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

Semi-Annual Report

March 31, 2020

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

Criminal Justice Training Commission Washington

Table of Contents

List of Abbreviations

AAG – Assistant Attorney General

ASO – Administrative Service Organization

BHA – Behavioral Health Administration, part of DSHS

BHASO –Behavioral Health Administrative Service Organization

CIT – Crisis Intervention Training

CJTC – Criminal Justice Training Commission

CMHA – Community Mental Health Agency

CMS – Centers for Medicare and Medicaid Services

CPC – Certified Peer Counselor

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

DCR – Designated Crisis Responder

DMHP – Designated Mental Health Professional (now called DCRs)

DSHS – Department of Social and Health Services

DOH – Department of Health

DRW – Disability Rights Washington

FDS – Forensic Data System

FRA – Forensic Risk Assessment

GAC – General Advisory Committee

HARPS – Housing and Recovery through Peer Services

HCA – Health Care Authority

IDD – Intellectual or Developmental Disability

IMD – Institutions for Mental Disease

ITA – Involuntary Treatment Act

LRA – Less Restrictive Alternative

MCO – Managed Care Organization

MCR – Mobile Crisis Responders

MHP – Mental Health Professional

NGRI – Not Guilty by Reason of Insanity

OCRP – Outpatient Competency Restoration Program

OFMHS – Office of Forensic Mental Health Services

PATH – Projects for Assistance in Transition from Homelessness

PR – Personal Recognizance

PSRP – Public Safety Review Panel

RTF – Residential Treatment Facility

SUD – Substance Use Disorder

WASPC – Washington Association of Sheriffs and Police Chiefs

Preamble

Welcome to the first semi-annual report (SAR) that will be published in March and September each year through the duration of implementation plan Phases 1 and 2 of the *Trueblood* contempt settlement agreement.

The report is designed to provide updates on each of the element areas and related programs being designed and implemented as part of the contempt settlement agreement. Many of the programs have been in consultation, design, and pre-launch phases. New programs are scheduled to launch into service throughout spring and summer 2020.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes where possible. For this initial SAR, a small number of elements contain programs with data available to view. Most of the elements have demonstration data to display how future reports might appear. As with the launch of any major new program, it will take time to receive usable and reliable data for reporting. As programs' begin operation and mature, this report will expand over time to include more data and reporting elements.

The data templates shown will be modified as programs develop. Data on program participation will be included in the SAR after programs have been operational for at least two calendar quarters.

Disclaimer

Since the drafting of this semi-annual report, the Covid-19 pandemic is beginning to impact *Trueblood* implementation efforts. Rapid changes are expected in the coming weeks that may impact the information contained in this report. The state is making efforts to minimize impacts to settlement activities, but due to the ongoing state of emergency, impacts are inevitable.

Background

All criminal defendants have the constitutional right to assist in their own defense. If a court believes a mental disability may prevent a defendant from assisting in their own defense, the court puts the criminal case on hold while an evaluation is completed to determine the defendant's competency.

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

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

As a result of this case, the state has been ordered to provide court-ordered in-jail competency evaluations within 14-days and inpatient competency evaluation and restoration services within 7-days of receipt of a court order. *Trueblood* applies to individuals who are detained in city and county jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of *Trueblood* also target individuals 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 evaluations can be prevented if fewer people with mental illness enter the criminal justice system and receive community-based treatment instead. When people get the treatment they need when they need it, they are more likely to avoid becoming entwined in the criminal system. The goals of the programs covered in this report include providing variable levels of care to prevent overuse of the highest and most intensive level of care, and providing that care in the community whenever possible and appropriate.

On December 11, 2018, the court approved the contempt settlement agreement related to the contempt findings in this case. The settlement is designed to move the state closer to compliance with the Court's injunction. The settlement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified and agreed upon geographic regions. The contempt settlement agreement includes three phases of two years each and can be expanded to include additional phases.

Phases run parallel to the Legislative biennia beginning with the 2019-2021 biennium. Currently, we are in Phase 1:

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

- Phase 2: July 1, 2021 – June 30, 2023 King County region
- Phase 3: July 1, 2023 – June 30, 2025 Region to be determined

The goals envisioned above, by the *Trueblood* Taskforce, are beginning to take shape within the Behavioral Health Transformation underway in the State of Washington. 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 a number of names and titles are referred to frequently over the many element sections. The definitions below provide common usage and understanding throughout the report.

Authority, the Authority, or HCA: Washington State Health Care Authority

CJTC or the Commission: Washington State Criminal Justice Training Commission

Crisis Housing Vouchers: Allows unhoused or unstably housed persons in behavioral health crisis to obtain short term housing assistance for up to 14-days.

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

Forensic Housing and Recovery through Peer Services or FHARPS: Staff teams with lived experience with behavioral health challenges that provide unstably housed and recently forensically involved individuals with supports to access supportive housing and recovery services.

Forensic Projects for Assistance in Transition from Homelessness or FPATH: An intensive case management program that identifies individuals most at risk of referral for competency restoration during the next six months. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

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

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

Mobile Crisis Response: Rapid field response teams that quickly intervene in behavioral health crisis situations to prevent arrests, incarceration, and to quickly connect clients to needed services.

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.

Peer Support Specialists: Persons who are trained, often as certified peer counselors, to assist forensically involved patients through the treatment process. Peers are especially valuable due to their lived experience facing mental health concerns and also having engaged with the criminal justice system.

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

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

Collaboration Model

Agencies and entities across the state of Washington must work in partnership to successfully implement the *Trueblood* contempt settlement agreement. No one organization has complete ownership or oversight of service delivery in the forensic, crisis, or behavioral health systems. Improvements to these systems can only come when public and private entities, service recipients, and their families build strong partnerships involving deep and meaningful collaboration and communication.

The goal of the report, located in its entirety in Appendix A, is to share the structures and systems developed by the *Trueblood* team to support the successful implementation of the *Trueblood* contempt settlement agreement.

The requirement to provide the report and collaboration model is limited to this first semi-annual report.

Evaluation and Monitoring Overview

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

Project Monitoring

The department will provide ongoing project monitoring analyses through monthly and quarterly reporting. Monthly monitoring reports will provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness metrics, and slowing the rate of growth in competency evaluation referral volume. Quarterly reporting on implementation elements (e.g., Forensic PATH and the Forensic Navigator program) will provide timely information on client engagement in implementation programs. Monitoring measures to be tracked will include:

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

A *Trueblood* Quarterly Dashboard containing client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for the elements listed below. Data will come from a range of sources, and largely from tools or system adaptations still to be developed. Additional program measures may be added as feasible. HCA is working to identify and implement long-term data collection tools for programs that will us an interim solution as well as strategies to optimize data quality, and efficient sharing, to support timely reporting. Programs included in the quarterly dashboard will be:

- FPATH (Forensic PATH)
- FHARPS (Forensic HARPS)
- Forensic Navigator Program
- OCRP
- Mobile Crisis Response

- Crisis Housing Vouchers.

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

All client-level data will be aggregated to protect client confidentiality and suppression guidelines will be followed.

Longer-term Impact Analyses

RDA will assess the impact of contempt 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 (MH) and substance use disorder (SUD) treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

The evaluation will encompass both an assessment of the overall phased regional impact of contempt settlement agreement components on outcomes, and to the extent feasible given program design, data availability, and resource constraints, the impact of specific components (e.g., the Forensic PATH program).

Timeline

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

1. Impacts on measures derived directly from FDS data (substantial compliance timeliness metrics, number of competency evaluation referrals, and number of competency restoration referrals) will be tested on a semi-annual basis beginning two quarters after the implementation of all major contempt settlement agreement components in July 2020. Initial tests of statistical significance of impacts in the first six months of full implementation are expected to be produced no earlier than the end of January 2021.

2. Impacts on behavioral health access and social outcome metrics will require significantly more time to measure. These measures are produced on a global scale for all Medicaid beneficiaries and require a 12-month measurement window, seven months of data maturity[1], one month of global measure production and testing, and one month for analysis of results for the *Trueblood* population. Analysis of first-year impacts (through the period ending June 30, 2021) on these measures will be available in March 2022.

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

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

Implementation Plan Elements

The sections that follow detail the 14 elements that serve as a services enhancement framework to implement Phases 1 and 2 of the *Trueblood* contempt settlement agreement.

Each element's report considers the following five items as they relate to the element specifically and to the *Trueblood* contempt settlement agreement and to the *Trueblood* implementation plan more holistically: (1) background on each element's inclusion in *Trueblood*; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) data pertaining to the element. As discussed above, few elements have data and other element teams are finalizing development of data models to support element programs. For the first semi-annual report, many of the programs remain in development and pre-startup. As a result, evaluative and outcome data is not yet available. Over time additional and more robust data will become available as part of this report.

Competency Evaluation – Additional Evaluators

The contempt settlement agreement requires hiring 18 additional evaluators over two years. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines, evaluators can also be assigned to address the need of completing non-*Trueblood* forensic assessments (such as civil petitions, Not Guilty by Reason of Insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state.

Current Status and Areas of Positive Impact

Since July 1, 2019, the Office of Forensic Mental Health Services (OFMHS) has hired 12 evaluators. Six additional interviews were held by early March 2020. With the additional evaluators, time was spent completing new employee orientation and on-boarding to complete forensic assessments per Washington state requirements. The new hires have allowed OFMHS to complete jail-based competency evaluations within 14-days near 90%[2] even though referrals have hit new record numbers in the last quarter of 2019. Furthermore, the new evaluators have allowed a record number of civil commitment petitions to be completed and an approximately 50% increase in forensic risk assessments completed.

Areas of Concern

In Fiscal Year 2019, Washington state had the highest number of referrals for competency evaluations (4,550[3]) to date. This increase in referrals occurred even though 12 fine-funded contempt programs and three state-funded prosecutorial diversion programs were in full operation. Without these programs, demand for evaluations would have likely sky-rocketed further in the past fiscal year.

Recommendations to Address Concerns

The department continues its efforts to resolve ongoing issues with attorney scheduling because that continues to be the primary reason for evaluations being completed after 14 days. A multi-partner meeting with King County to address scheduling of evaluations is planned for early summer. Furthermore, a second meeting to discuss scheduling with Spokane County Jail occurred in March. In some counties, evaluator supervisors have cultivated relationships with defense counsel leadership to elevate individual scheduling issues. Evaluator supervisors will continue to develop these relationships as a means to encourage timely scheduling.

---

[2] *Table 8. Class member status at WSH and ESH (totals) – Jail-based competency evaluations.* Aug.-Nov. 2019 Mature Data. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Final Monthly Report to the Court Appointed Monitor. January 31, 2020, p. 15.

[3] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated July 10, 2019.

Data – Competency Evaluation – Additional Evaluators

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

The department examined the number of orders filed by the courts between January 2017 and December 2019, and projected the number of evaluation orders through June 2023 using an exponential smoothing forecast model[4]. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the *Trueblood* settlement and Engrossed Substitute Senate Bill (ESSB) 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

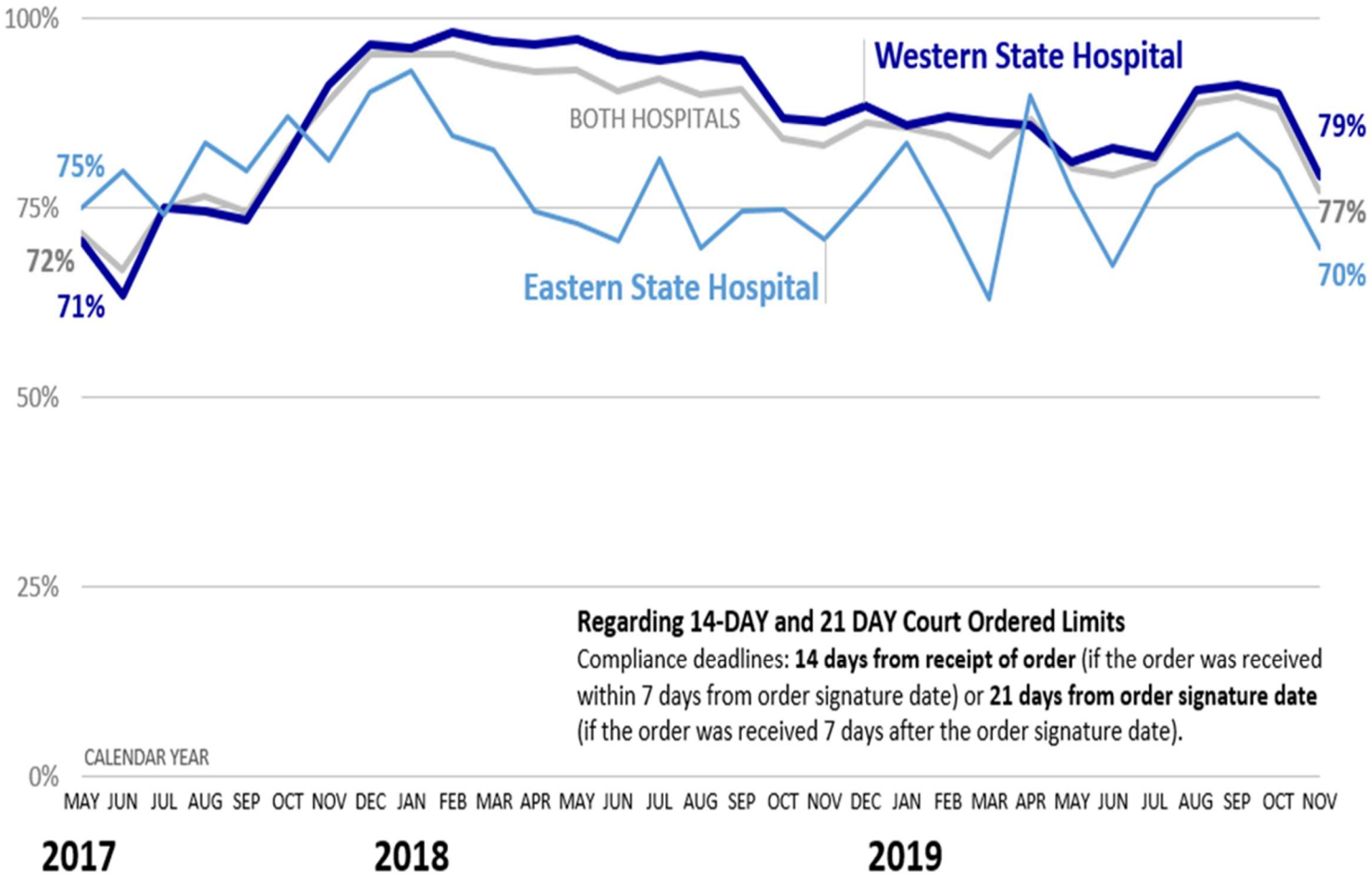
Projections indicate that the number of evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74 FTE's in the FY2021 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, 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.

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

FIGURE 1.

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

Percent complete or closed within court ordered limits



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

NOTE: Refer to page 15 and footnote 1 for additional details on jail-based competency evaluation completion rates.

Competency Restoration – Legislative Changes

As part of the SA, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. In particular, the state advanced bill proposals and supported legislation that furthered the goal of reducing the number of individuals ordered to receive competency evaluation and restoration services. The eventual bill came to be known as ESSB 5444, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. ESSB 5444 passed unanimously in both the House and Senate, and was signed by the governor on May 9, 2019.

Current Status and Areas of Positive Impact

As of July 28, 2019, ESSB 5444 went into effect. This bill changed the standard under which non-felony restoration may be ordered. Now, when a defendant in a non-felony criminal case is found to be incompetent, the court:

> (a) Shall dismiss the proceedings without prejudice and detain the defendant for sufficient time to allow the designated crisis responder to evaluate the defendant and consider initial detention proceedings under chapter 71.05 RCW, unless the prosecutor objects to the dismissal and provides notice of a motion for an order for competency restoration, in which case the court shall schedule a hearing within seven days to determine whether to enter an order of competency restoration.
>
> (b) At the hearing, the prosecuting attorney must establish that there is a compelling state interest to order competency restoration treatment for the defendant. The court may consider prior criminal history, prior history in treatment, prior history of violence, the quality and severity of the pending charges, any history that suggests whether or not competency restoration treatment is likely to be successful, in addition to the factors listed under RCW 10.77.092. If the prosecuting attorney proves by a preponderance of the evidence that there is a compelling state interest in ordering competency restoration, then the court shall order competency restoration in accordance with subsection (2)(a) of this section.

RCW 10.77.088(1)(a)-(b) (including changes made by ESSB 5444).

ESSB 5444 also modified the length of time that a defendant charged with a non-felony can be ordered for restoration. Here is the full language of the sub-section relevant to non-felony restoration time periods, as it will appear in the amended version of RCW 10.77.088(2)(b):

> "The placement under (a) of this subsection shall not exceed twenty-nine days if the defendant is ordered to receive inpatient competency restoration, or shall not exceed ninety days if the defendant is ordered to receive outpatient competency restoration. The court may order any combination of this subsection, not to exceed ninety days. This period must be considered to include only the time the defendant is actually at the facility and shall be in addition to reasonable time for transport to or from the facility."

Since the change in the law went into effect, there has been a decrease of orders for misdemeanor competency restoration, although it is too early to derive any clear trend.

Areas of Concern

The courts continue to issue a small number of misdemeanor restoration orders, signaling the potential need for continued education in the judicial community. The codification of the changes to RCW 10.77.088 was confusing because of multiple changes made to that statutory section during the 2019 Legislative session.

Recommendations to Address Concerns

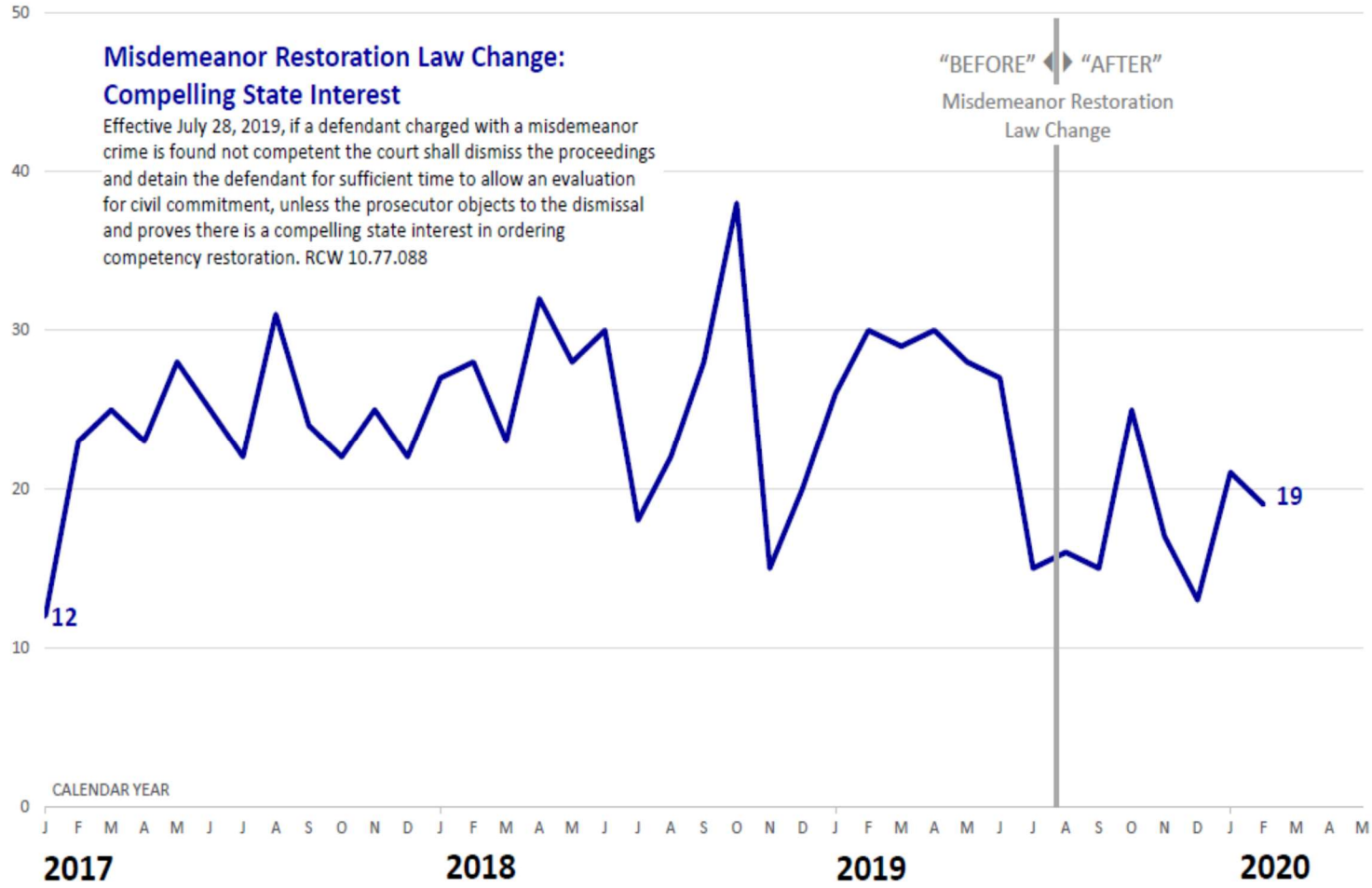
Additional communications and trainings about these changes will continue to enhance awareness, understanding, and application of the statutory changes. A technical correction bill has been pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The Governor signed the bill, and the corrections take effect on June 11, 2020. This will hopefully address any remaining confusion regarding the statute.

Data – Competency Restoration – Legislative Changes

DSHS is monitoring the number of misdemeanor restoration orders pre/post the 2019 law change requiring "compelling state interest." In December 2019, there were 12 misdemeanor restoration orders issued statewide, down from 16 the previous month (Figure 2). In January 2020, there were 21 misdemeanor restoration orders issued statewide, up from 13 the previous month (Figure 2).

FIGURE 2.

Misdemeanor Restoration Orders and the 2019 Law Change Requiring "Compelling State Interest" RCW 10.77.088



DATA SOURCE: Forensic Data System (FDS).

Competency Restoration – Community Outpatient Services

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

Current Status and Areas of Positive Impact

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

As of February 2020, an OCRP contractor has been identified to provide this new service in each of the three Phase 1 regions. Contracts for OCRP providers are in development with plans to have contracts executed by April 2020. Having contracts in place by April 2020, will allow for the following to occur prior to taking active assignments after July 1, 2020:

- Contractor start-up time to hire and train staff;
- Establishment of program manuals and local policy;
- Development of stakeholder relationships with forensic navigator's and local courts.

As of the drafting of this report one OCRP contractor has indicated that due to the COVID-19 pandemic, timelines may be impacted. Communication is ongoing with the contractor to support the contractor's efforts, and minimize potential impacts to implementation.

Areas of Concern

A single provider has been identified in each implementation region. This could be problematic for the more rural regions, although the provider contracts require services to be available to the entire region. It may also be problematic should it become necessary to terminate a provider contract. Under those circumstances, individuals could be court-ordered to participate in a service that may not exist.

Another continued concern is consistent support by system partners for this program. The department and the authority are partnering to meet directly with all municipal, district and superior courts in the implementation regions during the first quarter of 2020 to engage court staff in process collaboration, and to generate support for utilization of this program for qualified individuals. These system partners will control the flow of patients into the outpatient programs, and their reluctance could frustrate the success of the programs.

Recommendations to Address Concerns

DSHS and HCA will continue to engage court partners in discussions of this new program. Once contracts are awarded, contractor agencies will be included in the collaboration and engagement activities with Phase 1 region courts and local relationships and processes will be developed to sustain the program after full implementation. Additionally, continuity of care plan development is an important contingency to address the potentiality that a region's contracted provider could discontinue services or be terminated.

Data – Competency Restoration – Community Outpatient Services

Phase 1 region OCRP referrals, enrollment, and participant characteristics will be reported quarterly through the *Trueblood* Quarterly Dashboard (Table 1). The data will come from FDS, which is undergoing enhancements to accommodate OCRP information related to court orders, the Navigator Case Management System (NCM), and data reporting requirements included in each provider contract. Provider systems may require adaptations that limit initial dashboard reporting. DSHS and the HCA will collaborate with providers to ensure reliable and comparable data collection across contracted programs.

TABLE 1.

Outpatient Competency Restoration Program (OCRP) Enrollment and Participant Characteristics

MONTH YEAR

PRELIMINARY EXAMPLE

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88%	888	88%	888	88%	888	88%
Referrals	888	88%	888	88%	888	88%	888	88%
Clients Referred (unduplicated)	888	88%	888	88%	888	88%	888	88%
Clients Enrolled (unduplicated)	888	88%	888	88%	888	88%	888	88%
Among Enrolled Clients…								
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: Forensic Data System, Navigator Case Management System, and OCRP provider data systems.

Forensic Navigators

DSHS' Forensic Navigator Program seeks to divert forensically-involved criminal defendants out of jails and inpatient treatment settings, and into community-based treatment settings.

Program participants will each have a navigator assigned to them at the time the court orders a competency evaluation. For those participants deemed not competent to stand trial, and suitable for outpatient competency restoration, courts may elect to grant conditional release in order for those individuals to receive services in the community.

Navigators will work with participants by ensuring compliance with their conditions of release, attending outpatient competency restoration classes, and adhering to prescribed medications. Navigators will connect participants to additional supportive services in the community, such as housing, mental health and substance use treatment, supported employment services, and community-based case management services.

Current Status and Areas of Positive Impact

The Forensic Navigator Program is on track to launch on the target date of July 1, 2020. All deadlines set forth in the implementation plan have been met. Three navigators have been hired, with a fourth identified for hire. These four will constitute the team in Pierce County. Hiring for the Spokane and Southwest regions began at the end of February 2020, with the plan to offer all positions by the end of April 2020. All navigators will be trained and assigned to their respective regional offices by the end of May 2020. Equipment has been ordered and office facilities secured.

Program development is ongoing, with a training protocol, desk manual, and policy and procedures document already in draft form. Program staff are collaborating with BHA-IT and RDA in order to create a new caseload management system for navigators to use in the field.

Areas of Concern

Relationship building with courts, OCRP providers, and community-based service providers is well under way and ongoing. In meetings with Pierce County stakeholders/partners, concerns about the program such as use of the program versus diversion, potential overlap with existing specialty court programs, and a potential lack of clients approved for conditional release with pending felonies.

Recommendations to Address Concerns

Continue outreach and education to hear and address concerns, illustrate exactly how the programs will work, and how they will benefit multiple systems in the Pierce County region.

Data – Forensic Navigators

Forensic Navigator Program enrollment and participant characteristics will be reported quarterly, by Phase 1 region, through the *Trueblood* Quarterly Dashboard (Table 2). Forensic Navigators will be recording client data into a new Navigator Case Management System (NCM), currently under development by BHA-IT. Table 2 is a preliminary example of the reporting template RDA is actively developing.

TABLE 2.

Forensic Navigator Enrollment and Participant Characteristics

QUARTER

PRELIMINARY EXAMPLE

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88%	888	88%	888	88%	888	88%
Referrals	888	88%	888	88%	888	88%	888	88%
Clients Referred (unduplicated)	888	88%	888	88%	888	88%	888	88%
Clients Enrolled (unduplicated)	888	88%	888	88%	888	88%	888	88%
REFERRAL SOURCE								
District/Municipal Court	888	88%	888	88%	888	88%	888	88%
Superior Court	888	88%	888	88%	888	88%	888	88%
Among Enrolled Clients…								
CLIENT STATUS								
Active (on last day of reporting period)	888	88%	888	88%	888	88%	888	88%
Client Type (not mutually exclusive)	888	88%	888	88%	888	88%	888	88%
Pre-Competency Hearing Clients	888	88%	888	88%	888	88%	888	88%
Enrolled OCRP Clients	888	88%	888	88%	888	88%	888	88%
Coordinated Transition Clients	888	88%	888	88%	888	88%	888	88%
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: Navigator Case Management System (NCM).

Competency Restoration – Additional Forensic Beds

The vision of the parties in creating the contempt settlement agreement was to both reduce the number of people who become or remain class members and to more timely serve those who become class members.

The addition of beds at Eastern and Western state hospitals is intended to provide timelier competency evaluation and restoration services to class members.

The settlement requires that Eastern State Hospital (ESH) convert two previously administrative staff floors into forensic wards. These wards are 1North 3 (1N3) and 3North 3 (3N3). This project requires not just construction but also staffing increases and adjustments to the ESH admissions process and will result in 50 additional beds.

The contempt settlement agreement requires that Western State Hospital (WSH) convert two civil wards into forensic wards. These wards are E3 and E4. This project also requires construction and some staffing work to convert civil staffing models to the forensic model. This will result in the addition of 40 forensic beds.

In the 2019-2021 biennium, funding was allocated for additional forensic bed capacity. Over $27 million was allocated to the department for the addition of forensic bed capacity across the state. This includes two new competency restoration units at ESH. In the 2017-19 budget, the Legislature allotted funding for the conversion of two civil wards to forensic wards at WSH.

Current Status and Areas of Positive Impact – ESH

As of the drafting of this report this project is on schedule. However, the ongoing Covid-19 emergency is expected to impact construction activities, and impacts to the schedule are likely.

- Construction is on schedule.
- Major furniture, fixtures and equipment are on site.
- Hiring of new staff is underway with approximately 50% of the newly established positions filled by internal or external candidates.
- Work is ongoing to adjust admissions processes to support the opening of 1N3 and 3N3.
- Completed wards will contain total of 50 beds plus four total seclusion rooms and two total quiet rooms.

Current Status and Areas of Positive Impact – WSH

The state will require some additional time to complete the renovations of E4 and E4 at WSH. DSHS has been working diligently to identify all of the efficiencies possible to keep the timeline short, but it now appears that the work remaining cannot be completed by June 30th. Additionally, the ongoing COVID-19 pandemic emergency is expected to impact construction activities, and impacts to the schedule are likely. The contempt settlement agreement requires the state to file a motion with the Court to seek additional time beyond that date. That motion is currently under development.

- Major unexpected construction challenges are being overcome, although there will be timeline impacts.
- Major furniture, fixtures and equipment are on site.
- Staff have been notified of the upcoming conversion and work is underway to adjust the position classifications needed to support a forensic staffing model.
- Converted wards will contain 40 beds plus two seclusion rooms.

WSH is beginning the conversion of current staff positions to fill positions on the new CFS E3/E4 Wards (*Trueblood*). Schedules are currently being reviewed for final installation of furniture, equipment and supplies. The final configuration of the two wards will result in 40 new beds instead of 42, in order to accommodate a seclusion room on each ward.

Areas of Concern

The unexpected construction obstacles at WSH will impact the completion schedule. A detailed schedule is currently under review to estimate the final impact to the schedule.

At WSH, reconfiguration of the E3/E4 footprints to accommodate seclusion and restraint rooms on each ward resulted in the reduction of each ward by one bed. The total number of new beds between these two wards will now be 40 new beds, instead of 42 as originally planned.

The addition of 50 new forensic beds at ESH leaves the current admissions process insufficient to handle the increased volume of patients.

Recommendations to Address Concerns

The state will ask the Federal Court for permission to extend the timeline for completion of the renovations at WSH. The state has already implemented multiple strategies to minimize the delays created by these developments, and will continue to pursue any efficiency possible to minimize delays.

Although it is not possible to mitigate the change in bed count from 42 to 40 on E3 and E4, the state is continuing with development of additional wards at WSH beyond the commitments made in the contempt settlement agreement. These beds will not be completed on the same timeline as the E3/E4 project, but they will provide an additional 58 beds of forensic capacity at WSH.

The addition of 50 new forensic beds at ESH represents a substantial increase in patient treatment capacity. As a result, investment in cross-training and the hiring of new admissions staff is critical to a successful bed-expansion. For 2020, ESH's overall goal is to double admission capacity from six to eight patients per week to 12-16 per week. To accomplish this, 3S2 is being transformed into a second admission ward. In further service of this goal, the following training and cross-training initiatives are underway:

- Nursing and social work staff on the competency restoration ward 3S2 have received cross-training with staff on the current competency evaluation/restoration admission ward 1S1. During these trainings, staff on 3S2 have been provided instruction on how to complete the forms and documentation required for admissions.

- Nursing leadership has provided additional trainings to nursing staff in preparation to provide admissions functions.

- Forthcoming trainings will involve psychiatry and ward clerks (administrative assistants).

<u>Data – Competency Restoration – Additional Forensic Beds</u>
DSHS will continue to monitor average wait times for admission to inpatient evaluation and restoration as additional inpatient forensic beds become available (see Figure 3, page 31 – Closure of Maple Lane and Yakima Residential Treatment Facilities).

Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

DSHS opened two competency residential treatment facilities (RTF) to provide additional in-patient competency restoration services in 2016. The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order. Maple Lane Competency Restoration Program is staffed with a combination of state and contract employees. Yakima Competency Restoration Program is staffed by contract employees.

Both of these facilities will close as part of the overall integrated system changes contemplated in the *Trueblood* contempt settlement agreement. Both facilities have planned, hard closure dates – Yakima on December 31, 2021, and Maple Lane on July 1, 2024. As part of the contempt settlement agreement, low median wait times for inpatient competency services can trigger an earlier closure. For Yakima, that level is four consecutive months of a median of 13-days or less wait time for admission, and for Maple Lane, it is four consecutive months of a median wait time for admission of nine days or less.

The waitlist median times may be impacted by several projects associated with the contempt settlement agreement. This includes statute changes for misdemeanor restoration effective July 28, 2019; the net addition of four total forensic wards coming online at Eastern and Western state hospitals during summer 2020 (adding 90 new beds); and new outpatient competency restoration programs coming online in July 2020 in the contempt settlement agreement's Phase 1 regions: Pierce, Southwest, and Spokane.

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 each facility. Plans are similar for both Yakima and Maple Lane but have different components because of the staffing differences at the two facilities. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations during ramp down after the official closure notification is given. At this time, staffing remains at stable levels and within typical turnover margins.

Recommendations to Address Concerns

DSHS is continuously monitoring turnover, morale, and other factors, and actively taking steps to neutralize their effects as the hard closure dates, especially for Yakima, draw closer. Given the potential variability in closure dates due to contempt settlement agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient is discharged. Additionally, our contract oversight between the two main contractors will focus on the contract requirements to ensure sufficient staffing.

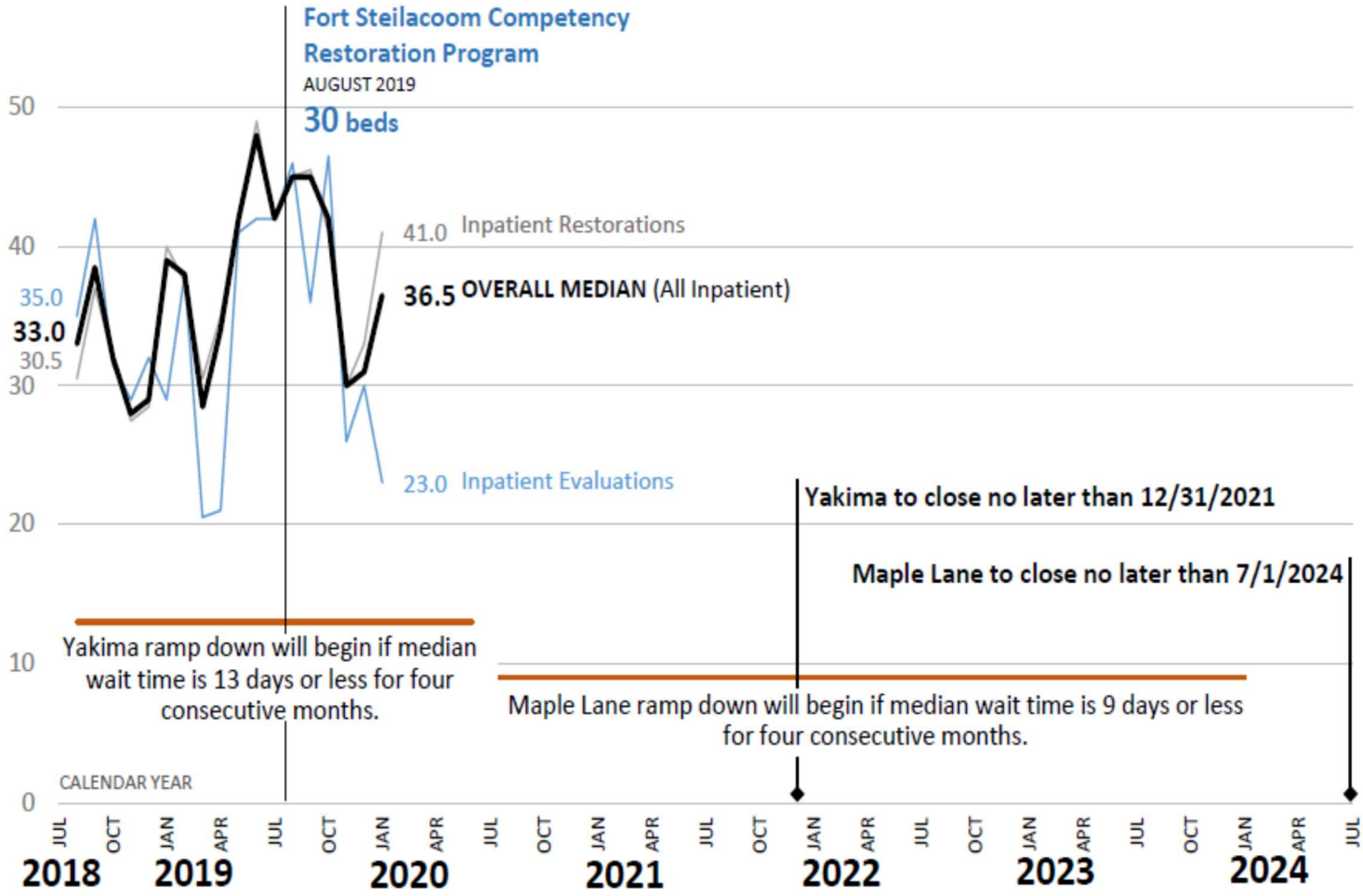
Data – Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services on a monthly basis (Figure 3). Wait times have not yet decreased to a level that would trigger early ramp down of the Maple Lane or Yakima facilities. In December 2019, the median wait time for inpatient competency services was 31-days. The Yakima ramp down will begin if median wait times reach 13 days or less for four consecutive months, with a hard closure date of December 31, 2021 regardless of wait times. The ramp down of Maple Lane will begin if median wait times reach nine days or less for four consecutive months. The facility will close by July 1, 2024 regardless of wait times.

FIGURE 3.

Closure of Maple Lane and Yakima Residential Treatment Facilities

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



DATA SOURCE: BHA Forensic Data System.

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

Crisis Triage and Diversion – Additional Beds, Enhancements, and Gap Recommendations

Washington state crisis stabilization/crisis triage (CS/CT) facilities are designed to deliver short-term clinical interventions in a safe structured environment and the support and behavioral health crisis stabilization services provided are offered in a community setting. These Department of Health licensed RTFs serve their communities by providing least restrictive alternatives to care. This allows individuals to be treated by a multi-disciplinary team for the purpose of diverting individuals from arrest, detention, and lengthy hospitalizations. Services within these facilities are short term and focus on stabilizing and returning the individual back to their community. While an emphasis is placed on voluntary admissions, these facilities are also designated to work with first responders to accept police drop-offs and police holds for up to 12-hours.

Through the *Trueblood* implementation plan, HCA seeks to enhance CS/CT services to divert individuals at risk for involvement in the criminal justice system. Using capital funding, HCA will work with the Department of Commerce to expand bed capacity in the Spokane region. HCA will also work with existing CS/CT facilities to improve their ability to accept police drop-offs in the interest of preventing individuals from being jailed when mental health treatment is indicated. Additionally, HCA will complete a gap analysis with recommendations regarding the three Phase 1 regions' CS/CT needs. Lastly, HCA will support the short-term housing needs of individuals experiencing homelessness served in Phase1 region CS/CT settings, while linking them to additional housing supports within their communities.

Current Status and Areas of Positive Impact

HCA supported the Department of Commerce in issuing a request for proposals for the expansion of 16 new beds for crisis stabilization in the Spokane region. The closing date for this RFP was December 31, 2019; the apparent successful bidder will be announced by the Department of Commerce when contracts have been finalized. Once funding is awarded, this site is planned to be operational by July 2021.

HCA is negotiating with CS/CT facilities and other RTFs providing residential crisis services in each of the three regions to enhance their ability to provide crisis stabilization services and accept police drop-offs. These negotiations remain in process with the expectation of completed contracts by March 31, 2020. Examples of planned enhancements include:

- Addition of peer bridger services at CS/CT or other RTFs. This will provide residential crisis services in order to support successful discharge plans linking individuals to routine behavioral health services while increasing the "through-put" of existing beds, thus making more beds available in the community.

- One-time purchases of equipment that will increase the acuity level a facility can accommodate.

- Additional staffing that will increase the acuity level a facility can accommodate.

- Training and technical assistance to support facilities in adapting practices to enable successful service for individuals referred via contact with law enforcement.

Development of the CS/CT gap analysis and subsequent recommendations for the three Phase 1 regions will be completed by March 30, 2020. The analysis will utilize the Public Consulting Group report, the House Bill 1109 Legislative Report on Crisis Stabilization and Crisis Triage Services, and information gleaned from the implementation process for project elements.

Beginning in November 2019, HCA contracted for the deployment of short-term housing vouchers (hotel/motel vouchers) in each region to meet the needs of individuals experiencing homelessness or unstable housing, who also had prior contact with the forensic mental health system or who were brought to a CS/CT facility as a diversion from arrest. RDA developed a tool for documenting vouchers and currently provides direct technical support to providers. HCA ensured regional immediate availability of this resource by contracting with CS/CT facilities and with an RTF providing crisis respite services in the absence of an existing CS/CT provider within its region.

Areas of Concern

With the exception of the Pierce County region, HCA found hesitancy on the part of CS/CT providers in accepting police drop-offs. Most providers did not design their facilities or staffing patterns with this referral source in mind. This led to a lot of initial hesitancy by providers to even engage in a dialogue about how to enhance their facilities. Without intentional planning for this need, staffing may be insufficient to meet the needs of this population and law enforcement personnel are unlikely to utilize this option if referrals are infrequently accepted.

Similarly, another concern revolves around the ability to break the cycle of perpetual crisis by introducing immediate housing and follow up supports. An aspect of these supports includes funding emergency hotel/motel vouchers that were designed to aid in supporting individuals, who would have historically recycled through the crisis system. As the authority transitions new programming into the Phase 2 King County region[5], maintaining adequate funding levels for crisis vouchers is a concern.

[5] Official population estimates as of April 1, 2019, indicate that the three Phase 1 regions have a combined population of 2,024,790 persons, and King County's estimated population is 2,226,300. King County comprises 52.4% population of the 11 counties in Phases 1 and 2. **Source:** Office of Financial Management, *April 1 Official Population Estimates:* www.ofm.wa.gov/washington-data-research/population-demographics/population-estimates/april-1-official-population-estimates

It is noteworthy that the current crisis service delivery landscape in Washington state is very dynamic. In the past year, some providers have closed facilities, an example of which is Telecare closing its evaluation and treatment facility in Vancouver in August 2019. However, other facilities are being developed and plan to come online in the coming year. This presents a challenge in planning as new construction often comes with delays.

Recommendations to Address Concerns

HCA will continue to work with CS/CT providers to enhance their ability to serve individuals with mental illness being diverted from arrest and jail. The planned enhancements are intended to increase the expertise and infrastructure to support this population and improve coordination with law enforcement. Despite the reluctance initially expressed by providers, they have been open to learning more about how to serve this population and are accepting of the enhancement opportunity offered through the *Trueblood* implementation plan.

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

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

Data – Crisis Triage and Diversion – Additional Beds and Enhancements

Additional crisis triage and stabilization beds and enhancement to services (e.g., accepting police drop-offs to serve persons in mental health crisis) may divert some individuals from arrest and incarceration. HCA will provide information on the date, location, and number of beds added. The department will assess the feasibility of detecting the impact of additional beds and services from other *Trueblood* efforts. Refer to Table 3, in the following section on Crisis Triage and Diversion – Residential Supports, for a preliminary example of the potential data in future semi-annual reports.

Crisis Triage and Diversion – Residential Supports

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

Current Status and Areas of Positive Impact

HCA has issued contracts to four Forensic HARPS teams — one in Spokane, one in southwest Washington and two in Pierce County. The teams are all currently recruiting and hiring staff. There will be at least one housing specialist and two certified peer counselors on each team. Services began March 1, 2020.

HCA, DSHS, the Office of Financial Management (OFM), and legislative staff have been in continued conversation about how each of the *Trueblood* elements will access residential supports using the allocation methodology from the Legislature. The following HARPS eligibility guidance will be issued through the Forensic HARPS contracts to ensure that individuals have access to needed residential supports. The Forensic HARPS eligibility guidance, which focuses on Forensic HARPS priority populations, is being shared with the teams as listed below:

Individuals who are identified as unstably housed, and:

- Ordered into an Outpatient Competency Restoration Program;
- On the HCA Referral List for Forensic PATH services;
- Referred by a Forensic Navigator; or
- Individuals exiting crisis triage/stabilization facilities who meet the following eligibility criteria as identified in section C.2 of the *Trueblood* contempt settlement agreement (located in Section 1, Introduction):
    - Have had at least one prior contact with the forensic mental system in the past 24-months, or, were brought to a crisis triage or stabilization facility via arrest diversion under RCW 10.31.110 as determined by the crisis triage and stabilization provider;
    - Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers; and

- Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;
    - Are unstably housed;
    - Are not currently in the community outpatient competency restoration program; and
    - Do not meet Involuntary Treatment Act (RCW 71.05) commitment criteria.

Other individuals may be eligible for Forensic HARPS services on a case-by-case basis and may be approved by the authority's Division of Behavioral Health and Recovery (DBHR). These include individuals who have a behavioral health condition and are involved in the forensic mental health system. Additionally, individuals may be referred from OCRP, Forensic PATH, the Forensic Navigators Program, from crisis stabilization facilities (that meet eligibility criteria), community behavioral health agencies, or elsewhere as long as the person being referred meets the eligibility criteria outlined above.

Areas of Concern

Long-term permanent housing vouchers are needed to achieve permanent supportive housing for individuals at risk of homelessness and who have touched the legal system. The participants served by the Forensic HARPS teams will only have short-term housing subsidies. Ongoing supportive services can and should be provided by the Foundational Community Supports (FCS) programs in each region, but the concern is how these individuals will financially sustain their housing due to the extremely limited number of permanent supportive housing vouchers/subsidies across our state. Another concern is the fact that individuals eligible and enrolled in Forensic HARPS may not meet the U.S. Department of Housing and Urban Development (HUD) eligibility guidelines for housing opportunities available through the local continuum of care projects.

Recommendations to Address Concerns

Extensive training and technical assistance will be provided to Forensic HARPS teams on how to access any available subsidies and vouchers in their local region as well as to employ every type of housing strategy to assist individuals in becoming housed. Forensic HARPS teams will be strongly encouraged to refer individuals to FCS or other community resources for supported employment. HCA believes that everyone can work with the appropriate supports.

HCA contracted with Advocates for Human Potential (AHP) to provide the Forensic HARPS teams with technical assistance and training. HCA is working with the trainers at AHP to develop

curriculum that is based on best practices to serve individuals who will be enrolled in the Forensic HARPS programs.

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) through the Forensic HARPS program. Information about the number served by each program will be reported quarterly, by Phase 1 region, through the *Trueblood* Quarterly Dashboard (see Tables 3 and 4 below). A data tracker was created for each program as an interim data collection tool until a longer-term solution is identified and implemented by HCA. Facilities and FHARPS will submit the data as required by their HCA provider contracts.

TABLE 3.

Crisis Triage and Stabilization Facility Housing Voucher Disbursals

MONTH YEAR

PRELIMINARY EXAMPLE

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY	888	88%	888	88%	888	88%	888	88%
Vouchers Disbursed	888	88%	888	88%	888	88%	888	88%
Recipients (unduplicated)	888	88%	888	88%	888	88%	888	88%
Total Amount Disbursed	888	88%	888	88%	888	88%	888	88%
Average Amount Per Recipient…	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: Crisis triage and stabilization facilities contracted to disburse crisis housing vouchers submit data to the Washington Health Care Authority (HCA).

TABLE 4.

Forensic HARPS (FHARPS) Enrollment and Participant Characteristics

MONTH YEAR

PRELIMINARY EXAMPLE

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88%	888	88%	888	88%	888	88%
Referrals	888	88%	888	88%	888	88%	888	88%
Clients Referred (unduplicated)	888	88%	888	88%	888	88%	888	88%
Clients Enrolled (unduplicated)	888	88%	888	88%	888	88%	888	88%
Among Enrolled Clients…								
CLIENT STATUS								
Active (on last day of reporting period)	888	88%	888	88%	888	88%	888	88%
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: FHARPS Data Tracker submitted by each FHARPS team to the Washington Health Care Authority (HCA).

Crisis Triage and Diversion – Mobile Crisis and Co-Responders

Currently in Washington state, Mobile Crisis Response (MCR) services are provided 24-hours per day, 365-days per year throughout the state, under HCA's contracts with regional Behavioral Health Administrative Service Organizations (BHASOs). In some large rural communities, MCR services are provided by designated crisis responders (DCR) while other communities are served by dedicated crisis interventionists. According to contract, MCR teams are required to meet a response time of two hours or less. Based on community discussions with the three Phase 1 implementation regions, the majority of MCR teams report that they are responding within 90-minutes or less.

Under the *Trueblood* implementation plan, HCA seeks to enhance the regional MCR service provision. This enhancement will support and provide supplemental assistance to traditional MCR services. The three Phase 1 regions are designing their enhanced services to provide a more timely response to community crisis calls and to ensure acceptance of referrals from co-responder teams.

Current Status and Areas of Positive Impact

Each Phase 1 region's MCR provider reports that they meet contractual obligations for timeliness, per the BHASO contracts. Each region has submitted their plan for enhancement and these plans are undergoing review by representatives from HCA, DSHS, and WASPC. These plans are responsive to the needs of each region, including meeting the often disparate urban and rural needs of individuals in crisis who are having concurrent contact with law enforcement. The BHASOs were encouraged to work with local law enforcement in the development of these plans. Feedback will be provided to each region with the anticipation of issuing contracts by the end of May.

Areas of Concern

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

Recommendations to Address Concerns

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

services. The review cannot take a one-size fits all approach and should be flexible in considering settings where crisis intervention can occur, the methods utilized, and the ways in which to address staffing shortages by employing a variety of service providers.

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

The number of interventions, client characteristics, average response time, and co-responder involvement will be reported by Phase 1 region through the *Trueblood* Quarterly Dashboard (see Table 5). DSHS and HCA are working with provider organizations to collect data through encounter information sent to the Behavioral Health Data System (BHDS). Data system changes across providers are to occur in 2020, and data should be available by January 2021 as required by the implementation plan. The Washington Association of Sheriffs and Police Chiefs (WASPC) is independently collecting data on co-responders.

TABLE 5.

Mobile Crisis Response Interventions and Client Characteristics

MONTH YEAR

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88%	888	88%	888	88%	888	88%
Referrals	888	88%	888	88%	888	88%	888	88%
Clients Referred (unduplicated)	888	88%	888	88%	888	88%	888	88%
Clients Enrolled (unduplicated)	888	88%	888	88%	888	88%	888	88%
Among Enrolled Clients…								
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%
RESPONSE TIME/DURATION								
Average Response Time (hours)	888	88%	888	88%	888	88%	888	88%
Average Duration (minutes)	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: Behavioral Health Data System[6].

[6] Table 5 above does not include data from WASPC. Per the *Trueblood* implementation plan, WASPC independently collects data on co-responders.

Crisis Triage and Diversion – Forensic PATH

As part of the *Trueblood* settlement, the state is funding enhanced outreach and engagement to connect identified individuals with behavioral health services using a federal model called Projects for Assistance in Transitions from Homelessness (PATH). In the contempt settlement agreement, this program is identified as Intensive Case Management for High Utilizers. HCA in partnership with DSHS' RDA has been tasked with creating a referral list to identify individuals who are at risk of repeat court orders for competency evaluations.

The teams created through this project will provide intensive outreach and engagement to the individuals identified on the referral list. The goal is to connect individuals with community resources and services by building relationships and rapport.

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

Current Status and Areas of Positive Impact

All contracts have been executed in the Phase 1 regions meeting the implementation deadline. All contractors are in the process of becoming fully staffed, and all of the contractors met the implementation deadline for submitting their staffing plan as well as hiring one certified peer counselor per team. Contractors are currently filling out their teams with personnel experienced in a wide breadth of human services occupations.

Areas of Concern

Contractors for this program may have limited experience working with a by-name list, and may experience some challenges in transitioning from a more assertive, street-based model of outreach to a model of outreach and engagement based on a by-name list.

Recommendations to Address Concerns

HCA plans to provide contractors' training from national experts on outreach and engagement to individuals while utilizing a by-name list. HCA scheduled specialized training for staff within the Phase 1 regions focusing on effective outreach and engagement. This training occurred February 10-11 in order to meet the implementation deadline of February 29.

Data – Crisis Triage and Diversion – Forensic PATH

Forensic PATH enrollment and participant characteristics will be reported, by Phase 1 region, in the *Trueblood* Quarterly Dashboard (Table 6). The number of clients contacted and enrolled from the HCA referral list (formerly known as the "high utilizer list") will be entered by Forensic PATH treatment providers into the Homeless Management Information System (HMIS) upon client consent, as required by the HMIS contract. A long-term data collection tool will be identified and implemented by HCA. Participant characteristics will be gathered from the HCA referral list, which is produced by the Research and Data Analysis division on a monthly basis.

TABLE 6.

Forensic PATH Enrollment and Participant Characteristics

MONTH YEAR

PRELIMINARY EXAMPLE

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88%	888	88%	888	88%	888	88%
Number on Referral List	888	88%	888	88%	888	88%	888	88%
Clients Contacted	888	88%	888	88%	888	88%	888	88%
Clients Enrolled in Forensic PATH	888	88%	888	88%	888	88%	888	88%
CLIENT STATUS								
Active (on last day of reporting period)	888	88%	888	88%	888	88%	888	88%
Discharged	888	88%	888	88%	888	88%	888	88%
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: PATH/HMIS.

Education and Training – Crisis Intervention Training (CIT)

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

<u>Current Status and Areas of Positive Impact</u>

To date, the Criminal Justice Training Commission (CJTC) has completed five of the nine funded 40-hour courses for law enforcement and trained 176 certified peace officers. There are 145 officers left to train to reach the 25% goal in the Phase 1 areas. There is a course presently scheduled for Vancouver, and the CJTC is working with Spokane and Tacoma to have courses scheduled to be completed by June.

Five of the 24 funded 8-hour corrections courses are complete with 112 corrections officers receiving training. In addition, Clark County Corrections hosted a 40-hour CIT for corrections exceeding the mandate. Clark County trained 110 officers in that program for a total of 222 corrections officers trained. There are an estimated 350 correctional officers left to train in the Phase 1 areas. Presently, the CJTC has four trainings scheduled in Tacoma and one in Goldendale over the next two months.

In addition to the sixteen hours of backfill costs already provided in Washington state, agencies in the Phase 1 regions are eligible to receive an additional 16 hours of cost coverage as a result of the *Trueblood* funding provided by the legislature. Not all agencies are availing themselves of this benefit. The CJTC team is continuing to provide significant outreach and education to Phase 1 regions to encourage them to use this available resource to remove barriers to participation.

The following email, complimenting a course instructor's abilities, is from the commander of the Pierce County Jail, Patti Jackson-Kidder:

I personally attended the 11.23.19 class and am reaching out to formally praise Al for a job well done. As you're well aware, due to staffing needs, most of my team members are "forced" to attend class on a day off . . . which isn't always best for class participation . . . I credit Al's skillset as instructor with [the] fact that every one of the participants (to include the "one" disgruntled attendee) enjoyed the class! Some of the men and women attended class after getting off work at 2300 the night before. KUDOS for a job well done!

The telecom/911 training has not yet been deployed. A curriculum was completed and an instructor selected, but they accepted a full-time job elsewhere and unfortunately can no longer train our clients. The CJTC is presently recruiting new instructors and expects to deploy the first course by the end of May in Goldendale.

Areas of Concern

At this time, the largest area for concern regarding implementation is low staffing levels in most county jails. Even with backfill and overtime provided, there are not sufficient personnel to cover the shifts to allow officers to attend training. One commander stated they are already mandating corrections officers work 16 hours of mandatory overtime every two weeks, which is the maximum permitted by the relevant labor agreement. The second area of concern primarily impacts smaller law enforcement agencies: allowing an officer to leave the jurisdiction for a week of training. While smaller agencies have only a few officers to train, one officer represents a significant percentage of the overall police force. The loss of one officer to a 40-hour training course is extremely difficult to absorb within existing resources.

Recommendations to Address Concerns

Offering the training courses on Saturdays in the Pierce region results in full courses each scheduled training. Officers on weekday shifts get fewer opportunities for overtime shifts; six of the seven trainings were scheduled for Saturday day shifts and all were filled. Additionally, trainers worked with small agencies to get their officers in whenever possible, which is challenging as described in the previous section. Staff from the CJTC, WASPC, HCA, and DSHS came together in March to have a focused conversation on the barriers experienced by small agencies and potential approaches to address those barriers. The results of these discussions will be shared with the *Trueblood* Executive Committee.

Data – Education and Training – CIT

The Criminal Justice Training Commission is monitoring law enforcement training completion rates through a Learning Management System. Per the contempt settlement agreement, 25% of patrol officers in each law enforcement agency are required to complete 40 hours of enhanced CIT. Data from December 2019 show that 35% of law enforcement officers from Phase 1 regions have completed CIT overall, with slightly more than 50% of officers trained in the Southwest and Spokane regions (Table 7). In the Pierce region, 16% of officers have been trained. These data suggested that small law enforcement agencies are experiencing barriers to meeting the 25% training threshold as compared to medium and large agencies. Data are not available for staff completion rates at 911 agencies as the training has not been deployed yet.

The contempt settlement agreement also states that the 25% target should be prioritized in agencies that serve areas with higher population densities over those with lower population densities. As of December 2019, law enforcement agencies serving high-density populations had

met the 25% goal at a higher rate than those serving lower density populations. In the Southwest region, 60% of officers in large agencies had completed 40 hours of CIT, as well as 69% of officers in similar sized agencies in the Spokane region. This was not the case in the Pierce region, however, with only 15% of officers in large agencies having completed the training. Individual law enforcement agency training completion rates are shown in Table 7. Data on training completion rates for each law enforcement agency in the Phase 1 regions are shown in Table 8.

TABLE 7.

Crisis Intervention Training (CIT) Program Measures

DECEMBER 2019

	TOTAL - ALL REGIONS			PHASE 1 REGIONS								
				PIERCE			SOUTHWEST			SPOKANE		
	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED
AGENCY												
Law Enforcement/Patrol	**2,083**	**722**	**35%**	944	147	16%	490	246	50%	649	329	51%
Small Agencies (1-20 Officers)	**356**	**42**	**12%**	109	8	7%	73	15	21%	174	19	11%
Medium Agencies (21-100 Officers)	**309**	**73**	**24%**	211	46	22%	71	24	34%	27	3	11%
Large Agencies (101+ Officers)	**1,418**	**607**	**43%**	624	93	15%	346	207	60%	448	307	69%
911/Dispatch	-	-										
Correctional Officers	-	-										

DATE: December 2019.

DATA SOURCE: Washington State Criminal Justice Training Commission.

NOTES: As part of the *Trueblood* contempt settlement agreement, crisis intervention trainings (CIT) are 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 I regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course.

TABLE 8.

Crisis Intervention Training (CIT)

Individual Agency Compliance Metrics: Phase 1 Regions

DECEMBER 2019

County	Agency	Number of Officers	Number of Officers Trained*	Percent Trained
PIERCE REGION				
Pierce	Bonney Lake Police Department	27	1	4%
Pierce	Buckley Police Department	9	0	0%
Pierce	Dupont Police Department	8	0	0%
Pierce	Eatonville Police Department	5	1	20%
Pierce	Fife Police Department	30	10	33%
Pierce	Fircrest Police Department	9	0	0%
Pierce	Gig Harbor Police Department	18	2	11%
Pierce	Lakewood Police Department	95	12	13%
Pierce	Milton Police Department	14	3	21%
Pierce	Orting Police Department	10	0	0%
Pierce	Pierce County Sheriff's Office	278	21	8%
Pierce	Puyallup Police Department	59	23	39%
Pierce	Roy Police Department	2	0	0%
Pierce	Ruston Police Department	5	2	40%
Pierce	Steilacoom Police Department	10	0	0%
Pierce	Sumner Police Department	19	0	0%
Pierce	Tacoma Police Department	346	72	21%
SOUTHWEST REGION				
Clark	Battleground Police Department	24	11	46%
Clark	Camas Police Department	26	3	12%
Clark	Clark County Sheriff's Office	141	38	27%
Clark	La Center Police Department	8	1	13%
Clark	Ridgefield Police Department	11	4	36%
Clark	Washougal Police Department	21	10	48%
Clark	WSU-Vancouver Police Department	3	0	0%
Clark	Vancouver Police Department	205	169	82%
Klickitat	Goldendale Police Department	9	5	56%
Klickitat	Klickitat County Sheriff's Office	20	1	5%
Klickitat	White Salmon/Bingen	5	4	80%
Skamania	Skamania County Sheriff's Office	17	0	0%
SPOKANE REGION				
Spokane County	Airway Heights Police Department	20	1	5%
Spokane County	Cheney Police Department	17	2	12%
Spokane County	Eastern WA University Police Department	14	4	29%
Spokane County	Liberty Lake Police Department	11	2	18%
Spokane County	Spokane Airport Police Department	13	0	0%
Spokane County	Spokane Police Department	326	274	84%
Spokane County	Spokane County Sheriff's Office	122	33	27%
Adams	Adams County Sheriff's Office	15	2	13%
Adams	Othello Police Department	16	1	6%
Adams	Ritzville Police Department	4	0	0%
Lincoln	Lincoln County Sheriff's Office	16	2	13%

County	Agency	Number of Officers	Number of Officers Trained*	Percent Trained
Lincoln	Odessa Police Department	2	0	0%
Lincoln	Reardon Police Department	1	0	0%
Ferry	Ferry County Sheriff's Office	8	0	0%
Ferry	Republic Police Department	2	0	0%
Stevens	Chewelah Police Department	5	1	20%
Stevens	Colville Police Department	10	0	0%
Stevens	Kettle Falls Police Department	3	0	0%
Stevens	Springdale Police Department	1	0	0%
Stevens	Stevens County Sheriff's Office	27	3	11%
Pend Oreille	Newport Police Department	4	1	25%
Pend Oreille	Pend Oreille County Sheriff's Office	12	3	25%
	Fish & Wildlife	131	3	2%
	WA State Patrol	1,032	158	15%
TOTAL		**3,246**	**883**	**27%**

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

NOTES: As part of the *Trueblood* contempt settlement agreement, crisis intervention trainings (CIT) are being offered to law enforcement and corrections officers throughout Washington State. Twenty-five% of patrol officers in each law enforcement agency in the Phase I regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Education and Training – Technical Assistance for Jails

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

The guidebook addresses the topics of pre- and post-booking diversion, identification of need and access to treatment, administration of involuntary medication, transition planning and continuity of care, and use of segregation as well as additional subject matter. The guidebook and related training is about 95% complete. The remainder is expected to be complete prior to the June 1, 2020 deadline.

Current Status and Areas of Positive Impact

In an effort to identify the training needs of jails in Washington, a survey was created and delivered to jails throughout the state. Eight jails responded with information regarding training needs and the preferred method of training delivery (e.g., webinar, in-person). Members of the JTA team conducted on-site visits to the three Phase 1 county jails in the Southwest region. During these on-site meetings, the JTA team convened discussion groups with a diverse group of disciplines that work in the jail to better understand site-specific training needs and the preferred method of delivery. The team toured the facilities, received information regarding the differences between larger suburban jails and those in smaller rural areas, and gained critical awareness regarding the ways in which those differences impacted training needs and contributed to distinct challenges. The JTA team plans to arrange similar visits to the other Phase 1 regions' jails.

Areas of Concern

The primary area of concern is regional awareness of the JTA program. Although the foundation of the program has been established and a communication plan created, program awareness, as well as attendance (by jail staff, etc.) at trainings offered by the JTA Team, could be enhanced.

Another area of concern is determining how the JTA program can be most effective in the delivery of training and other forms of assistance. One of the primary challenges is that jails have several common obstacles to receiving training (e.g., budget, staffing, technology), which may be a factor in the modest training attendance numbers.

Recommendations to Address Concerns

JTA arranged to staff a booth at the spring 2020 WASPC conference and planned to deliver an awareness campaign as well as to solicit additional information regarding JTA needs. Unfortunately, this important outreach opportunity became canceled due to the Covid-19 pandemic. The JTA team is working with WASPC to send information about their program and available trainings through the WASPC listserv, and they are planning to attend the fall WASPC conference to conduct outreach if the Covid-19 impacts have resolved.

JTA team members will meet with the Criminal Justice Training Commission administration to discuss opportunities for collaboration in the delivery of JTA program training to corrections officers as well as other potential opportunities for collaboration.

Data – Jail Technical Assistance

The Technical Assistance for Jails team plans to collaborate with DSHS' RDA to develop and implement a method to track data on training participation.

Enhanced Peer Support

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

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

Current Status and Areas of Positive Impact

The curriculum has been created and is currently going through the process of leadership and subject matter expert (SME). The project has met the March 1, 2020 deadline for curriculum development. Trainers and SMEs have been identified.

The continuing education training is scheduled for April 29-30; this will meet the May 1, 2020 deadline. This first training will be targeted to certified peer counselors employed in Phase 1 regions who are currently hired on *Trueblood* element service teams.

Both internal and external curriculum review workgroups were created to review and provide feedback on the curriculum development. The external curriculum workgroup is comprised of experienced certified peer counselors with lived experience in the forensic mental health system.

The peer work team anticipates positive outcomes by partnering with DSHS SMEs throughout this training's development. Peers will learn about the components of the legal system and how they intersect with the behavioral health system. Members of the legal and forensic mental health systems professions will learn about the successful impacts and effectiveness of peer services.

Traditionally, people with criminal court involvement have been reluctant to move forward to become certified peer counselors because of the possibility they would not be employable. However, changes to RCW 43.43.842 decreased restrictions for certified peer counselors to access the Agency Affiliated Counselor Credential through the Department of Health. These changes are projected to expand the workforce opportunities for individuals with lived criminal court and behavioral health experiences to work in the field. The reluctance to become a CPC has created a shortage of peers with the desired lived experience to fill the *Trueblood*-related service teams. Funds have been allocated to provide three additional certified peer counselor trainings targeted to the Phase 1 regions. These newly funded trainings will begin spring 2020 with the

objective of increasing the peer workforce of individuals with lived experience in the criminal court system.

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 individuals involved in our criminal court system are those who have shared that lived experience. This lived experience can come with a criminal history that might impede the certified peer counselor's ability to work with individuals while those individuals remain in jail.

Recommendations to Address Concerns

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

Data – Enhanced Peer Support

Data counts of certified peers receiving the enhanced training specific to serving persons with prior criminal justice system involvement will become available in future semi-annual reports and the *Trueblood* Quarterly Dashboard.

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 (WFD) specialists for the functional areas specified in the contempt settlement agreement. Additionally, the WFD administrator position became vacant in December 2019, and this vacancy has been filled as of March 2020.

Current Status and Areas of Positive Impact

WFD efforts are in development and early positive impacts include the establishment of professional networks and the gathering of potentially valuable data that will be used to further develop WFD training plans.

In an effort to assess workforce needs in the field of forensic behavioral health, the WFD team is participating in external WFD workgroups. These workgroups address identified barriers pertaining to the behavioral health workforce, such as background checks for potential employees, competency-based training, and licensing reciprocity. Additionally, the WFD team participates in the HCA Stakeholders Enhanced Peer Curriculum workgroup, which focuses on the inclusion of peer voices in curriculum development and training.

A WFD training and workforce needs survey was created and some surveys were completed during on-site visits to jails in the Phase 1 Southwest region. Surveys were sent to stakeholders in the functional areas of community, inpatient, and law enforcement and corrections. The survey results will be analyzed, and the information will be used to further inform the forensic workforce needs and gaps in Washington.

Additionally, OFMHS contracted with the consulting and research group Groundswell, Inc. to deliver a draft of a forensic workforce needs and gaps analysis on March 1, 2020. The final report is due to OFMHS by April 10, 2020. This report will provide a gaps analysis by:

1. Identifying a baseline set of professions that provide forensic mental health services;

2. Identifying statewide staffing needs in each of these categories projected over a ten-year period;

3. Identifying the gaps in availability to meet the need; and

4. Identifying training, certification, and degree programs in other states for the baseline set of professions compiled.

This information will then be used to formulate recommendations regarding enhancements to existing training, certification, and degree programs and for new such programs. The WFD team worked collaboratively with Groundswell, Inc. by compiling information and data and facilitating connections with relevant resources for the analysis and an initial draft report. No significant obstacles are anticipated in completing the final forensic workforce needs and gaps analysis.

The WFD team conducted a WFD and Training Needs Summit for healthcare providers who serve persons involved in the legal system on October 30, 2019.

The WFD team will evaluate all collected WFD survey results and develop training plans by May 1, 2020. No significant obstacles to on-time completion are anticipated. Breaking Barriers Master Instructor training workshop and implementation are on track to be conducted in April 2020. The Introduction to Forensic Mental Health curriculum and instructor-led training is being developed in collaboration with HCA and is scheduled for April 29-30, 2020.

Additional element requirements involve developing and coordinating training to include standardizing training manuals and guidelines. Currently, Breaking Barriers instructor training manuals are undergoing standardization, and consistent course catalogs describe all WFD/JTA offered trainings.

Areas of Concern

The WFD team is on track to complete all required element tasks on time or ahead of schedule. As of March 2020, there are no major areas of concern.

Recommendations to Address Concerns

As of March 2020, there are no concerns requiring recommendations.

Data – Workforce Development

The workforce development team plans to collaborate with DSHS' RDA to develop and implement a method to track data on training participation

Conclusions

Behavioral Health Transformation is well underway in Washington state. As new programs continue launching over the next several months, it promises to be a time of immense change and progress toward continued implementation of the *Trueblood* contempt settlement agreement. Noteworthy, is the recent completion of the first 100 required tasks and deadlines as part of the settlement's implementation plan. Accomplishment of this milestone shows significant progress since the final implementation plan's submission to the Court on June 27, 2019.

Excitement at milestone completion and upcoming program launches is tempered, however, by the dislocated reality facing nearly the entire world as of March 2020. The Covid-19 pandemic places significant constraints on daily life and normal operations of the state's behavioral health system. With these continued constraints comes the high likelihood, as discussed in the disclaimer, that Covid-19-related delays to *Trueblood* initiatives are expected, efforts to mitigate the effects notwithstanding.

For the next semi-annual report published in late September, several new programs will be operational, and many of the element led narratives will reflect the first several months of service delivery and the expected successes and challenges inherent in standing up new programs.

Appendix A – Collaboration Model and Report

The goal of the following report and collaboration model, which was briefly discussed in a previous section of the semi-annual report, is to share the structures and systems developed by the *Trueblood* team to support the successful implementation of the *Trueblood* contempt settlement agreement.

The requirement to provide the report and collaboration model is limited to this first semi-annual report.

Regional and Statewide

Collaboration & Engagement Plan

Washington State Health Care Authority

Washington State Department of Social & Health Services
Transforming lives

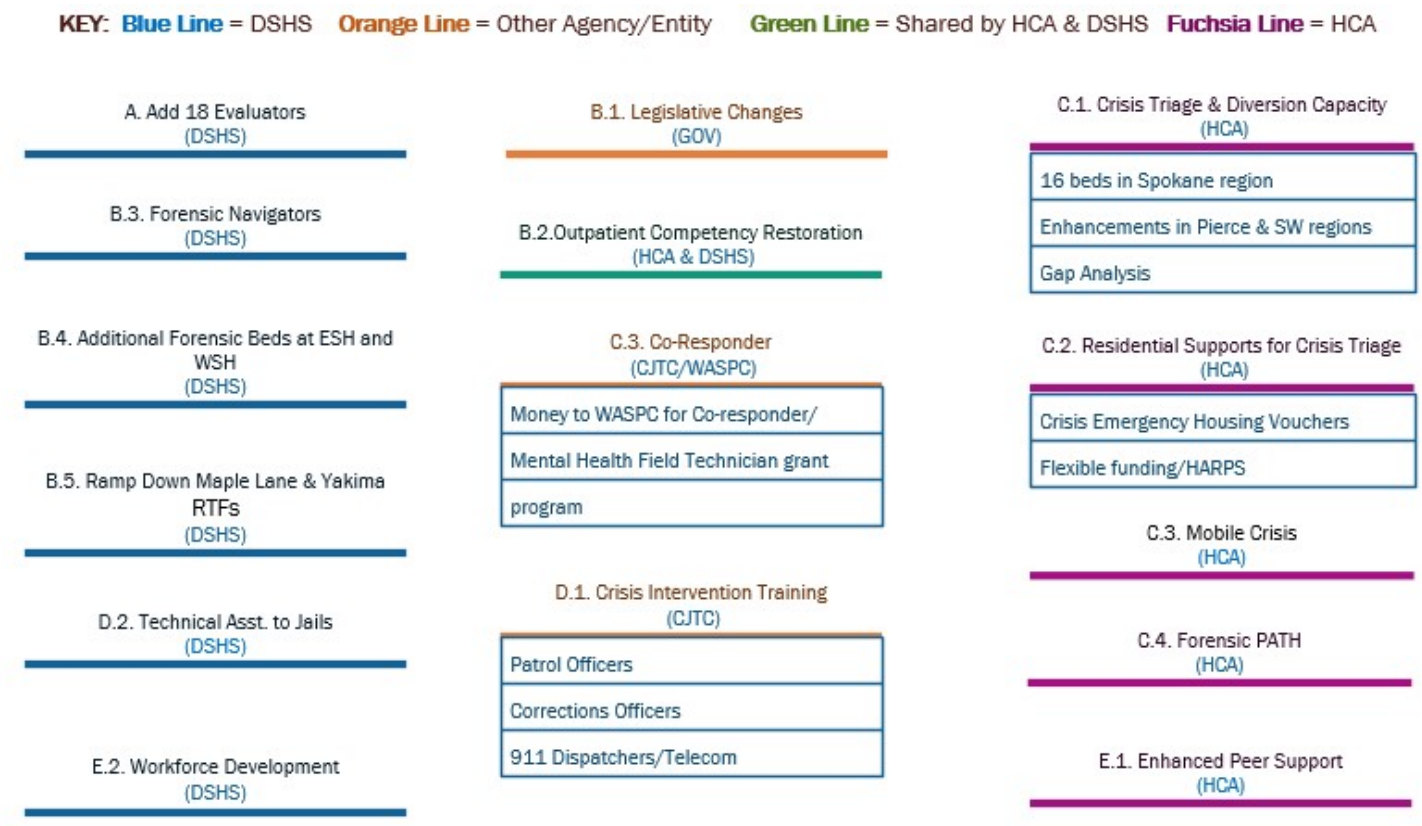
Criminal Justice Training Commission Washington

CONTENTS

BACKGROUND

Trueblood is an active lawsuit that challenged unconstitutional delays in competency evaluation and restoration services. In April 2015, a federal court found that the Department of Social and Health Services (DSHS) was taking too long to provide competency evaluation and restoration services. Because of that case, the state entered into a contempt settlement agreement that outlines an array of services to better deliver the right care, at the right time, to the right people and reduce the number of people who become or remain class members.

The contempt settlement agreement contains five main sections, each with multiple initiatives and projects that will be completed to support improvements in the forensic, crisis, and behavioral health systems in Washington State. The below visual shows the agency or entity that has primary fiscal and program development responsibility for the major components outlined in the settlement. The four main entities are DSHS, the Health Care Authority (HCA), the Criminal Justice Training Commission (CJTC), and the Washington Association of Sheriffs and Police Chiefs (WASPC).



PURPOSE AND SCOPE

Washington State Health Care Authority | Washington State Department of Social & Health Services — Transforming lives | Criminal Justice Training Commission, Washington

Agencies and entities across the state of Washington must work in partnership to successfully implement the *Trueblood* contempt settlement agreement. No single organization has complete ownership or oversight of service delivery in the forensic, crisis, or behavioral health systems. Improvements to these systems can only come when public and private entities, service recipients, and their families build strong partnerships involving deep and meaningful collaboration and communication.

The goal of this report is to share the structures and systems developed by the *Trueblood* team to support the successful implementation of the *Trueblood* contempt settlement agreement. This includes two main forms of collaboration:

Public to Public: Vertical and horizontal agreements and structures between public agencies in Washington state involved in *Trueblood.* Vertical refers to agreements between agencies at the same level of government while horizontal refers to intergovernmental work between local, regional, state, federal, and/or government to government.

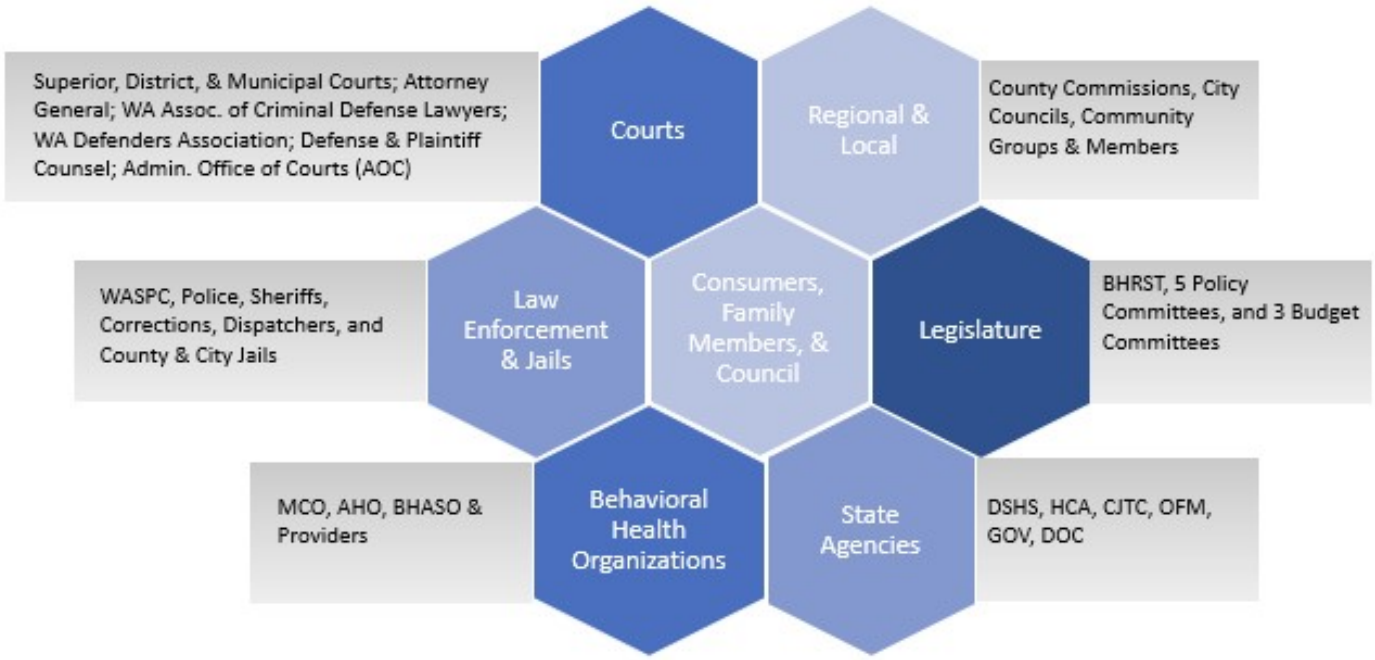
An early example of an instituted public to public structure for *Trueblood* was an early expansion of the memorandum of understanding between DSHS and HCA to include all activities related to *Trueblood*.

Public to Private: Contract work is an example of public to private. For *Trueblood* the state has primary responsibility for a service which is then operated by the private sector.

The *Trueblood* team holds a deep commitment and belief in human-centered, people-first service delivery. The systems and structures shared in this report have evolved over time with this commitment in mind. This current model is based on the knowledge and understanding developed during the initial period of planning and the start of implementation in Phase 1. We anticipate additional growth and improvement as partners and stakeholders continue to provide valuable feedback on how we work together.

STAKEHOLDERS AND PARTNERS

The below visual and list captures different partners and stakeholders that have an interest in or could be impacted by the implementation of the *Trueblood* contempt settlement agreement. All are valuable and important partners and stakeholders in the collaboration model.



Other Partners and Stakeholders

- Tribes
- Unions
- Non-Profit Advocacy Groups
- Public Safety Review Panel (PSRP)
- Homeless and Housing Advocates and Providers
- Employment Support Advocates and Providers

ENGAGEMENT CHALLENGES AND STRATEGIES

When developing a collaboration model, it is essential to consider the factors that are key to successful collaboration and build an intentional model that supports those factors. While different organizations have different perspectives about which factors are key, there is some consistency – especially in the areas of leadership, external engagement and communication, and internal engagement and communication. The following sections outline identified success factors for *Trueblood* collaboration, anticipated and/or realized challenges within those factors, and strategies that were initiated to prevent or reduce them.

SHARED LEADERSHIP: OWNERSHIP, SUPPORT, AND OVERSIGHT

Whether a project is simple or complex, a key success factor in any collaborative effort is leadership commitment to the shared vision, consistent and effective support, and intentional oversight. The Project Management Institute lists insufficient executive support via project sponsorship as a primary cause for project failure and one of the top drivers of project success. In fact, one in four organizations (26%) report that inadequate sponsor support is the primary cause of failed projects.

According to the Center for Technology in Government in their report on *Leadership and Project Success: Lessons from High Impact Government Innovations*,

"Leaders were a critical success factor in all of these innovation projects. Leaders communicated the value of the undertaking, they engendered and encouraged commitment from the working group, they negotiated the environment to get resources and build support, and handle criticism… Each of these aspects of leadership contributed to progress, acceptance, and success."

With a complex portfolio of projects, like those in *Trueblood*, that means ensuring leadership commitment and oversight across the full spectrum of entities connected to this work. Shared governance was built into every aspect of leadership involvement. This starts with the contempt settlement agreement, which contains requirements for a very robust legal governance structure including the federal court, an Executive Committee and a General Advisory Committee, all of which meet quarterly. The following visual depicts these three components:

The Federal Court has ultimate authority and oversight over the contempt settlement agreement. Prior to the approval of the agreement, the court appointed a court monitor who works closely with DSHS on the underlying issues that resulted in the class action lawsuit.

The Executive Committee is the primary decision-making body outlined in the contempt settlement agreement, charged with resolving issues, removing barriers, and bringing forward recommendations to the federal court. The Executive Committee is made up of:

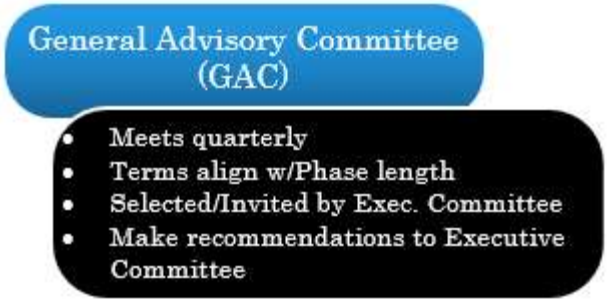
- Parties from the *Trueblood* lawsuit
- State agencies responsible for implementation
- Peer member

All members of the Executive Committee can bring forward topics for review and discussion which need review and support, thus ensuring a collaborative and fully engaged membership that is able to surface issues and questions at every level.

The General Advisory Committee (GAC) is an important conduit for the regions and the various agencies and entities that are implementing programs and services or otherwise impacted by *Trueblood* implementation.

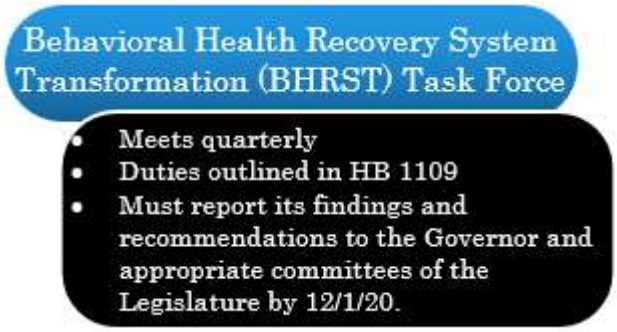
They receive reports, data, and information on implementation from *Trueblood* teams and provide a voice for challenges and barriers faced within the local communities. They also provide feedback and recommendations on implementation to both the *Trueblood* teams and the Executive Committee. The GAC is made up of:

- Executive Committee members
- Key partner and stakeholder members
- Peer member(s)



The Washington State Legislature has invested heavily in improvements to the behavioral health systems in Washington state. They were instrumental in providing the funding needed to implement Phase 1 of the contempt settlement agreement along with numerous other behavioral health related programs and services during the 2019 legislative session. They also passed House Bill 1109 which created a behavioral

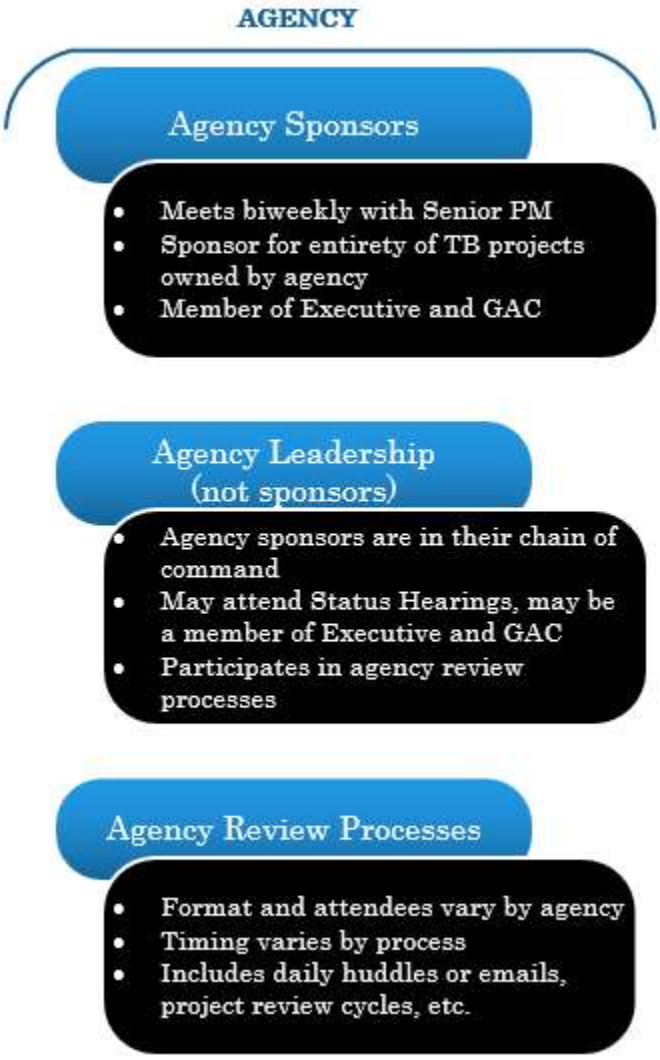
health recovery system transformation task force (BHRST). The BHRST task force consists of legislative and state agency members. They are tasked with receiving updates, monitoring, and providing recommendations to the Governor, the Office of Financial Management, and the Legislature on six different aspects of behavioral health in Washington State, one of which is the implementation of the contempt settlement agreement.



In addition to the legal oversight structure outlined in the contempt settlement agreement and the legislative oversight structure passed in HB 1109, both DSHS and HCA have implemented agency leadership and oversight structures to promote shared ownership including:

- Assigned an executive sponsor and a deputy sponsor for all *Trueblood* work to ensure adequate sponsor coverage and availability. Sponsor meetings are held jointly.
- Integrated *Trueblood* review into existing review processes or created specialized project review processes at the agency executive leadership level. At least one major agency review process at each agency is conducted jointly.
- Developed and implemented cobranding for *Trueblood* materials, which is reflected in the footer of documents like this collaboration plan and in presentation and communication materials.

This visual shows the agency components of governance and oversight that are overarching for the *Trueblood* implementation:



DSHS, HCA, CJTC and WASPC have engaged in shared planning and program development. Most project teams supporting implementation have cross-agency participation. In addition, DSHS and HCA executed an amendment to the existing memorandum of understanding to include sharing information on aspects of *Trueblood.*

All these structures together support cohesive and integrated shared leadership and oversight for *Trueblood* Implementation.

REGIONAL ENGAGEMENT AND COMMUNICATION

Trueblood is being implemented in phases, with three regions (10 counties) of Washington State in Phase 1. The vision with the contempt settlement agreement is to enhance but not supplant existing resources in these communities. The challenge with enhancing services in these counties is that each region has diverse behavioral health and crisis systems. They also have their own unique challenges and constraints due to geographical location and populations. To ensure that the contempt settlement agreement vision is realized, deep and significant participation and collaboration from each of the regions is needed throughout at all levels of implementation. To that end, stakeholders and partners in each region must have a voice and a mechanism for participation; both receiving information and sharing perspectives and impacts.

Regional engagement presents both an opportunity and a challenge. The success of public service delivery project as large as *Trueblood* is tied to how well the needs of the regions are met and how well the funding and contracting entities collaborate throughout the project's development and implementation. Clear and consistent communication and engagement builds public trust and cultivates an environment that ensures partners feel supported which drives their willingness to step forward and engage in new efforts. Trust is absolutely necessary for successful collaboration.

Successful and equitable engagement with all three regions in Phase 1 requires the consistent use of tools and mechanisms for sharing and receiving information and eliciting participation. Below is a list of the tools and mechanisms engaged as part of the broader *Trueblood* implementation:

- ***Trueblood* website** – this site, hosted under the Office of Forensic Mental Health Services within DSHS, has links to key information about *Trueblood* including links to the contempt settlement agreement, implementation plan, fact sheets about each program, court reports, and many other informational documents
- ***Trueblood* listserv** – this allows information about *Trueblood* implementation, including location and timing of regional engagements, workgroup and contract opportunities, job postings, etc. to be shared broadly to anyone who has signed up to receive those announcements
- **Dedicated *Trueblood* email box** – this allows anyone, anywhere to send questions or concerns or request for contact on any part of *Trueblood* implementation. These messages are triaged by the Project Management team and connected to the appropriate *Trueblood* team member(s)
- **Summits** – following the court's approval of the contempt settlement agreement, leadership at each agency conducted informational summits within each region to share *Trueblood* lawsuit and settlement information and begin connecting regional partners and stakeholders to members of the *Trueblood* team
- **Regional meet and greets** – following the hiring of the Project Management (PMs) team and the assignment of agency leads for each project, PMs and leads went out to each region to provide an

overview of *Trueblood* projects, introduce leads, and solicit questions and concerns from regional partners and stakeholders

- **County meet and greets** – following the regional meet and greets, the PMs and agency leads solicited and went out as requested to meet with partners and stakeholders in individual counties to share information and to hear from counties about local interests and concerns
- **Tribal roundtables and consultation** – HCA and DSHS conducted a series of roundtables and a consultation with federally recognized tribes within Washington state that resulted in an agreed-upon plan for tribal-state collaboration for the period 2019-2021 as it relates to *Trueblood*
- ***Trueblood* fact sheets** – in response to requests from partners and stakeholders for clearer information about the projects and programs that are part of *Trueblood*, agency staff developed one-page fact sheets for the *Trueblood* projects and for overarching topics like funding sources, a lawsuit overview, and frequently asked questions
- **Regional participation in GAC** – the majority of GAC members represent partners and stakeholders in the Phase 1 regions
- **Topical WebExs** – specific topics of interest to the regions are addressed and communicated on using topical WebExs that are open to everyone and provide consistent information across all regions. Past topics include the budget for *Trueblood*, Senate Bill 5444, and the Final Implementation Plan. Other topics will be presented, as needed, based on requests from our regional partners
- **Quarterly implementation WebEx** – the same information shared with GAC is also shared in a quarterly WebEx advertised through the *Trueblood* listserv. A landing page for all shared WebEx content is being built as an addendum to the *Trueblood* website
- ***Trueblood* implementation updates provided at regional venues** – across all three regions, the *Trueblood* team is providing updates – both at regular and reoccurring regional or county meetings, and as requested – to meet specific needs. Examples include the Spokane County Regional Interlocal Leadership Structure meetings, the Pierce Criminal Justice Steering Committee meetings, and the Washington State Association of Counties Legislative Steering Committee.

Individual project teams have developed tools and mechanisms to support more focused engagement with regional partners and stakeholders on specific projects. Below is a list of examples of those specific outreach and collaboration efforts:

- **Partner and stakeholder membership in workgroups** –*Trueblood* workgroups have external partners and stakeholders as members
- **Element-specific regional engagements** – Projects are engaging with regional members on individual projects to support their program development and implementation. Recent examples include the Mobile Crisis Response and Crisis Triage and Stabilization workgroups, which did paired outreach to crisis providers and related partners and stakeholders in each region; the Outpatient Competency Restoration Program and Forensic Navigator Programs, which did paired roadshows to connect with

court members, prosecuting and defense attorneys, and forensic evaluators in each region and via WebEx; and the Workforce Development and Jail Technical Assistance team, which is conducting jail site visits in each region to discuss training needs and barriers to training

- **Element-specific websites** – several of the programs have created individual websites to facilitate the sharing of information and resources with partners across the state. They include sites for Forensic Navigators, Workforce Development and the Jail Technical Assistance programs

Trueblood team members continuously work with partners and stakeholders on how to further improve engagement and communication efforts and strategies.

INTERNAL ENGAGEMENT AND COMMUNICATION

Successful collaboration requires internal alignment across all responsible agencies and entities. This means that internal engagement and communication must also be fully supported. To that end, the following has been instituted to support internal alignment:

- **Defined Roles** – at the start of implementation, leadership identified roles and responsibilities for those tasked with serving as a sponsor, element lead, project manager, or subject matter expert (SME) resource. Members within those roles have consistent expectations no matter which agency or entity they report to
- **Onboarding** – new members are onboarded to the *Trueblood* project, structures, and resources and provided clear contact information for accessing support
- **Element Workgroups** – many projects have workgroups convened to support implementation. Workgroups are cross-agency and have data workgroup members embedded in their project teams
- **Joint Element Workgroups** – several tightly connected project teams have instituted sync meetings to make sure programs are aligning appropriately. Examples include Outpatient Competency Restoration and Forensic Navigator programs and the Workforce Development and Peer Support programs
- **Infrastructure SME Workgroups** – at the start of implementation, several cross-agency infrastructure groups were convened to support project members and teams; this includes budget, contracts, data, communication, tribal liaisons, and public disclosure and records. These groups meet on varying schedules and manage both SME-specific tasks and provide support as requested by individual element workgroups as needed to support implementation
- **Monthly Meetings** – the broad *Trueblood* team comprised of leadership, element leads, PMs, and SMEs attend in-person meetings each month to discuss *Trueblood* topics and deliverables, seek legal advice, if needed, from the Attorney General's Office, and share updates
- **Weekly huddles** – the broad *Trueblood* team also calls in weekly for a 30-minute phone huddle to provide updates on implementation progress or seek assistance
- **Project Management structure** – PMs work on the same team and meet weekly to align on the work being done. All project management plans are built using the same format and outline to promote

consistency, and those plans are uploaded into Project Online in order to allow for the creation and use of dashboards to support project management. PMs have a cross-section of projects assigned to them to ensure big picture alignment and each PM is expected and able to support other project teams, as needed, if demand in one project is high and it needs additional support or coverage

CONCLUSION

The Collaboration and Engagement plan outlines the planning and effort invested in supporting successful implementation. *Trueblood* implementation is occurring in a unique environment with an unusual set of circumstances which has required creative and flexible thinking on how to bring hundreds of interested and invested parties together to achieve this complex list of outcomes. This collaboration model is not the product of any one individual but instead an organic outcome of many invested individuals who want the very best outcomes for those we serve. The Department expects the collaboration model to continue to grow and adjust as our project teams grow and adjust. The *Trueblood* team appreciates the valuable input and support that has helped us reach this point in the *Trueblood* implementation.

Appendix B – 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 (CJTC): *www.cjtc.wa.gov*

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

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

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

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

BHA Office of Forensic Mental Health Services (OFMHS): 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/2018Trueblood/623_OrderFinalApprovalSettlement.pdf*

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

Trueblood February 2020 Progress Report for the Court Monitor and Appendices A-K: *February* | *Appendix A-G* | *Appendix H* | *Appendix I* | *Appendix J* | *Appendix K*

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: 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