring and onboarding committee to keep current with changes and facilitate awareness and adherence to any procedural updates. Additionally, they staff an ongoing office hours opportunity for questions related to hiring and onboarding open to all OFMHS staff.

OFMHS workforce development staff also continue to provide training to contracted behavioral health provider staff regarding an orientation to the Breaking Barriers curriculum used in OCRP. Staff continue to work on completing an online version of this training to be used as new OCRP staff onboard. Additionally, OFMHS workforce development staff are nearing completion of a training for external and internal telehealth providers to assist them in establishing and completing a telehealth session. The online training has been recorded and is in the final stages of editing. Workforce development staff continue to work on training related to the OFMHS

mentorship program and companion materials. This program is designed to support staff with professional development and leadership opportunities. Workforce development staff are coordinating the efforts to launch this program. During this reporting period workforce development staff also developed a peer program which aligns new hires with peer mentors for their first six month of employment with OFMHS.

Areas of Concern

A broad challenge regarding workforce development continues to be the ongoing statewide workforce shortages within the field of mental health.

Recommendations to Address Concerns

To address concerns around workforce shortages within the field of mental health, workforce development staff engaged in the initiatives below that supported recruitment and retention efforts.

Enhance External Website (supporting recruitment and retention efforts): Our previous efforts led to a plan to revamp our external-facing website to increase engagement with our intended audience. Staff continue to add and revise content on this site.

Develop Trainings for Staff (supporting retention): In the previous reporting period, the workforce development team-initiated work on an online version of the Breaking Barriers curriculum for use in OCRP, and an online introduction to mentorship in preparation for a staff mentorship program. The mentorship program training materials are near completion and will be placed in the Learning Center before program rollout. Breaking Barriers has ten modules and newly hired staff are working to convert each to a more interactive online version.

Previously, workforce development staff also completed an online training to support FDS users. This training was uploaded to the state Learning Center. Staff established a companion internal website with additional materials and system updates and continue to support FDS users by maintaining this site to include updates to material. They are also developing a training for forensic navigators on using the case management system. This training will be comprised of three modules, the first of which has been completed. This will then be loaded into the Learning Center making it available for assignment to OFMHS staff.

Promote Careers in Behavioral Health (supporting recruitment): The workforce development team has scheduled attendance at job fairs/hiring events on both the east and west sides of the state. They will talk with job seekers to provide information on careers in behavioral health and to promote current openings.

Data-Workforce Development

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

Conclusions

Behavioral health transformation is well underway in Washington state. The two-year designated implementation period for Phase 1 of the Settlement Agreement concluded on June 30, 2021. Successful Phase 1 implementation required completion of 137 tasks[13] from the Phase 1 Final Implementation Plan. Each task item was completed and has contributed to the enhanced level of services that remain available to Trueblood class members and other eligible clients in the 10 counties that comprise the three Phase 1 regions. As of Dec. 31, 2023, 92 of 93 Phase 2 task items remain complete[14], and most Trueblood programming in the Phase 2 King region is already operational. The Phase 2 implementation period ran from July 1, 2021 through June 30, 2023.

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

The state remains committed to both implementing the elements of the Settlement Agreement and improving those elements already established in Phases 1 and 2. Phase 1 programs continue to gain experience serving their clients, and the more recently implemented Phase 2 programming continues rapidly gaining experience in the field and benefiting from the knowledge already gained from Phase 1 implementation and operations. Phase 3 implementation is now underway in five counties and two BHASO regions including the Thurston Mason Behavioral Health ASO, which incorporates Thurston and Mason counties and the Salish Behavioral Health Organization, which comprises Kitsap, Clallam, and Jefferson counties. Phase 3 implementation continues through June 30, 2025. As of Dec. 31, 2023, 20 of the 73 Phase 3 implementation tasks were completed on time or early including 19 that were completed early. Fifty-three implementation tasks remain to complete.

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

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

Appendix A-Related Resources

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

State Agency Resources:

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

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

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

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

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

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

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

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

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

Trueblood *February 2024 Progress Report for the Court Monitor and Appendices A-L:* February | Appendix A-G | Appendix H | Appendix I | Appendix J | Appendix K | Appendix L

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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

Appendix B-OCRP Dashboard

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

The program objective of the Outpatient Competency Restoration Program (OCRP), administered by the Healthcare Authority, is to provide timely and effective outpatient competency restoration services to individuals determined by the court as a) not competent to stand trial and b) appropriate for community-based services to restore competency. The intent of the OCRP is to reduce the number of people waiting to receive inpatient competency restoration, to provide competency services in a safe and cost-effective environment, and to provide the most appropriate level of care to the individual. OCRP services in Phase 1 Regions began July 1, 2020, and became available in the Phase 2 Region (King County) in October 2022. From July 2020 to December 2023, OCRP served 192 individuals.

REPORTING PERIOD

Cumulative: July 1, 2020 to December 31, 2023

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

CONTACTS

Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Theresa M Becker, PhD, Research Associate, RDA, 360.902.0714, theresa.becker@dshs.wa.gov
Paige Harrison, PhD, Senior Research Associate, RDA, 360.902.0805, paige.harrison@dshs.wa.gov

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TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	192	100%	56	100%	68	100%	38	100%	30	100%
Among Enrolled Individuals…										
RESTORATION ORDER TYPE (unduplicated)										
Felony	157	82%	43	77%	50	74%	--	--	--	--
Misdemeanor	35	18%	13	23%	18	26%	--	--	--	--
GENDER										
Female	38	20%	--	--	14	21%	--	--	--	--
Male	132	69%	38	68%	49	72%	31	82%	14	47%
Other/Unknown	22	11%	--	--	5	7%	--	--	--	--
AGE GROUP										
18-29 yrs	52	27%	17	30%	22	32%	--	--	--	--
30-49 yrs	100	52%	25	45%	33	49%	21	55%	21	70%
50+ yrs	40	21%	14	25%	13	19%	--	--	--	--
RACE/ETHNICITY*										
Non-Hispanic White	118	61%	28	50%	47	69%	33	87%	10	33%
Black, Indigenous, and People of Color	51	27%	--	--	--	--	--	--	--	--
Unknown	23	12%	--	--	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	46	24%	21	38%	--	--	--	--	--	--
Unstably Housed	105	55%	26	46%	49	72%	12	32%	18	60%
Homeless	39	20%	--	--	11	16%	16	42%	--	--
In a Facility	1	1%	--	--	--	--	--	--	--	--
Unknown	1	1%	--	--	--	--	--	--	--	--

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

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

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

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
CLIENT STATUS (on last day of reporting period)										
Enrolled	192	100%	56	100%	68	100%	38	100%	30	100%
Active	26	14%	--	--	--	--	--	--	--	--
Discharged	166	86%	--	--	--	--	--	--	--	--
Among Discharged Individuals…										
DISCHARGE REASON										
Charges Dismissed	20	12%	--	--	--	--	--	--	--	--
Opined Competent	68	41%	14	29%	28	47%	15	41%	11	52%
Opined Not Competent	5	3%	--	--	--	--	--	--	0	0%
Opined Not Restorable	4	2%	--	--	--	--	0	0%	0	0%
Returned to Jail	7	4%	--	--	--	--	0	0%	0	0%
Inpatient Medical Care	2	1%	--	--	--	--	--	--	--	--
Inpatient Civil Psychiatric Care	9	5%	--	--	--	--	--	--	--	--
Revoked Conditional Release	46	28%	12	25%	22	37%	--	--	--	--
Legal Authority Ended	3	2%	--	--	0	0%	0	0%	--	--
Death	2	1%	--	--	--	--	--	--	--	--
DISCHARGE LOCATION										
Community	104	63%	34	71%	35	58%	21	57%	14	67%
Residential Treatment Facility	3	2%	--	--	--	--	--	--	--	--
State Hospital	29	17%	--	--	12	20%	11	30%	--	--
Jail	17	10%	--	--	--	--	--	--	--	--
Unknown	13	8%	--	--	--	--	--	--	--	--
LENGTH OF STAY										
Average Length of Stay in Program (days)	73	N/A	83	N/A	66	N/A	77	N/A	60	N/A
HOUSING STATUS AT PROGRAM DISCHARGE										
Stably Housed	63	38%	20	42%	--	--	19	51%	--	--
Unstably Housed	49	30%	20	42%	--	--	--	--	13	62%
Homeless	22	13%	--	--	16	27%	--	--	--	--
In a Facility	18	11%	--	--	--	--	11	30%	--	--
Unknown/Missing	14	8%	--	--	--	--	--	--	--	--

DATA SOURCE: The Navigator Case Management system (NCM).

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

OCRP Definitions

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

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

Appendix C-Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health Administration Forensic Navigator Program

CUMULATIVE UPDATE

The Forensic Navigator Program is administered by the Behavioral Health Administration and is designed to support individuals navigating the state's community-based competency evaluation services and outpatient restoration programs. The program began July 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane region (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). The Forensic Navigator Program began in the Phase 2 Region (King County) on January 1, 2022. From July 2020 to December 2023, the Forensic Navigator program served 6,036 individuals.

This year, a new online Power BI report provides both quarterly and cumulative data that can be broken down by region to track program data and illustrate trends. The data presented here represents selected figures and tables from this Power BI report. The full report, including all data and definitions, can be accessed online here*.

REPORTING PERIOD

Cumulative: July 1, 2020 to December 31, 2023

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

CONTACTS

Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Megan Berry-Cohen, PhD, Research Associate, RDA, megan.berry-cohen@dshs.wa.gov
Paula Henzel, Senior Research Scientist, RDA, 360.902.0792, paula.henzel@dshs.wa.gov
Al Bouvier, Operations Research Specialist, RDA, 360.902.0732, alfred.bouvier@dshs.wa.gov

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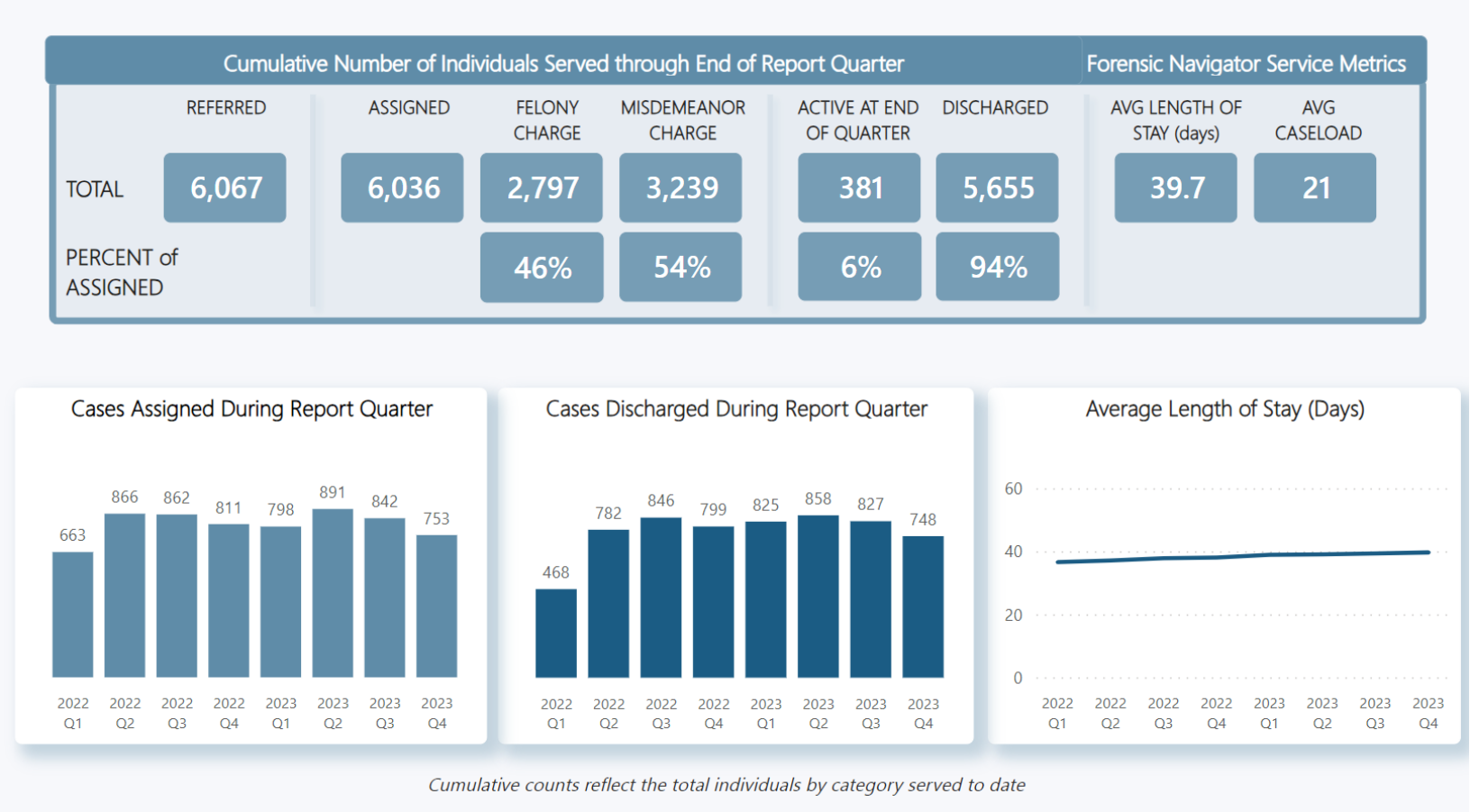
***FULL ONLINE POWER BI DASHBOARD: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program-0**

Figure 1.

Forensic Navigator Program Measures
Enrollment Summary



Cumulative counts reflect the total individuals by category served to date

Figure 2.

Forensic Navigator Program Measures
Case Status

Active Case Status at End of Quarter (last day of report period)

Case Status	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4
Active	110	141	133	139	173	151	338	387	379	384	337	382	392	381
Pre-Competency Hearing	106	128	117	125	155	135	318	368	344	340	290	325	335	332
OCRP Enrolled	3	11	14	10	14	13	15	15	22	28	26	33	34	23
Post OCRP	1	2	2	4	4	3	5	3	5	6	9	3	2	10
Reassess for OCRP	0	0	0	0	0	0	0	1	8	9	8	10	17	7
In Process of OCRP Removal	0	0	0	0	0	0	0	0	0	1	4	11	4	9

Figure 3.

Forensic Navigator Program Measures
Caseload by Region

Average Daily Caseload per Navigator by Region

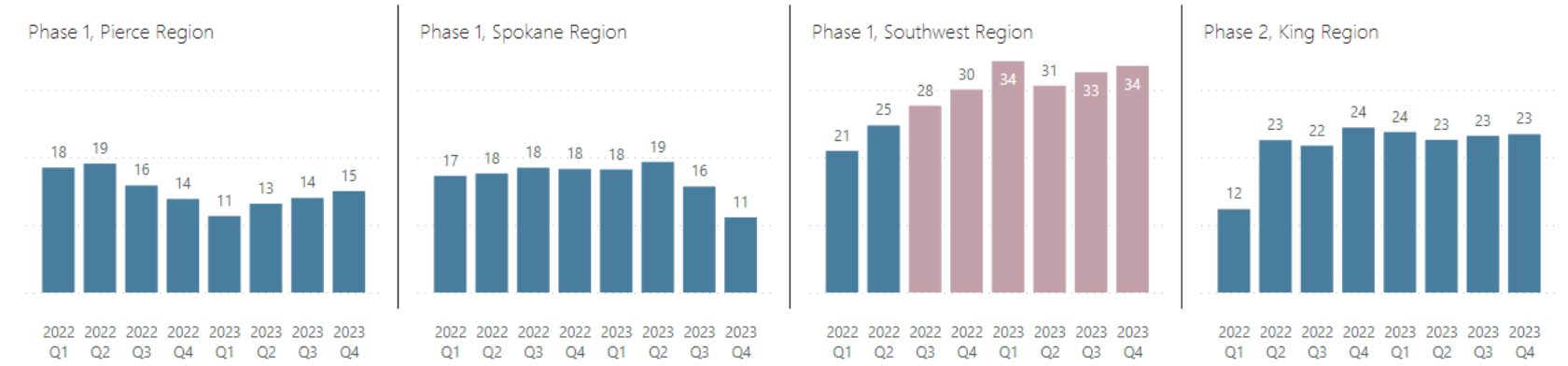


Table 1.

Forensic Navigator Program Measures

Cumulative Counts of Participant Demographics by Region

Region	Pierce Region		Spokane Region		Southwest Region		King Region		Total	
Category	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age										
18-29	364	25%	248	23%	205	28%	619	22%	**1,436**	**24%**
30-49	784	54%	597	55%	400	54%	1,573	57%	**3,354**	**56%**
50 +	304	21%	234	22%	133	18%	575	21%	**1,246**	**21%**
Gender										
Female	293	20%	263	24%	148	20%	502	18%	**1,206**	**20%**
Male	929	64%	798	74%	500	68%	1,518	55%	**3,745**	**62%**
Other/Unknown	230	16%	18	2%	90	12%	747	27%	**1,085**	**18%**
Race-Ethnicity										
American Indian or Alaska Native	36	2%	*		*		33	1%	**99**	**2%**
Asian	41	3%	*		*		109	4%	**177**	**3%**
Black or African American	336	23%	78	7%	82	11%	670	24%	**1,166**	**19%**
Hispanic or Latino	21	1%	11	1%	29	4%	99	4%	**160**	**3%**
Native Hawaiian or Other Pacific Islander	43	3%	*		*		20	1%	**79**	**1%**
White Only, Non-Hispanic	666	46%	807	75%	433	59%	914	33%	**2,820**	**47%**
Other Race	13	1%	*		*		79	3%	**100**	**2%**
Unknown	309	21%	148	14%	158	21%	905	33%	**1,520**	**25%**

Figure 4.

Forensic Navigator Program Measures

Services

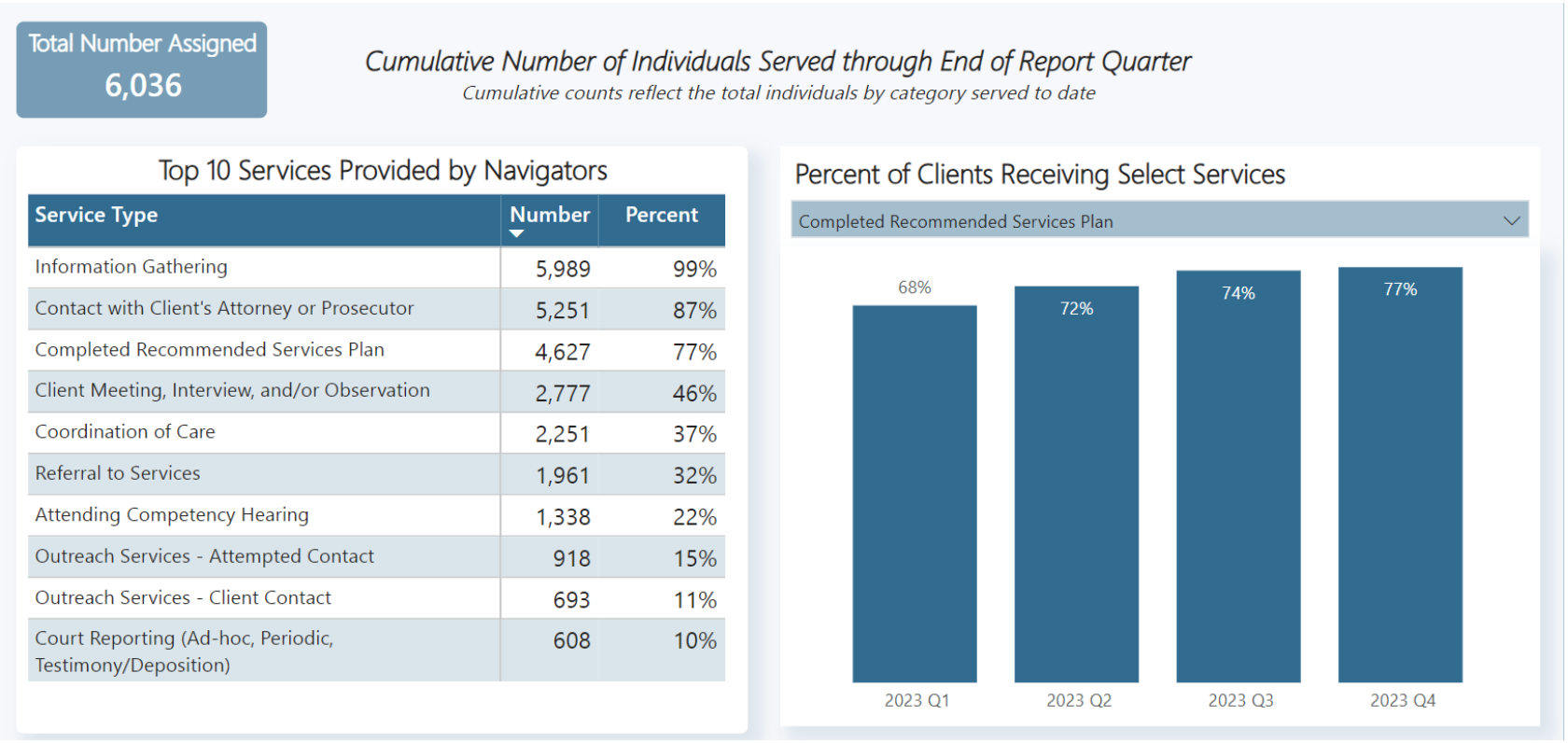


Figure 5.

Forensic Navigator Program Measures

Referrals

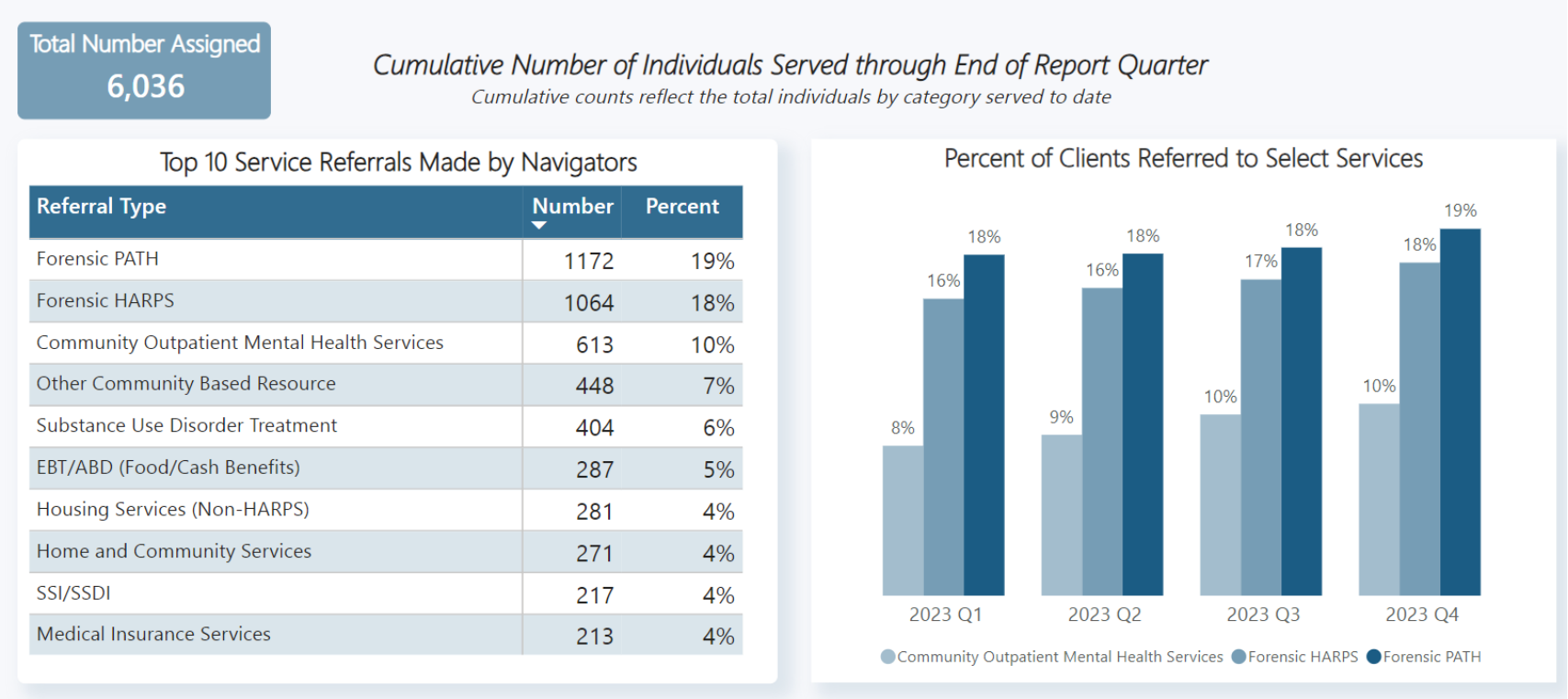


Table 2.

Forensic Navigator Program Measures

Discharges

Cumulative Number of Individuals Served through End of Report Quarter

Cumulative counts reflect the total individuals by category served to date

Number of Clients Discharged	Number with Warm Hand-Off	Percent with Warm Hand-Off	Average Length of Stay (days)
5,655	1,725	31%	39.7

Discharge Reasons

Discharge Reason	Number	% Discharged
Client Determined Competent	1,712	30%
Inpatient Restoration	1,158	20%
Released From Jail on Personal Recognizance (PR)	1,131	20%
Charges Dismissed	897	16%
Dismiss & Refer (to Designated Crisis Responder)	294	5%
Order Cancelled or Withdrawn	167	3%
Refused Forensic Navigator Program Services	106	2%
Felony (72-Hour) Civil Conversion	56	1%
Successful OCRP Completion - Coordinated Transition Completed	36	1%
Violation of OCRP Conditions of Participation/Court Ordered CR	31	1%
Successful OCRP Completion - Summary of Treatment Completed	15	0%
Not Restorable - Pre-Hearing/OCRP	14	0%
Client Death	11	0%
Diversion Program(s)	8	0%
Not Restorable - Developmental Disability	8	0%
Civil Conversion - Removal from OCRP	6	0%
Re-arrest	4	0%

Appendix D-Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Crisis Housing Voucher Disbursals

CUMULATIVE UPDATE

Beginning December 2019, Washington State Health Care Authority (HCA) contracted funds for select crisis triage and stabilization facilities. The intent of the program was to provide crisis housing vouchers for persons leaving a facility without housing. To better meet community needs, contracts were expanded to allow teams to distribute vouchers outside crisis triage and stabilization facilities. Vouchers were available in the Phase 1 Regions of the Trueblood settlement agreement including Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) regions on December 1, 2019. Vouchers were available in Phase 2 Region (King County) in July 2022. From December 2019 to December 2023, 728 vouchers were disbursed to 551 individuals.

REPORTING PERIOD

Cumulative: December 1, 2019 to December 31, 2023

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

CONTACTS

Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Paige Harrison, PhD, Senior Research Associate, RDA, 360.902.0805, paige.harrison@dshs.wa.gov
Megan Suter, PhD, Researcher, RDA, 360.902.0274, megan.suter@dshs.wa.gov

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TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started December 1, 2019*						PHASE 2 REGION *Started July 1, 2022*	
			PIERCE*		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY										
Vouchers Disbursed	728	100%	127	17%	251	34%	228	31%	122	17%
Recipients (unduplicated)	551	100%	125	23%	197	36%	140	25%	89	16%
Total Amount Disbursed	$705,935	N/A	$161,563	N/A	$266,855	N/A	$194,302	N/A	$83,215	N/A
Average Amount Per Recipient	$1,271	N/A	$1,299	N/A	$1,328	N/A	$1,388	N/A	$925	N/A
REFERRAL SOURCE										
Crisis Call Center	4	1%	--	--	--	--	--	--	--	--
Family/Friend	6	1%	--	--	--	--	--	--	--	--
Hospital	148	27%	49	39%	--	--	64	46%	--	--
Mobile Crisis Response	27	5%	--	--	--	--	25	18%	--	--
Designated Crisis Responder	35	6%	0	0%	0	0%	35	25%	0	0%
Tribe or Indian Healthcare Provider	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Responder	5	1%	--	--	--	--	0	0%	0	0%
Other Healthcare Provider	39	7%	--	--	24	12%	--	--	--	--
Law Enforcement (Police, Co-Responders)	60	11%	14	11%	--	--	--	--	39	44%
Court/Criminal Justice Referred	14	3%	--	--	--	--	--	--	13	15%
Self	187	34%	--	--	139	71%	--	--	17	19%
Other	26	5%	20	16%	--	--	--	--	--	--
GENDER										
Female	174	32%	31	25%	62	31%	47	34%	34	38%
Male	371	67%	94	75%	134	68%	88	63%	55	62%
Other/Unknown	6	1%	0	0%	1	1%	5	4%	0	0%
AGE GROUP										
18-29	115	21%	28	22%	39	20%	25	18%	23	26%
30-49	299	54%	63	50%	111	56%	78	56%	47	53%
50+	138	25%	34	27%	47	24%	37	26%	19	21%
RACE/ETHNICITY**										
Non-Hispanic White	341	62%	--	--	--	--	88	63%	--	--
Black, Indigenous, and People of Color	197	36%	56	45%	44	22%	40	29%	57	64%
Unknown	13	2%	--	--	--	--	12	9%	--	--

	TOTAL - ALL REGIONS		Started December 1, 2019						Started July 1, 2022	
			PIERCE*		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Voucher Recipients…										
FORENSIC HARPS (FHARPS) STATUS* **										
Referred to FHARPS	120	22%	26	21%	--	--	61	44%	--	--
Contacted by FHARPS staff	109	20%	24	19%	--	--	58	42%	--	--
Enrolled in FHARPS	109	20%	24	19%	--	--	58	41%	--	--
Housed or sheltered by FHARPS	96	17%	21	17%	--	--	50	36%	--	--
Among Individuals Housed or Sheltered by FHARPS…										
FIRST FHARPS HOUSING TYPE*										
Permanent	3	3%	--	--	--	--	--	--	--	--
Transitional	13	14%	--	--	--	--	--	--	--	--
Shelter/emergency	80	83%	18	86%	--	--	43	86%	--	--
Other	0	0%	0	0%	0	0%	0	0%	0	0%

DATA SOURCE: Excel trackers submitted to the Washington State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage system (PDAMS), which became available November 2023.

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

*Pierce Region data are incomplete due to RI International not submitting the final excel tracker due in November 2023. HCA will continue efforts to obtain this data.

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

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

Crisis Housing Voucher Definitions

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

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

Appendix E-FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

Forensic Housing and Recovery Through Peer Services (FHARPS), administered by the Healthcare Authority, is designed to provide residential support to unstably housed individuals with former or current involvement with the forensic mental health system, or individuals at risk of becoming involved in the system due to mental health needs. The program began March 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) regions. FHARPS services began in the Phase 2 Region (King County) in April 2022. From March 2020 to December 2023, FHARPS enrolled 1,096 individuals.

REPORTING PERIOD
Cumulative: March 1. 2020 to December 31. 2023

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

CONTACTS
Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Theresa M Becker, PhD, Research Associate, RDA, 360.902.0714, theresa.becker@dshs.wa.gov
Paige Harrison, PhD, Senior Research Associate, RDA, 360.902.0805, paige.harrison@dshs.wa.gov

Contents

TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	1,840	100%	779	100%	375	100%	430	100%	256	100%
Contacted	1,292	70%	570	73%	319	85%	216	50%	187	73%
Enrolled	1,096	60%	458	59%	288	77%	210	49%	140	55%
Among Referred Individuals…										
REFERRAL SOURCE										
Trueblood partner programs	1,168	63%	345	44%	262	70%	308	72%	253	99%
Forensic Navigator	712	*39%*	*176*	*23%*	*188*	*50%*	*95*	*22%*	*253*	*99%*
Forensic PATH	268	*15%*	*109*	*14%*	*38*	*10%*	*121*	*28%*	*0*	*0%*
OCRP	17	*1%*	--	--	--	--	--	--	--	--
Crisis Stabilization Center	150	*8%*	*48*	*6%*	*33*	*9%*	*69*	*16%*	*0*	*0%*
Co-Response Team	21	*1%*	--	--	--	--	*11*	*3%*	*0*	*0%*
Mobile Crisis Response	2	0%	--	--	--	--	--	--	--	--
Behavioral Health Facility - Outpatient	268	15%	130	17%	89	24%	49	11%	0	0%
Inpatient Facility	57	3%	37	5%	--	--	13	3%	--	--
Family/Self	51	3%	34	4%	--	--	16	4%	--	--
Other	294	16%	232	30%	--	--	43	10%	--	--
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT										
Phone	436	34%	244	43%	161	50%	31	14%	0	0%
Court	1	0%	--	--	--	--	0	0%	0	0%
Hotel/Motel	42	3%	36	6%	--	--	--	--	0	0%
Jail	415	32%	69	12%	131	41%	30	14%	185	99%
Crisis Stabilization Center	65	5%	14	2%	--	--	49	23%	--	--
Behavioral Health Facility - Outpatient	134	10%	59	10%	11	3%	64	30%	0	0%
Inpatient Facility	34	3%	21	4%	--	--	12	6%	--	--
Shelter	14	1%	12	2%	0	0%	--	--	--	--
Street/encampment	11	1%	--	--	0	0%	--	--	0	0%
Temporary Residence	8	1%	--	--	--	--	--	--	0	0%
Other	132	10%	99	17%	--	--	24	11%	--	--
Among Enrolled Individuals…										
PARTICIPANT STATUS (on last day of reporting period)										
Active	383	35%	134	29%	68	24%	63	30%	118	84%
Discharged	713	65%	324	71%	220	76%	147	70%	22	16%
GENDER										
Female	323	29%	159	35%	74	26%	53	25%	37	26%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Male	756	69%	291	64%	210	73%	153	73%	102	73%
Other/Unknown	17	2%	8	2%	4	1%	4	2%	1	1%
AGE GROUP										
18-29	266	24%	117	26%	79	27%	35	17%	35	25%
30-49	626	57%	227	50%	172	60%	138	66%	89	64%
50+	201	18%	114	25%	36	13%	35	17%	16	11%
Unknown	3	0%	0	0%	--	--	--	--	0	0%
RACE/ETHNICITY*										
American Indian or Alaska Native	77	7%	33	7%	27	9%	--	--	--	--
Asian	22	2%	11	2%	--	--	--	--	--	--
Black or African American	264	24%	161	35%	34	12%	34	16%	35	25%
Hispanic or Latino	108	10%	49	11%	32	11%	--	--	--	--
Native Hawaiian or Pacific Islander	17	2%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	532	49%	202	44%	151	52%	145	69%	34	24%
Other Race	72	7%	18	4%	41	14%	--	--	--	--
Unknown	106	10%	--	--	31	11%	--	--	51	36%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Unstably Housed	477	44%	122	27%	187	65%	47	22%	121	86%
Homeless	619	56%	336	73%	101	35%	163	78%	19	14%

DATA SOURCE: Excel trackers submitted to the Washington State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA and HCA will collaborate on improvements.

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

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

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	1,096	100%	458	100%	288	100%	210	100%	140	100%
Housed or Sheltered	828	76%	403	88%	191	66%	170	81%	64	46%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies only	15	1%	--	--	--	--	--	--	--	--
Support Services and Subsidies	1,081	99%	448	98%	288	100%	206	98%	139	99%
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	68	8%	45	11%	--	--	12	7%	--	--
Transitional	333	40%	179	44%	52	27%	42	25%	60	94%
Shelter/emergency	424	51%	179	44%	128	67%	--	--	--	--
Other	3	0%	0	0%	--	--	--	--	0	0%

DATA SOURCE: Excel trackers submitted to the Washington State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA and HCA will collaborate on improvements.

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

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS										
Enrolled	1,096	100%	458	100%	288	100%	210	100%	140	100%
Active (on last day of reporting period)	383	35%	134	29%	68	24%	63	30%	118	84%
Discharged (during reporting period)	713	65%	324	71%	220	76%	147	70%	22	16%
Among Individuals Discharged…										
SUBSIDY										
Average total subsidy since enrollment	$6,469	N/A	$7,153	N/A	$6,844	N/A	$4,641	N/A	$1,843	N/A
DISCHARGE REASON										
Transitioned to other housing support	109	15%	90	28%	--	--	18	12%	--	--
Received maximum subsidy	18	*3%*	--	--	--	--	--	--	--	--
Did not receive maximum subsidy	91	*13%*	--	--	--	--	--	--	--	--
Transitioned to self-support	92	13%	46	14%	28	13%	18	12%	0	0%
Admitted to a facility	43	6%	12	4%	--	--	19	13%	--	--
Received maximum assistance (no transition)	63	9%	29	9%	22	10%	12	8%	0	0%
Withdrew	100	14%	31	10%	43	20%	--	--	--	--
Loss of contact	203	28%	67	21%	88	40%	48	33%	0	0%
Served by another FHARPS team	5	1%	--	--	--	--	0	0%	0	0%
Other	98	14%	45	14%	25	11%	--	--	--	--
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	207	N/A	225	N/A	175	N/A	232	N/A	42	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	234	33%	145	45%	51	23%	38	26%	0	0%
Unstably Housed	60	8%	24	7%	29	13%	--	--	--	--
Homeless	87	12%	51	16%	--	--	--	--	--	--
In a Facility	81	11%	18	6%	--	--	42	29%	--	--
Unknown	251	35%	86	27%	98	45%	48	33%	19	86%

DATA SOURCE: Excel trackers submitted to the Washington State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA and HCA will collaborate on improvements.

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

FHARPS Definitions

VARIABLE NAMES	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLES, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Referred	Individuals referred to FHARPS during the reporting period.
Contacted	Individuals contacted to attempt to enroll in the program during the reporting period.
Enrolled	Participants enrolled during the reporting period.
Referral source	Source of the referral to FHARPS services. If more than one source referred the participant for FHARPS services, providers are instructed to enter the first referral source.
Trueblood Partner Programs	Programs implemented as part of Trueblood settlement activities.
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 Facility	Any inpatient facility providing treatment for mental health, substance use, or medical needs; excludes crisis stabilization centers and outpatient services.
Shelter	Service agency that provides temporary residence for homeless individuals and families.
Street/Encampment	On the street or in a homeless camp/encampment site (an area with multiple homeless individuals).
Temporary Residence	Shelter or other temporary shared quarters (couch surfing, doubled up); excludes hotel/motel.
Other	Other locations not listed as a location option.
Participant Status	Participant program enrollment status.
Active (on last day of reporting period)	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged (during reporting period)	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
HOUSING SUPPORT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Participants enrolled during the reporting period.
Housed or Sheltered	Participants who accepted at least one housing placement since enrollment. Includes temporary housing in shelters and motels.
Services Participant Agreed To	Participants may choose to receive subsidy assistance only, or subsidies with support services.
Subsidies Only	Participant agreed to receive only subsidy support.
Support Services and Subsidies	Participant agreed to support services (e.g., transportation, seeking housing, assisting with lease and landlord relations, referrals to additional services, etc.) from an FHARPS peer or housing specialist and subsidy support.
First Housing Type	First housing type placement after program enrollment. Includes temporary housing in shelters and hotels/motels.
Permanent	Includes the following housing types: Scattered site, Project site, alternative housing (e.g., rental or purchase of mobile home, RV, tiny home, etc.).
Transitional	Includes the following housing types: Transitional, Oxford House, Recovery Residence, Sober Living, Shared Living, Single Site, Tiny Home Villages, Master Leasing.
Shelter/Emergency	Includes the following housing types: shelter, hotel/motel.
Other	Other housing types not listed as a housing type option or missing/unknown first housing type(s).
DISCHARGE TABLE, Cumulative	
Participant Status	Participant program enrollment status.

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

Appendix F-FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

Led by the Washington State Health Care Authority (HCA), the Forensic PATH program offers enhanced engagement and connection to services for individuals identified as most at risk of being referred for a competency evaluation within the next six months. Teams within behavioral health agencies will connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The Forensic PATH program began on March 1, 2020 in the Phase 1 regions and April 1, 2022 in the Phase 2 region. Between March 1, 2020 and December 31, 2023, the Forensic PATH program has enrolled 621 individuals.

March 1, 2020 to December 31, 2023

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

CONTACTS
Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Tasha Fox, PhD, Research Associate, RDA, 360.902.0221, tasha.fox@dshs.wa.gov
Paula Henzel, Senior Research Scientist, RDA, 360.902.0792, paula.henzel@dshs.wa.gov

Contents

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION										
Number on Referral List	3,280	100%	1,015	100%	333	100%	626	100%	1,306	100%
Attempted Contacts	1,257	38%	596	59%	123	37%	374	60%	164	13%
Contacted	1,087	33%	266	26%	169	51%	288	46%	364	28%
Enrolled	621	19%	200	20%	127	38%	123	20%	171	13%
PRIORITIZED POPULATION										
Prioritized Referral List	1,635	50%	579	57%	153	46%	385	62%	518	40%
Attempted Contacts	679	42%	355	61%	56	37%	213	55%	55	11%
Contacted	529	32%	154	27%	87	57%	154	40%	134	26%
Enrolled	307	19%	107	18%	65	42%	71	18%	64	12%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	334	54%	111	56%	45	35%	54	44%	124	73%
Discharged*	287	46%	89	45%	82	65%	69	56%	47	27%
Average Length of Stay in Program (days)	290.4	N/A	340.5	N/A	271.0	N/A	332.5	N/A	167.4	N/A
DISCHARGE REASON										
Successful exit	55	19%	25	28%	--	--	17	25%	--	--
Loss of contact	129	45%	35	39%	32	39%	33	48%	29	62%
Needs could not be met by program	17	6%	--	--	--	--	--	--	--	--
Withdrew	17	6%	--	--	--	--	--	--	--	--
Incarceration	30	10%	--	--	14	17%	--	--	--	--
Admitted to hospital	8	3%	--	--	--	--	--	--	--	--
Transferred to another FPATH program	2	1%	--	--	--	--	--	--	--	--
Death	11	4%	--	--	--	--	--	--	--	--
Other	18	6%	--	--	--	--	--	--	--	--
GENDER										
Female	132	21%	42	21%	29	23%	32	26%	29	17%
Male	431	69%	144	72%	95	75%	86	70%	106	62%
Other/Unknown	58	9%	14	7%	3	2%	5	4%	36	21%
AGE GROUP										
18-29	143	23%	49	25%	32	25%	31	25%	31	18%
30-49	384	62%	110	55%	79	62%	79	64%	116	68%
50+	94	15%	41	21%	16	13%	13	11%	24	14%
RACE/ETHNICITY**										
American Indian or Alaskan Native	25	4%	--	--	--	--	--	--	--	--
Asian	22	4%	--	--	--	--	--	--	--	--
Black or African American	149	24%	51	26%	23	18%	13	11%	58	34%
Hispanic or Latino	42	7%	11	6%	12	9%	--	--	--	--
Native Hawaiian and Other Pacific Islander	7	1%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	276	44%	64	32%	81	64%	60	49%	57	33%
Other Race	32	5%	--	--	--	--	--	--	17	10%

Unknown	103	17%	59	30%	--	--	28	23%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	43	7%	13	7%	--	--	18	15%	--	--
Unstably Housed	117	19%	44	22%	21	17%	31	25%	21	12%
Homeless	388	62%	121	61%	92	72%	67	54%	108	63%
Unknown	73	12%	22	11%	--	--	--	--	40	23%
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	63	22%	31	35%	--	--	16	23%	--	--
Unstably Housed	21	7%	--	--	--	--	--	--	--	--
Homeless	48	17%	14	16%	23	28%	--	--	--	--
In a Facility	43	15%	--	--	19	23%	13	19%	--	--
Unknown	112	39%	27	30%	20	24%	34	49%	31	66%

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. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. Individuals may report more than one race/ethnicity.

TABLE 2.

Forensic PATH Services

CUMULATIVE: March 1, 2020 - December 31, 2023

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS										
Total Forensic PATH Service Encounters	12,131		4,270		1,970		3,693		2,198	
Average Service Encounters (per participant, per month)	2.2		2.2		2.5		2.4		2.0	
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services	0.3		0.1		0.3		0.8		0.2	
Re-engagement	0.0		0.0		0.1		0.1		0.0	
Screening	0.1		0.2		0.0		0.1		0.2	
Clinical assessment	0.0		0.0		0.0		0.0		0.0	
Habilitation/rehabilitation	0.0		0.0		0.1		0.0		0.0	
Community mental health	0.1		0.0		0.3		0.0		0.0	
Substance use treatment	0.0		0.0		0.0		0.0		0.0	
Case management	1.2		1.6		1.0		1.0		1.0	
Residential supportive services	0.1		0.0		0.4		0.0		0.0	
Peer services	0.1		0.0		0.0		0.1		0.4	
Service coordination	0.2		0.1		0.2		0.2		0.2	
Other	0.0		0.0		0.0		0.0		0.0	
Among Enrolled Individuals…										
REFERRALS - *Number of participants with at least one referral*										
Any Referral	219	35.3%	74	37.0%	52	40.9%	79	64.2%	14	8.2%
Referral Type										
Community mental health	69	11.1%	23	11.5%	--	--	27	22.0%	--	--
Substance use treatment	38	6.1%	--	--	--	--	20	16.3%	--	--
Primary health/dental care	31	5.0%	--	--	--	--	23	18.7%	--	--
Job training	1	0.2%	--	--	0	0.0%	0	0.0%	--	--
Educational services	2	0.3%	--	--	0	0.0%	--	--	0	0.0%
FHARPS housing	96	15.5%	38	19.0%	28	22.0%	--	--	--	--
Permanent housing (non-FHARPS)	20	3.2%	--	--	--	--	--	--	--	--
Temporary housing (non-FHARPS)	32	5.2%	13	6.5%	--	--	--	--	--	--
Other Housing Services (non-FHARPS)	47	7.6%	16	8.0%	25	19.7%	--	--	--	--
Housing services (pre-August 2021)	28	4.5%	12	6.0%	--	--	12	9.8%	--	--
Income assistance	10	1.6%	--	--	--	--	--	--	0	0.0%
Employment assistance	12	1.9%	--	--	--	--	--	--	0	0.0%
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	40	6.4%	--	--	--	--	31	25.2%	0	0.0%

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

FPATH Definitions

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

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

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

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

Appendix G-Crisis Intervention Training Dashboard

CIT Dashboard

Crisis Intervention Training (CIT)

CUMULATIVE UPDATE

Per the Trueblood settlement agreement, crisis intervention trainings (CIT) are being offered to law enforcement, 911 dispatch, and corrections officers throughout Washington State. At a minimum, 25% of patrol officers in the Phase 1 and 2 regions are required to complete 40 hours of enhanced CIT, while 100% 911 dispatchers and correctional officers are required to complete an eight-hour course. Contempt settlement-mandated crisis intervention trainings began on July 1, 2019 for Phase 1; July 1, 2021 for Phase 2; and July 1, 2023 for Phase 3 - however, trainings prior to this date have been included for some 911 dispatchers.

REPORTING PERIOD

Monthly: December 2023

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

Contents

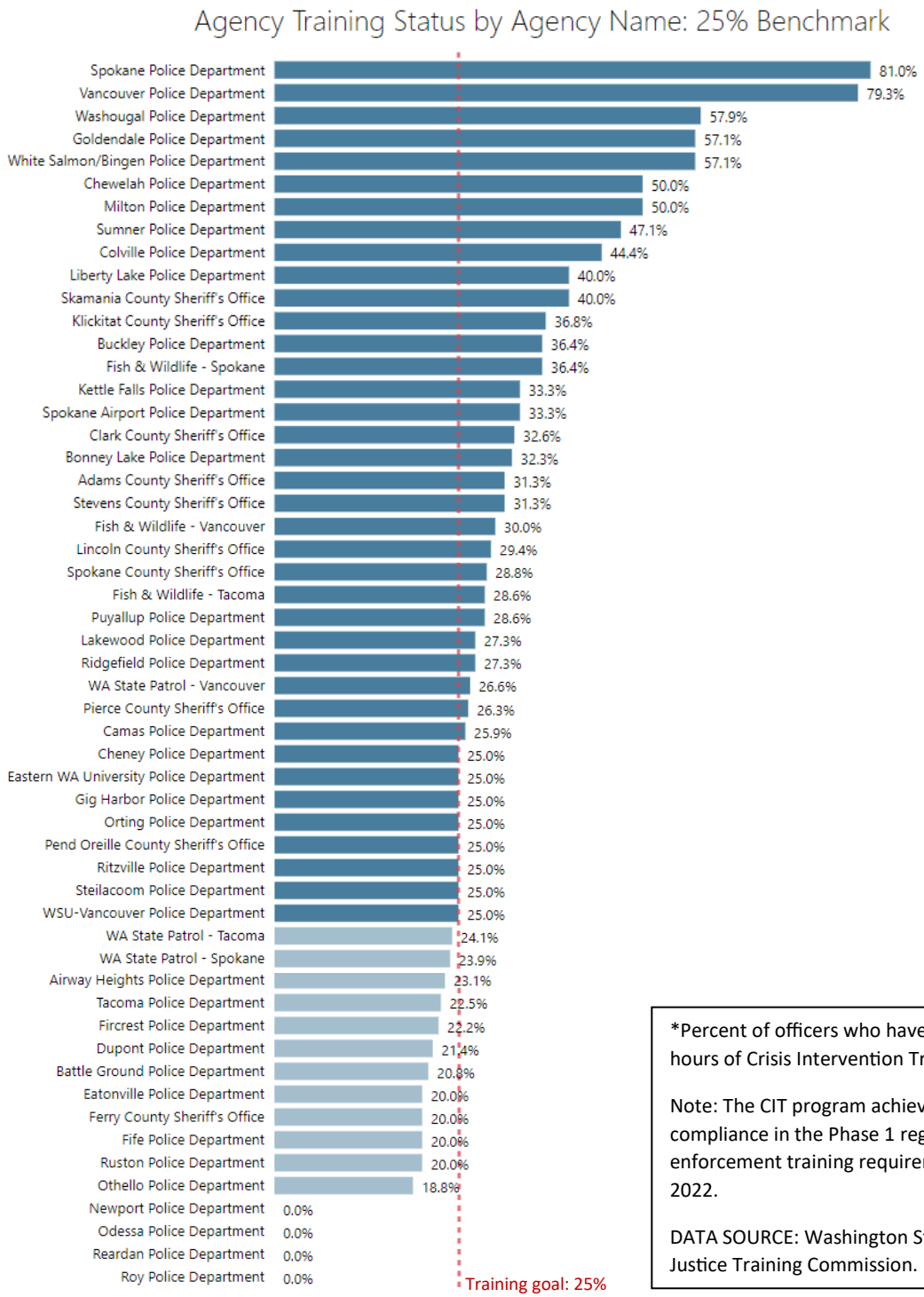
CONTACTS

Alice Huber, PhD, Director, RDA, 360.902.0707, alice.huber@dshs.wa.gov
Tasha Fox, PhD, Research Associate, RDA, 360.902.0221, tasha.fox@dshs.wa.gov
Paula Henzel, Senior Research Scientist, RDA, 360.902.0792, paula.henzel@dshs.wa.gov

Figure 1.

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

DECEMBER 31, 2023



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

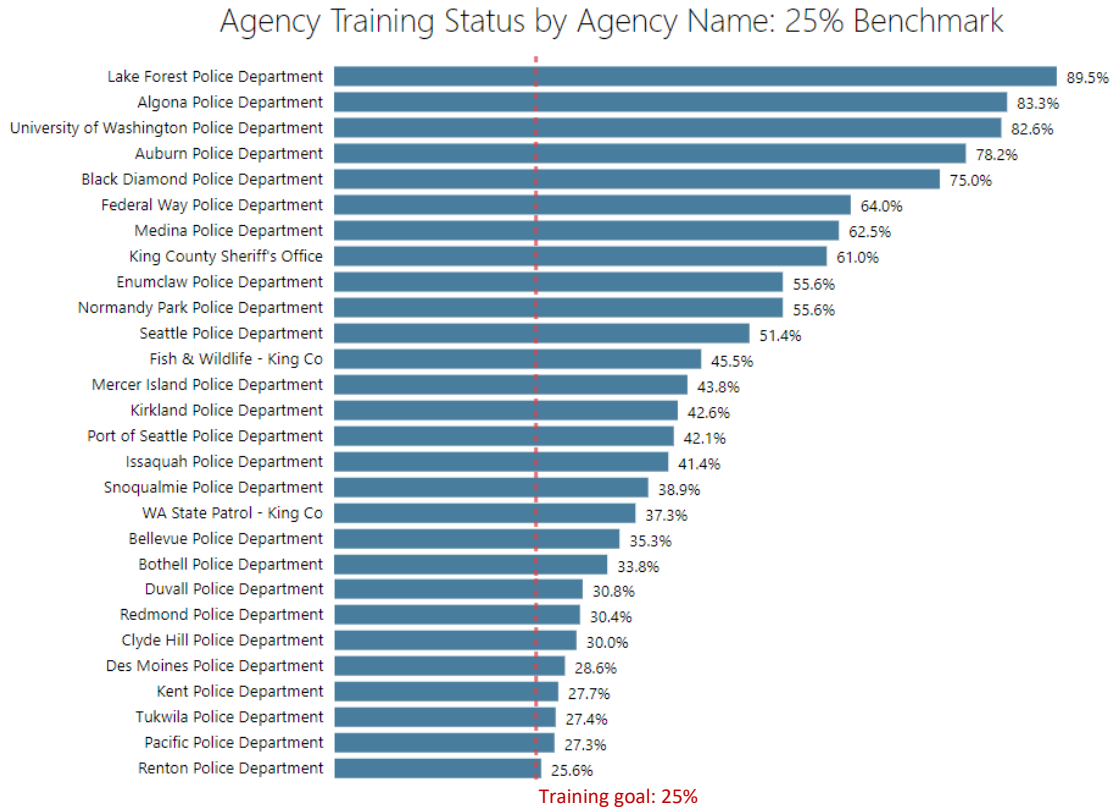
Note: The CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

DECEMBER 31, 2023



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

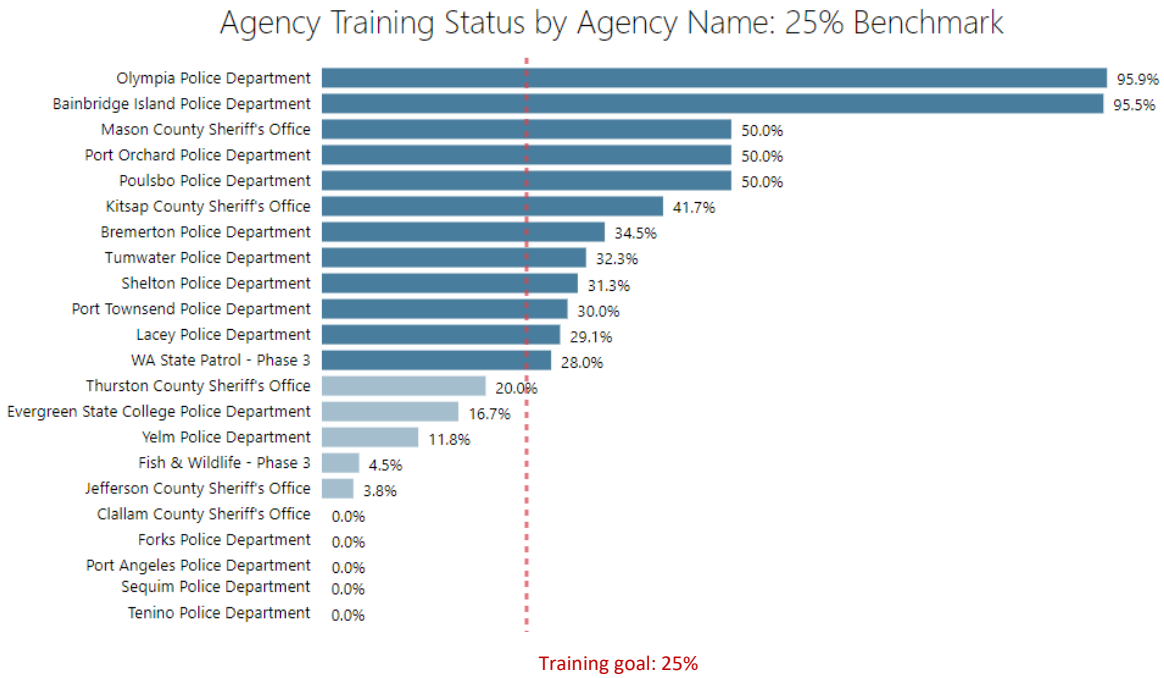
Note: The CIT program achieved 100 percent compliance in the Phase 2 region for the law enforcement training requirement in June 2023.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 3.

Crisis Intervention Training Program Measures
Agency Training Status: 25% Benchmark, Phase 3 Region*

DECEMBER 31, 2023



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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 1.

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

DECEMBER 31, 2023

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

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**1,504**	**693**	**46.1%**	**593**	**154**	**26.0%**	**391**	**128**	**32.7%**	**2,488**	**975**	**39.2%**
Fish & Wildlife - Phase 1							28	9	32.1%	**28**	**9**	**32.1%**
Pierce Region	609	148	24.3%	230	63	27.4%	124	38	30.6%	**963**	**249**	**25.9%**
Southwest Region	349	215	61.6%	51	12	23.5%	82	36	43.9%	**482**	**263**	**54.6%**
Spokane Region	546	330	60.4%	58	16	27.6%	157	45	28.7%	**761**	**391**	**51.4%**
WA State Patrol - Phase 1				254	63	24.8%				**254**	**63**	**24.8%**
Phase 2	**2,613**	**1,329**	**50.9%**	**412**	**156**	**37.9%**	**135**	**73**	**54.1%**	**3,160**	**1,558**	**49.3%**
Fish & Wildlife - Phase 2							11	5	45.5%	**11**	**5**	**45.5%**
King Region	2,479	1,279	51.6%	412	156	37.9%	124	68	54.8%	**3,015**	**1,503**	**49.9%**
WA State Patrol - Phase 2	134	50	37.3%							**134**	**50**	**37.3%**
Phase 3	**120**	**50**	**41.7%**	**559**	**200**	**35.8%**	**118**	**31**	**26.3%**	**797**	**281**	**35.3%**
Fish & Wildlife - Phase 3				22	1	4.5%				**22**	**1**	**4.5%**
Salish Region	120	50	41.7%	170	41	24.1%	75	23	30.7%	**365**	**114**	**31.2%**
Thurston-Mason Region				292	137	46.9%	43	8	18.6%	**335**	**145**	**43.3%**
WA State Patrol - Phase 3				75	21	28.0%				**75**	**21**	**28.0%**
Total	**4,237**	**2,072**	**48.9%**	**1,564**	**510**	**32.6%**	**644**	**232**	**36.0%**	**6,445**	**2,814**	**43.7%**

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, 2, and 3 regions are required to complete 40 hours of enhanced CIT. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers. The CIT program achieved 100 percent compliance for the law enforcement training requirement in June 2022 (Phase 1 regions) and June 2023 (Phase 2 region).

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 2.

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

DECEMBER 31, 2023

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

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**445**	**429**	**96.4%**				**73**	**56**	**76.7%**	518	485	93.6%
Pierce Region	238	232	97.5%				10	8	80.0%	**248**	**240**	**96.8%**
Southwest Region							23	15	65.2%	**23**	**15**	**65.2%**
Spokane Region	207	197	95.2%				40	33	82.5%	**247**	**230**	**93.1%**
Phase 2	**517**	**508**	**98.3%**	**24**	**24**	**100.0%**	**35**	**30**	**85.7%**	576	562	97.6%
King Region	517	508	98.3%	24	24	100.0%	35	30	85.7%	**576**	**562**	**97.6%**
Phase 3				**198**	**44**	**22.2%**	**30**	**0**	**0.0%**	228	44	19.3%
Salish Region				121	44	36.4%	10	0	0.0%	**131**	**44**	**33.6%**
Thurston-Mason Region				77	0	0.0%	20	0	0.0%	**97**	**0**	**0.0%**
Total	**962**	**937**	**97.4%**	**222**	**68**	**30.6%**	**138**	**86**	**62.3%**	1,322	1,091	82.5%

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

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

DECEMBER 31, 2023

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

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**247**	**247**	**100.0%**	**88**	**80**	**90.9%**	**134**	**122**	**91.0%**	**469**	**449**	**95.7%**
Spokane Region	101	101	100.0%	28	24	85.7%	57	48	84.2%	**186**	**173**	**93.0%**
Pierce Region	146	146	100.0%							**146**	**146**	**100.0%**
Southwest Region				60	56	93.3%	20	17	85.0%	**80**	**73**	**91.3%**
WA State Patrol - Phase 1							57	57	100.0%	**57**	**57**	**100.0%**
Phase 2	**238**	**232**	**97.5%**	**119**	**106**	**89.1%**	**89**	**89**	**100.0%**	**446**	**427**	**95.7%**
King Region	238	232	97.5%	119	106	89.1%	77	77	100.0%	**434**	**415**	**95.6%**
WA State Patrol - Phase 2							12	12	100.0%	**12**	**12**	**100.0%**
Phase 3				**108**	**100**	**92.6%**	**58**	**27**	**46.6%**	**166**	**127**	**76.5%**
Salish Region				51	51	100.0%	27	16	59.3%	**78**	**67**	**85.9%**
Thurston-Mason Region				57	49	86.0%	17	0	0.0%	**74**	**49**	**66.2%**
WA State Patrol - Phase 3							14	11	78.6%	**14**	**11**	**78.6%**
Total	**485**	**479**	**98.8%**	**315**	**286**	**90.8%**	**281**	**238**	**84.7%**	**1,081**	**1,003**	**92.8%**

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

DATA SOURCE: Washington State Criminal Justice Training Commission.