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 26, 2021

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

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List of Abbreviations in this Document

AAG – assistant attorney general
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
CMS – Centers for Medicare and Medicaid Services
CPC – certified peer counselor
CS/CT – crisis stabilization/crisis triage
DBHR – Division of Behavioral Health and Recovery, part of HCA
DCR – designated crisis responder
DSHS – Department of Social and Health Services
DOH – Department of Health
DRW – Disability Rights Washington
ESH – Eastern State Hospital
FDS – Forensic Data System
HARPS – Housing and Recovery through Peer Services
HCA – Health Care Authority
MCR – mobile crisis response
OCRP – Outpatient Competency Restoration Program
OFMHS – Office of Forensic Mental Health Services, part of DSHS
PATH – Projects for Assistance in Transition from Homelessness
RDA – Research and Data Analysis, part of DSHS
RTF – Residential Treatment Facility
SAR – semi-annual report
SUD – substance use disorder
VTC – video technology conferencing
WASPC – Washington Association of Sheriffs and Police Chiefs
WSH – Western State Hospital

Preamble

This is the March 2021 semi-annual report; the SAR is published in March and September each year through the duration of implementation of the Trueblood Contempt Settlement Agreement.

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

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes where possible. For this third SAR, a greater number of elements contain programs with data available to view. Most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. It is still premature for evaluative data for these new programs. As with the launch of any major new program, it will take time to receive usable and reliable data for in-depth reporting. As programs continue their operations and mature, this report will expand over time to include more data and reporting elements. With few exceptions data is current through December 31, 2020. Exceptions are clearly noted.

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

Impacts of the COVID-19 Pandemic

In March 2020, the COVID-19 pandemic began impacting Trueblood implementation efforts. The state of Washington has experienced an ongoing state of emergency since mid-March 2020, and this has affected aspects of operations and preparations for service enhancements. Initial effects included supply procurement challenges, impacts to ward construction, and delays to competency evaluation interviews when there was no safe way to interview a defendant. Rapid changes in the early spring and summer required significant adaptation, and responding to COVID-19 outbreaks in many of our facilities has required additional changes throughout fall 2020 and winter 2020-21. The Behavioral Health Administration has begun vaccination of direct care personnel in its residential facilities as part of the state's COVID-19 vaccination plan. While the vaccination campaign has succeeded in delivering vaccines to critical patient contact positions, the state has encountered some of the shortages and supply chain difficulties impacting vaccine delivery throughout the country. Vaccine administration will be ongoing through at least spring 2021 as more doses become available. Additional changes to operations may occur at any time. As permitted by evolving employee, client, and contractor safety considerations, the state is continuously undertaking efforts to minimize impacts to settlement activities, but impacts are ongoing and inevitable. Specific impacts, as well as the state's efforts to overcome those impacts, are discussed in more detail below.

Background

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

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

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

As a result of this case, the state has been ordered to provide court-ordered in-jail competency evaluations within 14 days and inpatient competency evaluation and restoration services within seven days of receipt of a court order. Now that state-contracted outpatient competency restoration services began last summer, outpatient restoration services must likewise be provided within seven days of receipt of a court order. Trueblood applies to people who are detained in jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of Trueblood also target people who have previously received competency evaluation and restoration services, who are released and at risk for re-arrest or re-institutionalization.

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

On December 11, 2018, the Court approved the Contempt Settlement Agreement related to the contempt findings in this case. The Agreement is designed to move the state closer to compliance with the Court's injunction. The Agreement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified geographic regions. The 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.

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

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

The goals envisioned as part of this Agreement 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. The definitions below provide common usage and understanding throughout the report.

Agreement: Trueblood Contempt Settlement Agreement

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

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

CJTC or the Commission: Washington State Criminal Justice Training Commission

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

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

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

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

Forensic Projects for Assistance in Transition from Homelessness or FPATH: An intensive case management program that identifies people most at risk of referral for competency

restoration. Individuals identified on a referral list generated by Research and Data Analysis (RDA) have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those individuals most vulnerable to access housing, treatment and resources in an effort to divert them from future intersections with law enforcement. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

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

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

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

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

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

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

Evaluation and Monitoring Overview

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

Project Monitoring

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

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

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

- FPATH
- FHARPS
- Forensic navigator program
- OCRP
- Mobile crisis response

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

- Crisis housing vouchers

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

RDA is working with the various teams to establish a reliable and efficient data processing system for the Trueblood-related data. This requires significant work to determine how to receive and store data securely from various sources/providers, conduct initial error checks, follow-up quickly with individual providers on suspected errors, merge data into existing systems, create a central repository, establish consistent definitions and counting rules, perform reliable analyses, and generate accurate reports.

Data maturity — the point at which data are consistently entered and submitted — also takes time, particularly for new programs, most of which are using interim data collection methods until more efficient ones can be deployed. For these reasons, early program data will take a bit longer to curate. Once data collection and data processes are stabilized, the time from submission to Trueblood dashboard reporting will decrease, assuming that data providers submit required data in a timely manner.

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

Following a new program's implementation, program data will be reported by RDA through the Trueblood dashboard in the first quarter for which information is determined to be consistent and reliable for each program. RDA anticipates most program's data will be ready to report two quarters after program implementation. Prior to a program's program-level data release and dashboard development, circumstances occasionally exist where early higher-level program data can be released with proper precautions taken to ensure client confidentiality and compliance with appropriate state and federal statutes.

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 and substance use disorder treatment services

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

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

Timeline

Monitoring metrics will be produced on a monthly or quarterly timeline, including continuation of existing monthly reporting streams. Longer-term impact analyses and evaluation results (i.e., estimates of the impact of 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 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. Analysis is currently underway.

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

3. Preliminary estimates of the impact of specific 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,

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

seven months for data maturity, and at least two months for data integration, analysis, and reporting.

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 Agreement.

Each element's report considers the following five items as they relate to the element specifically and to the Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) data pertaining to the element. As previously described, data for new programs takes time to mature. Data tables included in this report reflect what was possible to produce from data recorded through December 31, 2020. A number of tables presented in the September 2020 SAR, in draft form, are now populated with programmatic operations data from an initial period of operations that commenced during calendar year 2020. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served in the new Trueblood programs increase.

Competency Evaluation – Additional Evaluators

The contempt settlement agreement requires hiring 18 additional forensic evaluators over two years. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines, evaluators can also be assigned to address the need of completing non-Trueblood forensic assessments (such as 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

From July 1, 2019 to June 30, 2020, OFMHS hired 13 evaluators meeting the Agreement requirements for fiscal year 2020. In the current fiscal year, OFMHS has hired 10 more forensic evaluators with start dates ranging from July 1, 2020 to June 1, 2021. Five of these positions were elements of the Agreement while the additional five evaluators filled pre-existing vacancies. As of February 8, 2021, all 74.0 full-time equivalent evaluator positions have been filled. The new hires have allowed OFMHS to complete jail-based competency evaluations within 14 days for 83-90 percent[3] of clients during the August–December 2020 time period. Furthermore, the new evaluators have allowed a record number of civil commitment petitions to be completed and a 254 percent increase in forensic risk assessments (FRA) completed in 2020 (85) on top of an approximately 50 percent increase in completed FRA's in 2019 (24) compared to the previous year. Completion of competency evaluations for class members remains prioritized over other types of evaluations, including FRAs.

Areas of Concern

In Fiscal Year 2020, Washington state had its highest number of referrals for all competency evaluations (4,710[4]) to date. This continued increase (3.4%) in all referrals occurred even though 12 fine-funded contempt programs and three state-funded prosecutorial diversion programs were in full operation. Furthermore, within the total competency evaluation increase, jail-based evaluations increased 5.67%. Without these programs, demand for evaluations would have increased even more in the past and the 2020 fiscal year. Additionally, the arrival of COVID-19 in late winter 2020, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for months during the pandemic.

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[3] *Table 8. Class member status at WSH and ESH (totals) – Jail-based competency evaluations.* Jan. 2020-Dec. 2020, 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. February 28, 2021, p. 19.

[4] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2020.

Recommendations to Address Concerns

The department continues its efforts to resolve ongoing issues with defense attorney scheduling. Scheduling continues to be the primary reason the state submits good cause exceptions and that some evaluations are completed after 14 days. The department is working with internal and external partners to put forward agency request legislation related to competency "immunity" in the next legislative session. Internally the department worked with information technology to complete development on a real time report tracker database for evaluators across the state to allow for the ability to shift resources as needed. Furthermore, the department has been working with various jails to establish a telehealth presence to complete evaluations remotely. Video technology conferencing (VTC) for competency evaluations is seeing more interest from jails and other entities seeking to continue evaluations while minimizing physical contact/proximity of clients and staff due to the COVID-19 pandemic.

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

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

OFMHS continues to work with and educate jails, VTC users, and IT staff to address issues and provide ongoing support for video evaluations. Additionally, support is being provided for video evaluations conducted at Western State Hospital, and all evaluations at RTFs (Maple Lane, Fort Steilacoom Competency Restoration Program, and Yakima). OFMHS has also added the capability to use Zoom for Healthcare in addition to the DSHS VTC Cisco application, to provide an alternative application to enable expanded use.

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

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

Data – Competency Evaluation – Additional Evaluators

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

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

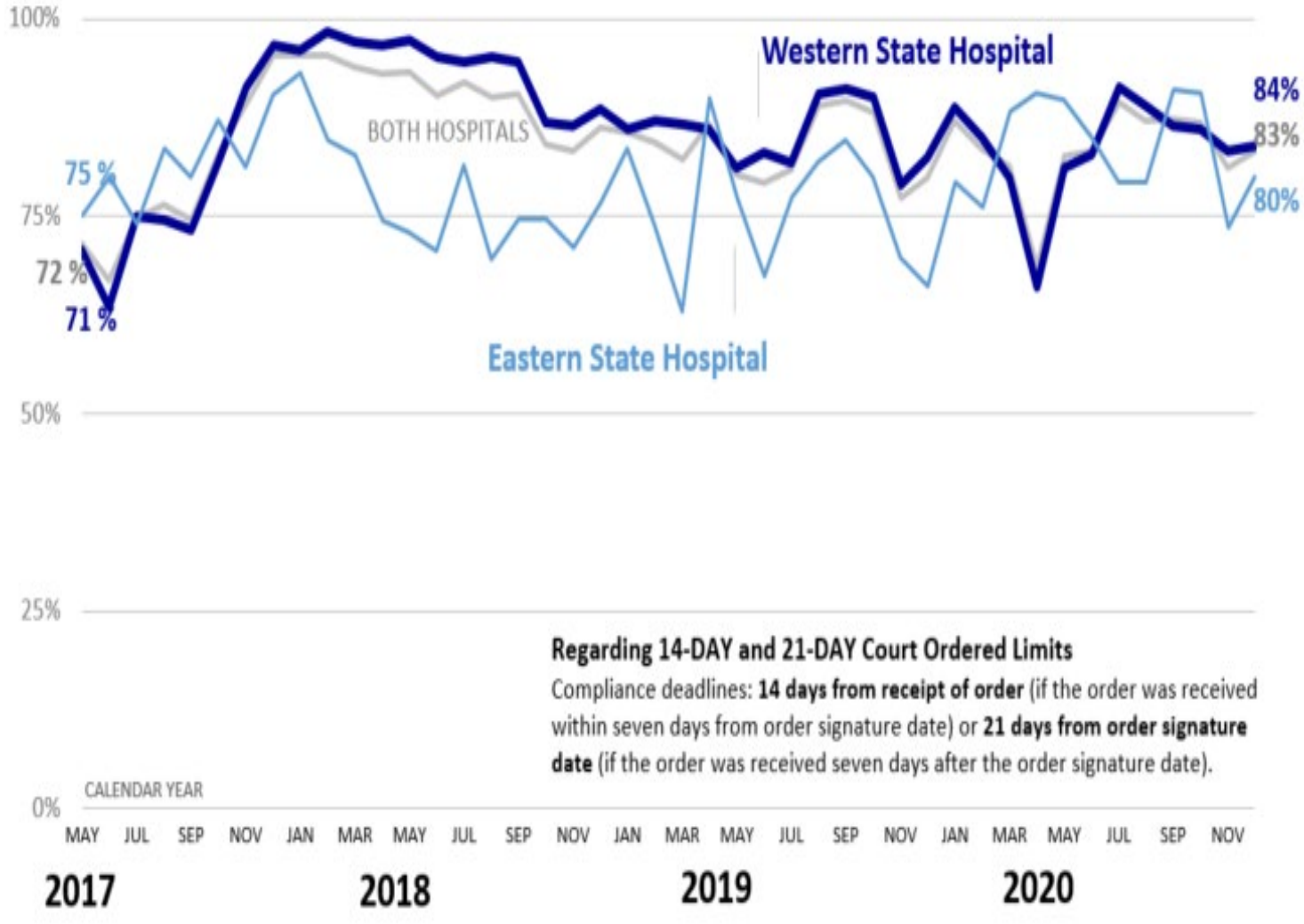
Projections indicate that the number of evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74.0 FTE in the FY2021 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, 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.

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

FIGURE 1.

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

Percent complete or closed within court ordered limits



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

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

Competency Restoration – Legislative Changes

As part of the Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supported legislation towards this goal. One 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 into law by the governor on May 9, 2019.

Current Status and Areas of Positive Impact

ESSB 5444 went into effect on July 28, 2019. At a high level, this bill changed the standard under which non-felony restoration may be ordered and made a number of other changes necessary to support new programs, like outpatient competency restoration. 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. Since the change in the law went into effect, there has been a slight decrease in orders for misdemeanor competency restoration.

Areas of Concern

The courts continue to issue a small number of misdemeanor restoration orders, signaling the potential need for continued outreach to 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. There was concern that confusion was leading to potential misapplication of the new standards.

Recommendations to Address Concerns

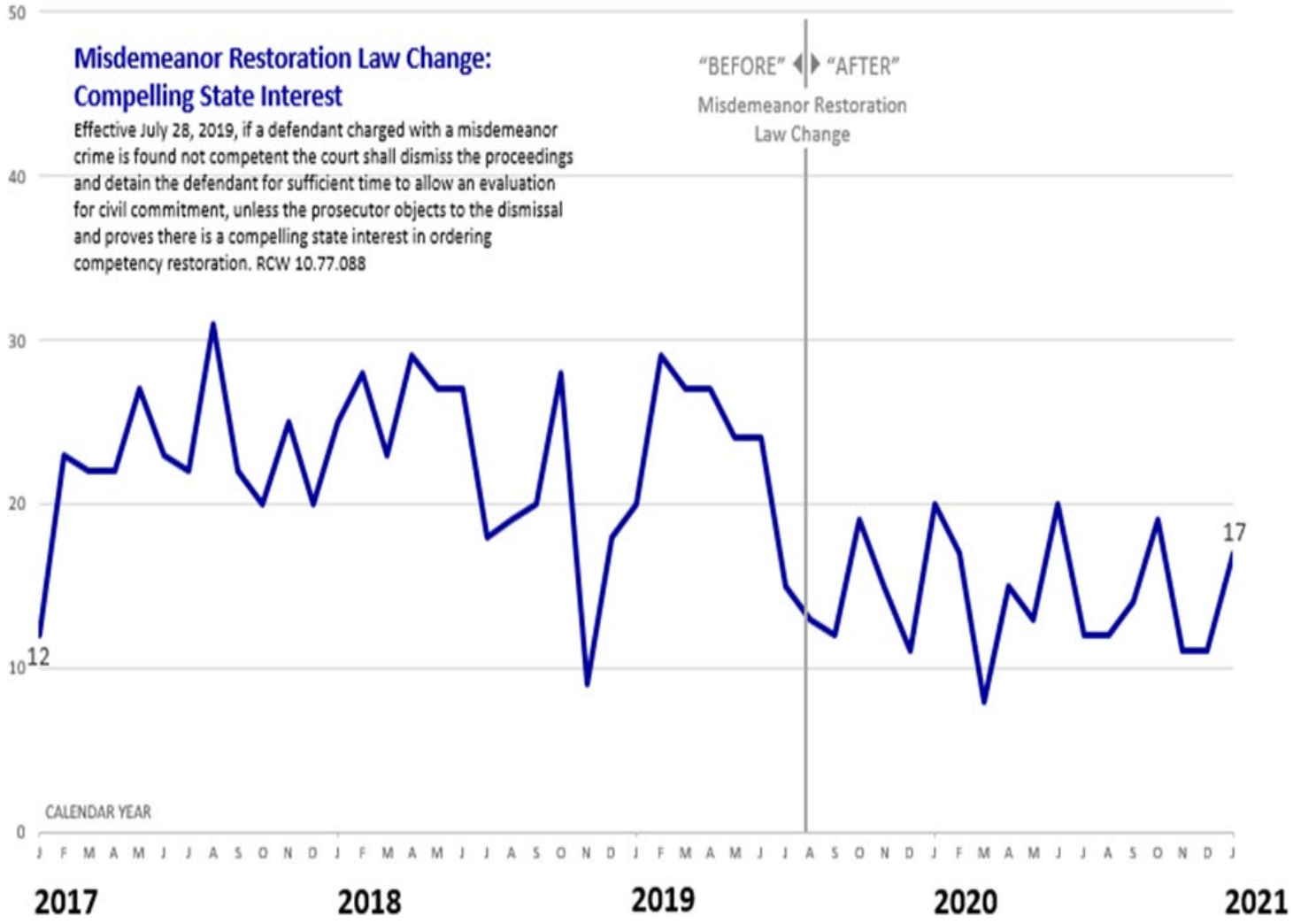
Additional communications and trainings about these changes will continue to enhance awareness, understanding, and application of the statutory changes. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. This will hopefully address any remaining confusion regarding the statute. The website that hosts the official code reviser's version of statutes was slow to be updated with these changes, but as of the publication of this report, the clarified version of RCW 10.77.088 now appears on that website. Because this is one of the primary resources used by courts and attorneys, the state is hopeful this change will help to resolve any persisting confusion. Additionally, ongoing data analysis will allow targeted outreach to any jurisdictions that show temporary or ongoing data patterns that are higher than expected under RCW 10.77.088.

Data – Competency Restoration – Legislative Changes

DSHS continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088). Misdemeanor restoration orders have decreased slightly since the 2019 law change. During the 18-month period prior to the 2019 law change courts issued an average of 23 misdemeanor restoration orders per month, which decreased to an average of 14 per month during the 18-month period after the law change. In January 2021, there were 17 misdemeanor restoration orders issued statewide (Figure 2).

FIGURE 2.

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



DATA SOURCE: Forensic Data System (FDS).

Competency Restoration – Community Outpatient Services

The Outpatient Competency Restoration Program element of the Agreement is managed by the Health Care Authority in collaboration with the department. DSHS will continue providing court-ordered inpatient competency restoration services; however, OCRP provides an 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 and implemented. A consulting firm, Groundswell Services, Inc., also conducted a review, which assisted in this model's development by providing evidence-based critique and analysis of other states' OCRP models.

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

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

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

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

Areas of Concern

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

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

Workforce hiring challenges and COVID-19 continue to be an area for concern. HCA is working closely with the providers in the regions to address these challenges.

Coordination and timing of jail releases was identified as a concern when reviewing cases where individuals were removed from OCRP. Preliminary findings indicated that when an individual was released after hours without coordination with the Trueblood elements or was released near the end of a work week, it has been more challenging to connect the person to services. OCRP and navigators are working with the local jails in Phase 1 to attempt to discourage releasing individuals after hours.

Recommendations to Address Concerns

Providers have established mechanisms to provide remote and virtual services to individuals in rural communities, as needed, with the goal of serving individuals in person as much as possible. Additionally, continuity of care plan development is an important contingency to address the potential for a region's contracted provider to discontinue services or be terminated.

DSHS and HCA will continue to engage court partners in discussions of this new program. Currently, contractor agencies are included in collaboration and engagement activities in all of the Phase 1 regions and relationships are being developed among the programs. HCA, in partnership with DSHS, is working to engage King County for Phase 2 implementation of OCRP. Staff from the King County Prosecuting Attorney's Office and staff from the King County Department of Public Defense have agreed to participate in the planning and implementation of

OCRP in King County. Since March 2020, both HCA and DSHS have been participating in the King County Competency Continuum workgroup that includes membership from King County law enforcement, defense council, prosecution, judges, county staff, and advocates. HCA and DSHS will also be targeting community partner groups of court and jail staff to begin the stakeholdering process for OCRP.

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

Data – Competency Restoration – Community Outpatient Services

OCRP services began on July 1, 2020. Between July 1 and December 31, 2020, 17 individuals were enrolled in OCRP and eight were discharged. Additional details will be presented when there are a minimum of 25 cases to analyze (Table 1). Program data is from interim Microsoft Excel data trackers until each provider incorporates required data into their record systems. Data should be considered preliminary as the program and data collection are still evolving.

Navigators and OCRP staff continue to work with criminal courts to facilitate referrals to outpatient restoration and participation in the program is expected to increase in the months ahead. Program data is from pilot Microsoft Excel data trackers. Additional data will be provided from the FDS and the Navigator Case Management System (NCM).

TABLE 1. **PRELIMINARY EXAMPLE**

Outpatient Competency Restoration Program Enrollment and Participant Characteristics

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
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 interim OCRP Microsoft Excel trackers submitted by providers to the Washington Health Care Authority.

Forensic Navigators

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

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

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

Current Status and Areas of Positive Impact

As of February 16, 2021, the Forensic Navigator program is averaging about 25 new cases per week. Forensic navigators have also been in close contact with attorneys, outpatient competency restoration programs, and have referred program participants to outpatient forensic service providers in the three Phase 1 regions. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators have continued to facilitate connections for eligible clients to housing and recovery programs as well as to forensic peer services and case management supports, even when class members are not ordered into outpatient restoration, and even when the forensic navigator has been discharged and is no longer actively assigned to the client.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one which primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not extend to a larger group of individuals for whom competency to stand trial has been raised, particularly those for whom a competency evaluation is ordered at or after their release from jail. Thus far, forensic navigators have also been serving those individuals. However, as the volume of clients grows, there may come a time when forensic navigators must prioritize their caseloads for class members.

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

As with any new program, there have been lessons learned in what works for these programs to interface smoothly. DSHS and its service partners are working well together in order to iron out these programmatic alignments. Extensive process mapping, with the use of RACI matrices, has been completed. Soon to occur is value stream mapping (VSM) between the Forensic Navigator program and partner programs OCRP, FHARPS, and FPATH. As a result of the VSM process, it is expected that participant programs will decrease gaps, streamline processes, and gain operational efficiencies.

Recommendations to Address Concerns

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

Data – Forensic Navigators

A total of 531 individuals were assigned a Forensic Navigator between July 1, 2020 (program start) through December 31, 2020 (Appendix B, Table 1). The majority of individuals assigned a navigator were male (73 percent), half (52 percent) were between the age of 30 to 49, and half (52 percent) were non-Hispanic White. Just over half (52 percent) were charged with a felony crime, and 48 percent were charged with a misdemeanor.

Forensic Navigators worked to gather information for the courts for nearly all individuals assigned a navigator during the reporting period (98 percent, Appendix B, Table 2). Client meetings, interviews or observations were conducted with over half (57 percent) of individuals assigned a navigator. A recommended service plan was completed for half (50 percent) of individuals. About one in four individuals (26 percent) received a referral to other community services. The most common types of referrals were to other Trueblood partner programs. One in five individuals (19 percent) received a referral to the FPATH program and 18 percent received a referral to FHARPS.

A total of 384 individuals were discharged during the reporting period, with an average length of stay in the program of 27 days (Appendix B, Table 3). Nearly one-third (32 percent) of cases were closed because the individual was determined competent, 28 percent of cases were closed because the individual was ordered by the court to receive inpatient restoration. Nearly half (42 percent) of individuals in the Spokane region were discharged after they were released from jail on personal recognizance.

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

Competency Restoration – Additional Forensic Beds

The vision of the parties in creating the 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 Agreement requires that Eastern State Hospital convert two former 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 Agreement requires that Western State Hospital 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. More than $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.

Both Eastern and Western State hospitals experienced construction delays and supply chain impacts as a result of the COVID-19 pandemic. Because of the ever-evolving impacts and necessary staffing adjustments on site to preserve health and safety, the department was unable to determine the exact time delay expected. As a result, the department was granted additional time to complete the construction from the Court with the understanding that the department will provide updates on the status of both projects to the Court twice monthly until completion.

Current Status and Areas of Positive Impact – ESH

As of the date of this report, Eastern State Hospital has completed construction of the two new wards which includes 50 beds plus four total seclusion rooms and two total quiet rooms. 1N3 began accepting patients June 1st and 3N3 began accepting patients August 3.

Current Status and Areas of Positive Impact – WSH

As of the date of this report, Western State Hospital has completed renovations of E3 and E4 adding 40 beds plus two seclusion rooms to the forensic system. E4 began accepting patients on February 8 and E3 on February 15.

Areas of Concern

Both the WSH and ESH additional forensic bed projects are complete. Operationally, BHA strives to minimize client and staff exposure to COVID-19 during the pandemic.

Recommendations to Address Concerns

BHA has implemented a number of protocol changes to minimize COVID-19 risk and reduce potential spread. These changes include, ward admission holds, census reductions to improve social distancing, designated wards for COVID-19 patients, and administering thousands of doses of COVID-19 vaccines.

Data – Competency Restoration – Additional Forensic Beds

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 33 – 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 fewer wait time for admission, and for Maple Lane, it is four consecutive months of a median wait time for admission of nine days or fewer.

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

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup is developing full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for 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 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

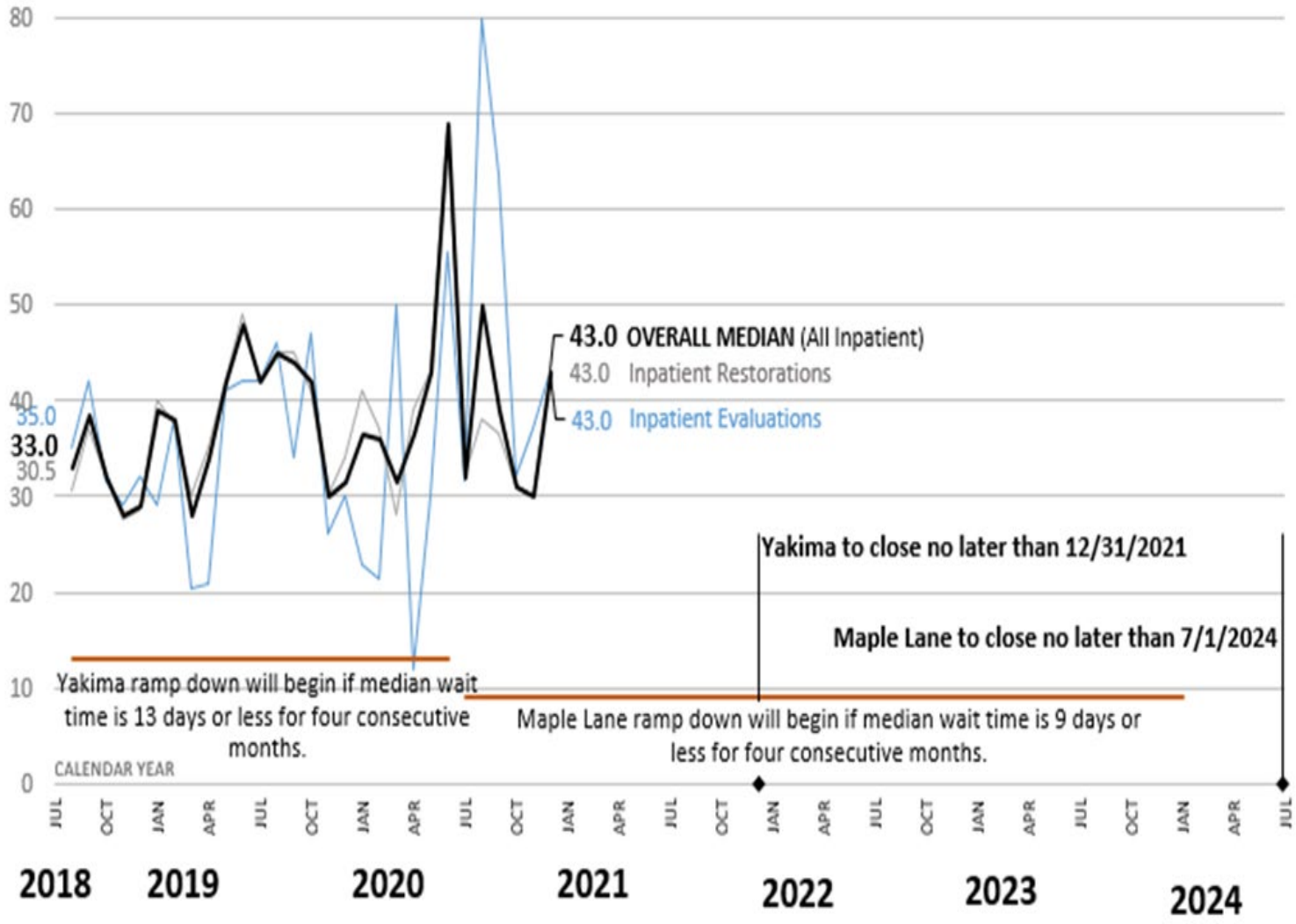
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services on a monthly basis (Figure 3). Wait times have not yet decreased to a level that would trigger early ramp down of the Maple Lane or Yakima facilities. In December 2020, the median wait time for inpatient competency services was 43-days. The Yakima ramp down will begin if median wait times reach 13 days or fewer 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 fewer for four consecutive months. Per the Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 3.

Closure of Maple Lane and Yakima Residential Treatment Facilities

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

FEBRUARY 2021



DATA SOURCE: BHA Forensic Data System.

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

Crisis Triage and Diversion – Additional Beds, 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 to offer support and behavioral health crisis stabilization services in a community setting. These Department of Health-licensed community behavioral health agencies serve their communities by providing least restrictive alternatives to care. This allows individuals to be treated by a multi-disciplinary team for the purpose of diverting individuals from arrest, detention, and lengthy hospitalizations. Services within the facilities are short term and focus on stabilizing and returning the individual back to their community. While an emphasis is placed on voluntary admissions, these facilities are also designated to work with first responders to accept police referrals, drop-offs and police holds.

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

Current Status and Areas of Positive Impact

HCA supported the Department of Commerce in issuing a request for proposals for the expansion of 16 new beds for crisis stabilization in the Spokane region with the successful bidder identified as Spokane County and the City of Spokane. After a thorough and competitive bidding process for a social service provider, Pioneer Human Services was selected as the operational agency for the Mental Health Crisis Stabilization Facility. The HCA, DSHS, and Department of Commerce meet monthly to monitor the construction efforts. In addition to construction, HCA is discussing the anticipated workforce needs in the Spokane region, maintaining open communication with community partners, agencies, and other first responders who will be making referrals once the facility opens.

HCA is currently contracting with four licensed community behavioral health agencies in each of the three regions to enhance their ability to provide crisis stabilization services to acute populations and to increase police drop-offs, referrals, and holds. Examples of those enhancements include:

- Additional staff and salary enhancements to reduce turnover

- Facility improvements
- Infrastructure such as technology, medical equipment and furniture
- Client Experience enhancement strategies
- Programmatic supplies that promote wellness
- Transportation
- Specialized training for staff to work with acute populations.

Challenges in serving individuals in congregate settings due to COVID-19 have been significant. Department of Health guidelines include reducing the number of individuals confined to the space due to physical distancing requirements and other changes in procedures meant to lessen the potential for disease spread. Agency staff dealing with their own personal concerns, including their risk for infection, makes providing crisis stabilization services more challenging.

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

Areas of Concern

Intentional planning is required to address the needs of individuals that are referred by law enforcement as either drop-offs or holds as most facilities did not envision this population for their services. To address this, it is vital that facilities can staff up as needed, are provided with technical training assistance for meeting the needs of the population, and can identify and utilize available community resources to better support the needs of the individual. Without these resources, staffing may be insufficient or ill prepared to meet the needs of this population and law enforcement personnel are unlikely to utilize the facility as a viable option if referrals are infrequently accepted.

CS/CT facility provide services 24/7/365, so the CS/CT facility must be able to provide timely behavioral health assessments, evaluate behaviors, and rapidly stabilize individuals presenting as symptomatic. Individuals admitted from a police hold are required to be examined by a mental health professional within three hours of arrival, not counting time periods prior to medical clearance, if needed. Therefore it is important that facility standards be reevaluated and redesigned to provide brief optimal services. HCA has worked with the Department of Health to support the use of recliners for individuals requiring only a short-term stay of under 23 hours

reserving the standard beds for individuals that merit longer treatment stays enabling the CS/CT facility to utilize the beds for individuals requiring longer respite and stabilization.

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

It has been previously noted that the current crisis service delivery landscape in Washington state is very dynamic. This was very evident in the Trueblood Phase 1 regions where some providers closed facilities such as Telecare in the Southwest region; however, Lifeline Connections opened filling some of the void left by Telecare's closure. The addition of these resources will help support the needs of the regions where they are situated.

Recommendations to Address Concerns

HCA will continue to work with CS/CT providers to enhance their ability to serve 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 the 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 a 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 FHARPS teams, has allowed for a warm handoff while providing needed support and housing. Funding for this service may require adjustment to address a larger geographic population and to ensure adequate ability to serve clients.

Data – Crisis Triage and Diversion – Additional Beds and Enhancements

Additional crisis triage and stabilization beds and enhancement to services (e.g., accepting police drop-offs to serve persons in mental health crisis) may divert some individuals from arrest and incarceration. HCA will provide information on the date, location, and number of beds added. The department will assess the feasibility of detecting the impact of additional beds and services

from other Trueblood efforts. Data on crisis housing vouchers distributed by crisis triage and stabilization facilities is included in the Crisis Triage and Diversion – Residential Supports section and (Appendix C).

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

The four FHARPS teams continue to enroll, house, and provide supportive services. Each team has successfully assisted individuals to obtain temporary, transitional and permanent housing. Regularly scheduled meetings occur in all three regions to coordinate and collaborate between all elements (FPATH, FHARPS, Forensic Navigators, OCRP). The HCA staff facilitate these meetings. These meetings have created opportunities to improve care coordination, communication and service delivery between the teams in each region.

FHARPS teams have participated in ongoing technical support and training. Recent training topics have included Housing First, trauma informed care, motivational interviewing, and person-centered/recovery-based approaches. Ongoing technical assistance is being provided to FHARPS teams specifically around data collection and service delivery.

An Exception To the Rule was written and approved by the Trueblood sponsors to extend the subsidy length of time for people in the program that have exceeded their six-month subsidy limit. The FHARPS teams can request an extension of supportive housing services and subsidies on a case-by-case basis.

The five crisis stabilization facilities located in the Phase 1 regions are issuing short-term housing vouchers to people discharging who are experiencing homelessness. HCA/DBHR is working with the staff at these facilities to enhance their knowledge of community-based supportive housing resources and programs for the broader population of those with a clinical need. The goal is to ensure that everyone exiting these facilities who utilizes a short-term housing voucher is also connected to community-based programs for ongoing support and linkage to resources. Individuals who meet the specific eligibility in section C(2)b-1 as defined in the Agreement receive FHARPS services and subsidies.

Areas of Concern

Affordable housing stock and access to long-term permanent housing vouchers are limited and in short supply. The HCA participated in the Department of Commerce Housing Trust Fund competitive procurement review of capital investments for affordable housing. FHARPS teams are actively developing relationships with private market landlords, mainstream housing resources such as the deed recording fees and affordable housing providers in each region to

increase access to permanent supportive housing outcomes for people at risk of homelessness and who have touched the legal system. The participants served by the FHARPS teams will only have transitional housing subsidies. Ongoing supportive services can and should be provided by the Foundational Community Supports 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.

Enrollment in FHARPS in large part IS voluntary and some individuals choose not to pursue more permanent housing options. FHARPS teams make efforts to engage individuals while keeping them sheltered in temporary residences as they pursue long-term stable housing options. In some instances, participants' behaviors do not align with motel policies resulting in requests to leave. Those individuals continue to receive support in order to be placed in different motels while the behaviors are addressed. In a testament of the ongoing support that the FHARPS team provides, one individual has been placed in seven different motels, and the team continues to support this person. The team observes that the biggest challenge is overcoming the barrier of co-occurring disorders and active substance use. There are a few individuals who have been re-incarcerated or detained to involuntary treatment. On release from jail or hospitalization, FHARPS teams have continued to support those individuals.

Another challenge vocalized by the FHARPS teams are landlords who express reluctance to fill their vacancies due to the statewide eviction moratorium related to COVID-19. The landlords state they would rather leave their units empty than "risk" occupying them and having difficulty with the tenant.

Substance use appears to be the overarching barrier for many individuals who are not doing well in the program. The teams have been encouraged to use their motivational interviewing skills to work with those individuals in hopes that they will want to access treatment while employing a Housing First philosophy. The teams all know that if someone goes into a treatment setting, they will have the support and financial resources offered by the FHARPS team after graduation.

Recommendations to Address Concerns

The FHARPS program administrator has and will continue to provide ongoing technical assistance. The teams have been encouraged to use motivational interviewing and other evidenced-based techniques to help participants overcome their barriers to successful placements in housing. HCA has worked with teams on developing a robust housing portfolio for the individuals served. FHARPS teams will be strongly encouraged to refer individuals to community resources for supported employment.

Data – Crisis Triage and Diversion – Residential Supports

Residential supports are provided through two mechanisms: (1) crisis housing vouchers provided by crisis triage and stabilization facilities; and (2) the FHARPS program. A data tracker

was created for each program as an interim data collection tool until a long-term solution is identified and implemented by HCA. Facilities and FHARPS providers submit the data as required by their HCA provider contracts. Data should be considered preliminary as the program and data collection are still evolving.

Vouchers

The crisis stabilization and triage (CS/CT) facilities contracted to provide housing vouchers distributed 89 vouchers to 64 individuals between December 1, 2019 and December 31, 2020 (Appendix C, Table 1). Spokane distributed 6 in 10 vouchers (63%). The total amount disbursed was $80,250, and the average amount per recipient was $1,254. Voucher recipients leaving CS/CT facilities were there based on referrals from a number of sources including hospitals (45%), law enforcement (19%), mobile crisis response, and other health care providers (9% each).

Overall, most voucher recipients were male (72%), between 30 and 39 years old (52%), and non-Hispanic White (63%). Starting March 1, 2020 (when FHARPS began), voucher recipients were referred to FHARPS, where they may be eligible for additional support. Based on matching housing voucher and FHARPS program data, 92 percent of those receiving vouchers were enrolled in FHARPS between March 1 and December 31, 2020, and 80 percent of voucher recipients were housed or sheltered at least once by FHARPS. The majority of initial housing placements (96%) were shelter/emergency housing types, which includes motels.

FHARPS

A total of 611 individuals were referred for FHARPS services from March 1 to December 31, 2020 (Appendix D, Table 1). Of these referrals, 355 (58%) were contacted[6] and 319 (52%) were enrolled. The Southwest region contacted and enrolled the largest portion of their referrals (85% and 67%, respectively).

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 44 percent of referrals. Crisis stabilization and triage (CS/CT) facilities referred 97 individuals (higher than the 64 individuals receiving housing vouchers). In the Spokane region, CS/CT facilities made up 21 percent of referrals, and 41 percent of initial contacts by FHARPS staff occurred at CS/CT facilities. Outpatient behavioral health facilities were responsible for 21 percent of referrals. About three-quarters (74%) of initial contacts were made by phone, highest in the Southwest region (99%).

About 6 in 10 (63%) of individuals enrolled in FHARPS were male, 57 percent were between 30 and 49 years old, and 56 percent were non-Hispanic white. Most individuals were homeless at the time of enrollment (77%).

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

Of those enrolled, 95 percent opted to receive housing support services and subsidies, and 84 percent were housed or sheltered during the reporting period (Appendix D, Table 2). About 72 percent of first housing types were emergency/shelter placements, which includes motels. Nearly half (49%) of individuals enrolled between March 1 and December 31, 2020 were also discharged during the period, with an average length of support of 127 days (Appendix D, Table 3). The average total subsidy support received by those discharged was $4,928.

Most cases were closed due a loss of contact (35%), reaching the maximum subsidy cap without transition (17%), transitioning to other housing support (15%), or transitioning to self-support (10%). Housing status at discharge was unknown for 36 percent of individuals (consistent with the loss of contact rate). Another 28 percent were stably housed and 24 percent were homeless.

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

Crisis Triage and Diversion – Mobile Crisis and Co-responders

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

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

Overall enhancements have included:

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

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

Spokane region:

- Frontier Behavioral Health is developing and implementing a Trueblood-centered segment of its mobile crisis service designed and trained to work with individuals who

are identified as either class members or potential class members. FBH reports a long history of providing crisis intervention services, operation of the Regional Crisis Line, and is currently piloting a co-deployment team with the Washington Association of Sheriffs and Police Chiefs to respond to individuals presenting with mental health distress.

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

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

Pierce region:

- Providing a more rapid response time for interaction with law enforcement and co-responders by expanding coverage area and creating two service bases to cover the region.

- Coordinated communication with tribal and law enforcement partners.

Southwest region:

- Enhanced mobile crisis staffing (crisis interventionist) in rural areas of the region to ensure timely response.

- Creation of a behavioral health post-crisis follow-up service pilot program to support individuals after they had a crisis service contact.

Areas of Concern

Acquiring signatures for the initial MCR contracts was an arduous task as the BHASO contracts required multilevel ratification from boards of county commissioners or corporate legal departments. These authorizations were necessary before the BHASO could enter negotiation with their regional agencies or develop contract language for their services.

In consultation between HCA and DSHS staff, regional representatives from the crisis response systems, and local rural law enforcement representatives, the law enforcement representatives stated that they struggled with managing the need for providing secure transportation for people who needed to be brought to metropolitan areas for treatment. These trips take the already limited number of officers offline during transport, which can take hours depending on the distance traveled. Another concern was that in the most rural areas, despite having funding to hire staff, qualified candidates simply do not apply to work in these remote regions. Additionally, some regions possess very limited 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 to address staffing shortages by employing a variety of service providers. The timeline for contracting future services must be established within the region's ratification system and consider the processes for which they operate. These steps must be done before establishing any final date of signature.

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

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

Data from the contracted MCR providers was submitted to HCA's Behavioral Health Data System by January 31, 2021 and are being evaluated for data quality issues. Additional updates to the BHDS platform are required. When data are of sufficient quality, the number of interventions, individual characteristics of those served, and average response time will be reported through the Trueblood Quarterly Dashboard (see Table 2). The Washington Association of Sheriffs and Police Chiefs is responsible for co-responder's data.

TABLE 2. **PRELIMINARY EXAMPLE**

Mobile Crisis Response Interventions and Client Characteristics

QUARTER

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

DATA SOURCE: Washington State Health Care Authority (HCA) Behavioral Health Data System (BHDS)[7].

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

Crisis Triage and Diversion – FPATH

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

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

Current Status and Areas of Positive Impact

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

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

Teams continue to prioritize their outreach and engagement efforts to individuals prioritized by the following criteria: individuals living in rural areas, individuals who have had four or more referrals for competency evaluation in the past 24 months regardless of housing status, and/or individual experiencing homelessness. The intent behind prioritization is to assist in connecting

those most at risk of additional referrals for competency evaluations to services in hopes of diverting them away from further justice involvement.

FPATH teams have increased their referrals and coordination with the FHARPS program for housing supports. Eligible people court ordered for forensic navigator/outpatient competency restoration may also utilize FPATH for case management services.

HCA has provided ongoing trainings on trauma informed motivational interviewing, diversity equity and inclusion, as well as individualized technical assistance with FPATH teams to address service delivery and data collection.

HCA's FPATH program administrator has built effective relationships with service agencies to provide needed support and technical assistance during the COVID-19 pandemic to meet the needs of the eligible individuals and connect them to services. Support included best practices on outreach and engagement during a public health crisis. Even with physical distancing requirements, all teams have been able to provide outreach services and engage with clients.

Areas of Concern

Due to the lag time between the forensic data system and RDA's generation of the referral list, some individuals referred by the forensic navigators are not appearing on the referral list. While the list does not ultimately control eligibility, this lag can sometimes make it more difficult to quickly identify eligible individuals. HCA and DSHS are working closely to identify a solution to this challenge.

Recommendations to Address Concerns

FPATH, in collaboration with RDA, DSHS, and HCA IT, is working to come up with a permanent solution to address the issue of the referral list that would eliminate the inaccuracies that are causing concern. Until this solution is identified and implemented, the interim remedy is to ensure that the appropriate referrals are being made even when an individual is not immediately found on the referral list.

Data – Crisis Triage and Diversion – FPATH

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

The FPATH program began March 1, 2020. Between March 1 and December 31, 2020, 752 individuals within the Phase 1 regions were referred to the program (Appendix E, Table 1). The HCA has asked providers to focus outreach efforts on a subset of these individuals based on

housing status (prioritizing unstably housed and homeless), number of referrals (4 or more in the past24 months), and county of residence (prioritizing rural counties). The number of individuals on the prioritized list was 372.

Of all individuals on the referral list, FPATH providers attempted to contact 415 (55%), and successfully contacted 208 (28%). Initial data indicate that a total of 102 individuals (14% of overall referrals) were enrolled in the FPATH program (Appendix E, Table 1). Of these, the majority were male (77%) and between 30 and 49 years old (55%). More than half of enrollees (57%) were homeless, while 23 percent were unstably housed, indicating that providers are focused on enrolling those in the priority population. The Southwest region contacted and enrolled the largest portion of their referrals (47% and 35%, respectively).

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

Education and Training – Crisis Intervention Training

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

Current Status and Areas of Positive Impact

To date, the Criminal Justice Training Commission has completed seven 40-hour courses for law enforcement and trained 143 certified peace officers. Within these classes CJTC has trained a total of 230 attendees that consisted of law enforcement officers, mental health professionals, dispatchers, emergency responders, security officers, and corrections officers. There are 207 officers left to train to reach the 25 percent goal in the Phase 1 areas. Please note, this does not account for State Patrol and the Washington State Department of Fish and Wildlife as CJTC is determining the exact numbers in those districts. CJTC's database tracks WSP and Fish and Wildlife as a whole, not by each district. CJTC will need to schedule two classes in the Spokane region, one in the Southwest region and four in the Pierce region to be completed by June 30, 2021.

Six of the 24 funded eight-hour corrections courses are complete with 155 corrections officers receiving training. In addition, Clark County Corrections hosted a 40-hour CIT for corrections, exceeding the mandate. Clark County trained 110 corrections officers in this program, for a total of 342 corrections officers trained by attending the eight-hour corrections course or the 40-hour course, which exceeds the requirement. There are an estimated 397 correctional officers left to train in the Phase 1 areas.

Phase 1 regions are eligible to receive 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.

CJTC collaborated with the state 911 office for delivery of the eight-hour CIT course for dispatchers. The telecom/911 training have been deployed and will be offered throughout Phase 1. Roughly 60 dispatchers have been trained with 505 left to train in the Phase 1 areas.

Areas of Concern

Currently, the largest area for concern regarding implementation are the effects that COVID-19 has on developing and implementing the training either in person or online. Another area of

concern that has been discussed 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, even with the available backfill funding. A final area of concern is that 911 operator classes have experienced lower than anticipated enrollment.

Recommendations to Address Concerns

CJTC has developed an 8-hour corrections course that is being offered via an online platform and classes are now available. With this training being available online, we may be able to train more officers per class rather than being limited to the number of seats offered in person. For the 40-hour course, CJTC is working with agencies to locate larger venues to accommodate social distancing and will resume in person when it is safe to do so. In person trainings have been scheduled for late spring.

Data – Education and Training – CIT

CJTC monitors law enforcement training completion rates through a Learning Management System. Per the Agreement, 25 percent of patrol officers in each law enforcement agency are required to complete 40 hours of enhanced CIT by June 30, 2021. Trainings began July 1, 2019. Figure 4 displays training completion rates for each individual law enforcement agency in the Phase 1 regions. Fourteen of the 52 law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies had higher training completion rates than small agencies in all three regions.

Training rates have remained relatively stable across Phase 1 regions since September 2020. As of January 31, 2021, 18 percent of officers were trained in the Pierce region, compared to 48 percent in the Southwest region, and 41 percent in the Spokane region. Previously, these rates were 14 percent, 48 percent, and 40 percent, respectively (see September 2020 semi-annual report). Statewide, Washington State Patrol agencies have demonstrated a training rate of 16 percent. Due to the impact of COVID-19, in-person trainings continue to be impacted throughout the state.

The Agreement also states the 25 percent training target should prioritize agencies that serve areas with higher population densities. As of January 31, 2021, large agencies serving the areas of greater population density within the Southwest and Spokane regions have higher rates of training completion (Southwest 57% and Spokane 52%) than the Pierce region (18%, Table 3 below). Similar rates were observed in the September 2020 semi-annual report.

The Agreement also requires all 911 dispatchers and correctional officers complete an eight-hour CIT course by June 30, 2021. As of January 31, 2021, 11 percent of 911 dispatchers had completed CIT training, with completion rates of approximately 9 percent in the Pierce region, 16 percent in the Spokane region, and 4 percent in the Southwest region (Table 4). In addition, approximately 64 percent of correctional officers in Phase 1 regions completed CIT training, ranging from about 23 percent in the Spokane region to 92 percent in the Southwest region (Table 5). These rates have increased since September 2020, when 46 percent of correctional officers had completed the training across the Phase 1 regions (see September 2020 semi-annual report).

TABLE 3.

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

JANUARY 31, 2021

Region	Pierce Region			Southwest Region			Spokane Region			Statewide - WA State Patrol			TOTAL - ALL REGIONS		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	**# of Officers**	**# of Officers Trained**	**% Trained**
Large	667	118	17.7%	345	195	56.5%	556	291	52.3%	107	8	7.5%	**1675**	**612**	**36.5%**
Medium	221	55	24.9%	52	12	23.1%	30	4	13.3%	162	36	22.2%	**465**	**107**	**23.0%**
Small	116	9	7.8%	91	27	29.7%	163	13	8.0%	11			**381**	**49**	**12.9%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

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

TABLE 4.

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

JANUARY 31, 2021

Region	# of Dispatchers	# of Dispatchers Trained	% Trained
Spokane Region	233	36	15.5%
Pierce Region	187	16	8.6%
Southwest Region	81	3	3.7%
Statewide - WA State Patrol	54	5	9.3%

TABLE 5.

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

JANUARY 31, 2021

Region	# of Officers	# of Officers Trained	% Trained
Southwest Region	155	142	91.6%
Pierce Region	262	164	62.6%
Spokane Region	99	23	23.2%

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington state. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1 regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers.

DATA SOURCE: Washington State Criminal Justice Training Commission.

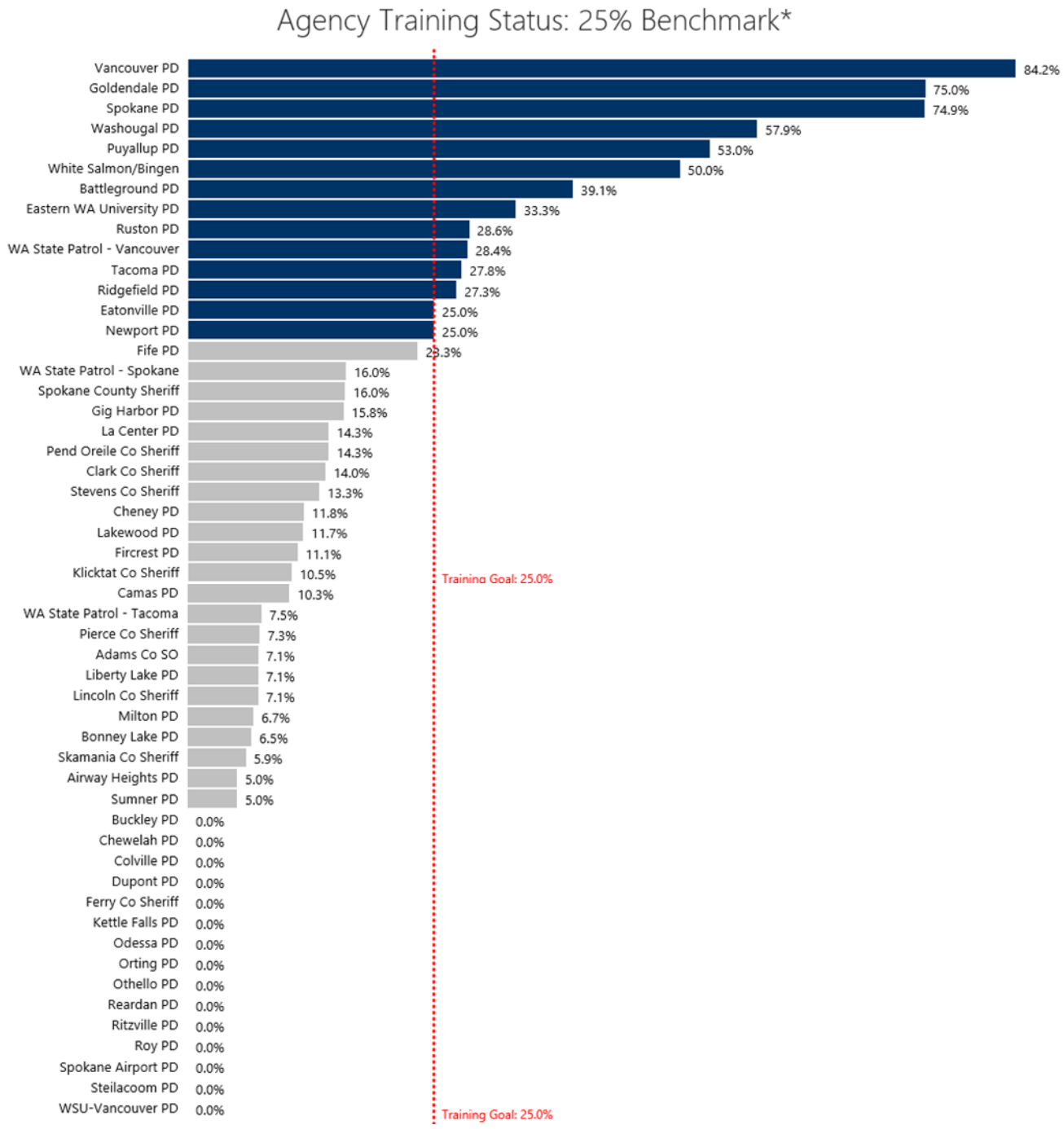
Figure 4 displays training completion rates for each law enforcement agency in Phase 1 regions. Fourteen law enforcement agencies in the Phase 1 regions are meeting or exceeding the 25 percent benchmark.

FIGURE 4.

Crisis Intervention Training (CIT)

Individual Agency Compliance Metrics: Phase 1 Regions

JANUARY 31, 2021



*Percent of officers who have received 40 hours of Crisis Intervention Training.
View TABLE 5 above for clarifying details on FIGURE 4.

Education and Training – Technical Assistance for Jails

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

The guidebook addresses the topics of pre- and post-booking diversion, identification of need and access to treatment, administration of involuntary medication, transition planning and continuity of care, and use of segregation as well as additional subject matter. The guidebook was completed on May 14, 2020, prior to the June 1, 2020 deadline. It is now available on the JTA website[8] and has served as a support document for trainings on the topics it covers.

Current Status and Areas of Positive Impact

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

Efforts are underway to extend the reach of JTA trainings and improve audience engagement. As part of this effort, the team collaborates with a BHA communications consultant to improve content and user interface of our public-facing website. JTA recently purchased licenses for a suite of authoring tools intended to create more engaging and interactive online learning experiences.

There has been a significant increase in the use of videoconferencing software to conduct forensic evaluations remotely as an adaptation to the limitations imposed by COVID-19 on in-person evaluations. Members of the JTA team have been centrally involved in providing guidance and technical assistance statewide in support of this transition to increased online forensic evaluations at jails throughout the state.

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

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 had arranged to staff a booth at the spring 2020 WASPC conference and planned to deliver an awareness campaign as well as to solicit additional information regarding JTA needs. Unfortunately, this important outreach opportunity was canceled due to the COVID-19 pandemic. Opportunities to present at this and other relevant conferences in the future will be pursued.

As noted, work is underway to improve the effectiveness of our public-facing website, and to improve engagement with online trainings through the use of updated software tools. Efforts are also underway to collaborate with WASPC in the posting of training opportunities and the best practices manual.

Data – Jail Technical Assistance

The Technical Assistance for Jails team needs to develop and implement a method to accurately track data for online training participation that does not present an obstacle to participants and thereby reduce attendance. Consultation with communications and RDA will continue.

Enhanced Peer Support

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

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

Current Status and Areas of Positive Impact

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

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

A new Enhanced Peer Services program administrator began on October 1, 2020. Due to COVID-19 and the continued need for physical distancing for the foreseeable future, the Enhanced Peer Services program administrator is working on transitioning the interactive in-person training to a virtual format. The current goal for the virtual version of the trainings is summer 2021.

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 were allocated to provide three additional certified peer counselor trainings targeted to the Phase 1 regions. These trainings began in May 2020 and were completed at the end of June 2020 in support of 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

Between March and December 2020, 18 certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 regions completed the overview modules. One additional program staff also completed the overview.

Workforce Development

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

Current Status and Areas of Positive Impact

The WFD team has been involved in a range of initiatives. An initial draft of a comprehensive training plan has been circulated among OFMHS leadership. Once finalized, this document will provide guidance in the scope, process, and focus of training provided by WFD. It will also begin to define the parameters of the WFD team's functions with the broader workforce development system in the state of Washington. It should serve as a strategic document in defining the work of the WFD team and be useful as a means of communicating the team's functions to key stakeholders.

Other documents developed in support of the training plan include a series of brochures illustrating the career pathways for key work positions within the forensic mental health system. These are intended as an outreach and education tool for potential members of the workforce, to be used to increase awareness of and to stimulate interest in the field, as well as to provide information about the training and qualifications required. These brochures also provide a graphic illustration of the developmental pathway for each position, and they can be used to identify key points of engagement with potential workers to steer them toward positions in the forensic mental health workforce. These documents are currently under internal review.

WFD team members are delivering training in support of a recently implemented New Employee Orientation program for OFMHS staff. They have also been involved in developing training in an updated version of the Breaking Barriers curriculum for competency restoration, designed to train staff at the Residential Treatment Facilities, although the planned in-person training in this curriculum has been delayed by the COVID-19 pandemic.

In addition to providing the second annual report to the Legislature on forensic mental health workforce needs, the WFD team is preparing a "one-time report" to the Legislature, to specifically address the workforce needs to support each of the elements within the Agreement. This report will provide short-, medium-, and long-term recommendations for the next 10 years. In addition, the report will identify which recommendations would require low, medium, and high costs to implement.

Efforts to establish relationships and opportunities for collaboration within post-secondary education have resulted in dialogues with Shoreline Community College and the University of Washington. Shoreline Community College has a series of courses in forensic topics, and

consultation has begun to explore ways in which this may serve the needs of expanding the workforce required to serve the Trueblood class members. The University of Washington recently established The UW Center for Mental Health, Policy and the Law. This group has expressed interest in building partnerships. An introductory meeting was held on September 3, 2020. A follow up meeting took place March 5, 2021.

Areas of Concern

The WFD team is on track to complete all required element tasks on time or ahead of schedule. Currently, the major areas of concern are related to the short- and medium-term impacts of COVID-19. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. It will be important to continue to establish such relationships, to raise awareness of and to stimulate interest in forensic workforce career opportunities, and to provide education and training to prepare people to enter and successfully work in this field.

Recommendations to Address Concerns

The primary focus to address the identified concerns is to expand the reach and improve the effectiveness of online methods to reach the necessary audiences. Improvement of existing websites, enhancement of online and distance learning offerings, and presentations at virtual conferences and online classes are being pursued as potential ways to more effectively reach our audiences.

Data – Workforce Development

A search for relevant data to support strategic planning and to eventually document progress has been initiated and continues. Thus far, available workforce data from existing sources are not sufficiently specific to the forensic mental health field. It appears that more focused data will need to be collected from specific employers. Consultation with RDA and members of state workforce development organizations has been initiated and will continue.

Conclusions

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

Excitement over recent progress is tempered, however, by the challenging reality continuing to face the United States and a number of other countries throughout the world as of March 2021. Throughout fall 2020 and winter 2021, COVID-19 impacts intensified and illness became more widespread. The COVID-19 pandemic continued to place significant constraints on daily life and normal operations of the state's behavioral health system. COVID-19-related impacts to Trueblood initiatives are ongoing, and additional impacts could emerge, efforts to mitigate the effects notwithstanding.

By the next semi-annual report, to be published in late September 2021, HCA and the department expect they will be in the midst of implementing funding appropriated for sustaining Phase 1 programming and expanding into Phase 2 of the Agreement. The new 2021-2023 biennial budget and Phase 2 of the Agreement take effect concurrently on July 1. A negotiated Phase 2 final implementation plan is expected to be approved by the Court and in place to guide King County implementation activities.

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

Appendix A – Related Resources

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

State Agency Resources:

Washington State Criminal Justice Training Commission (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-resources

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*/2018*Trueblood*/623_OrderFinalApprovalSettlement.pdf*

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

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

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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

Appendix B – Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health Administration Forensic Navigator Program

QUARTERLY UPDATE

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

REPORTING PERIOD

Cumulative: July 1 ,2020 to December 31, 2020

Prepared by Washington State Department of Social and Health Services
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Contents

TABLE 1.

Forensic Navigator Enrollment and Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Total Population (unduplicated)								
Referred	545	100%	260	100%	106	100%	179	100%
Forensic Navigator Assigned	531	97%	253	97%	102	96%	176	98%
Among Clients Assigned a Forensic Navigator…								
Client Status (on last day of reporting period)								
Active	147	28%	73	29%	25	24.5%	49	28%
Pre-Competency Hearing	135	25%	66	26%	22	21.6%	47	27%
OCRP Enrolled	9	2%	--	--	--	--	--	--
Post-OCRP (Coordinated Transition)	3	1%	--	--	--	--	--	--
Discharged	384	72%	180	71%	77	75.5%	127	72%
Gender								
Female	107	20%	57	23%	14	13.7%	36	20%
Male	389	73%	183	72%	82	80.4%	124	70%
Unknown	35	7%	--	--	--	--	--	--
Age Group								
18-29	141	27%	68	27%	29	28.4%	44	25%
30-49	278	52%	134	53%	48	47.1%	96	55%
50+	112	21%	51	20%	25	24.5%	36	20%
Race/Ethnicity								
Non-Hispanic White	275	52%	136	54%	67	65.7%	72	41%
Minority	127	24%	95	38%	22	21.6%	--	--
Unknown	129	24%	22	9%	13	12.7%	94	53%
Most Serious Current Criminal Charge								
Felony	278	52%	127	50%	45	44.1%	106	60%
Misdemeanor	253	48%	126	50%	57	55.9%	70	40%
Housing Status at Program Intake								
Stably Housed	118	22%	47	19%	28	27.5%	43	24%
Unstably Housed	71	13%	41	16%	13	12.7%	17	10%
Homeless	154	29%	68	27%	40	39.2%	46	26%
Unknown	188	35%	97	38%	21	20.6%	70	40%

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

--Cells suppressed due to small n's.

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

TABLE 2.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Population								
Active Clients (at any point during the reporting period)	531	100%	253	100%	102	100%	176	100%
Average Daily Forensic Navigator Caseload		9.4		10.2		8.0		9.2
Among Active Clients (at any point during the reporting period)								
Forensic Navigator Services								
Assisting Clients with Attending Classes and Appointments	12	2%	--	--	--	--	--	--
Attending Competency Hearing	149	28%	75	30%	56	55%	18	10%
Client Meeting, Interview, and/or Observation	303	57%	139	55%	65	64%	99	56%
Client Support-Network Interactions	38	7%	21	8%	0	0%	17	10%
Completed Recommended Services Plan	265	50%	122	48%	56	55%	87	49%
OCRP Compliance Monitoring	15	3%	--	--	--	--	--	--
Contact with Client's Attorney or Prosecutor	357	67%	182	72%	62	61%	113	64%
Coordination of Care	184	35%	52	21%	49	48%	83	47%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	76	14%	36	14%	16	16%	24	14%
Information Gathering	521	98%	244	96%	102	100%	175	99%
Medication Monitoring	8	2%	--	--	--	--	--	--
Outreach Services - Attempted Contact	98	18%	13	5%	23	23%	62	35%
Outreach Services - Client Contact	55	10%	11	4%	15	15%	29	16%
Post-OCRP Client Check-in (up to 60 days)	2	0%	--	--	--	--	--	--
Post-OCRP Coordinated Transitions	1	0%	--	--	--	--	--	--
Referral to Services	138	26%	56	22%	30	29%	52	30%
Referrals								
Adult Protective Services (APS)	0	0%	0	0%	0	0%	0	0%
Community Outpatient Mental Health Services	6	1%	--	--	--	--	--	--
Designated Crisis Responder (DCR) Referral	0	0%	0	0%	0	0%	0	0%
EBT/ABD (Food/Cash Benefits)	4	1%	--	--	--	--	--	--
Educational Services	0	0%	0	0%	0	0%	0	0%
Employment Assistance	0	0%	0	0%	0	0%	0	0%
Forensic HARPS Services	93	18%	51	20%	15	15%	27	15%
Forensic PATH Services	99	19%	42	17%	19	19%	38	22%
Home and Community Services	1	0%	--	--	--	--	--	--
Housing Services (Non-HARPS)	1	0%	--	--	--	--	--	--

TABLE 2.

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Job Training	0	0%	0	0%	0	0%	0	0%
Medical Insurance Services	1	0%	--	--	--	--	--	--
Other Community Based Resource	3	1%	--	--	--	--	--	--
Primary Health Care/Dental Care	1	0%	--	--	--	--	--	--
SSI/SSDI	1	0%	--	--	--	--	--	--
Substance Use Disorder Treatment	5	1%	--	--	--	--	--	--
Supported Employment	1	0%	--	--	--	--	--	--
VA Benefits	0	0%	0	0%	0	0%	0	0%

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

--Cells suppressed due to small n's.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Clients Discharged								
Clients discharged during the reporting period	384	100%	180	100%	77	100%	127	100%
Discharge Reason								
Charges Dismissed	33	9%	18	10%	--	--	--	--
Client Death	1	0%	--	--	--	--	--	--
Client Determined Competent	122	32%	66	37%	29	38%	27	21%
Dismiss & Refer (to DCR)	34	9%	23	13%	--	--	--	--
Diversion Program(s)	0	0%	0	0%	0	0%	0	0%
Felony (72-Hour) Civil Conversion	6	2%	--	--	--	--	--	--
Civil Conversion - Removal from OCRP	1	0%	--	--	--	--	--	--
Inpatient Restoration	106	28%	60	33%	22	29%	24	19%
Not Restorable - Developmental Disability	2	1%	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	1	0%	--	--	--	--	--	--
Order Canceled or Withdrawn	1	0%	--	--	--	--	--	--
Re-arrest	12	3%	--	--	--	--	--	--
Refused Forensic Navigator Services	4	1%	--	--	--	--	--	--
Released from Jail on Personal Recognizance (PR)	60	16%	--	--	--	--	53	42%
Successful OCRP Completion - Coordinated transition completed	0	0%	0	0%	0	0%	0	0%
Successful OCRP Completion - Summary of treatment completed	0	0%	0	0%	0	0%	0	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	1	0%	--	--	--	--	--	--
Length of Stay								
Average Length of Stay in Forensic Navigator Program (days)	384	26.7	180	24.9	77	27.1	127	29.1

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

--Cells suppressed due to small n's.

Forensic Navigator Program Definitions

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

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

Post-OCRP Client Check-in (up to 60 days)	After a client successfully completes OCRP, Forensic Navigator attempted to follows-up with the client and/or community provider (via phone, email, or in person) to determine whether the client is receiving community mental health services.
Post-OCRP Coordinated Transitions	Forensic Navigator engaged in any form of communication (phone, email, in-person) with community providers to establish on-going behavioral health care for a client after OCRP discharge.
Information Gathering	Forensic Navigator gathered one or more documents, or other reported information relevant to the client, prior to the competency evaluation hearing. Includes, but not limited to, behavioral health, educational, and/or law enforcement agency records.
Referral to Services	Forensic Navigator referred a client to a specific outpatient service (substance use, mental health treatment, employment, etc.). Active Forensic Navigator support on behalf of or in conjunction with a client to connect them to another provider, agency or organization for services.
Referrals	Referrals made by the Forensic Navigator on behalf of a client. Among active clients (at any point during the reporting period).
Adult Protective Services (APS)	Forensic Navigator referred client to Adult Protective Services.
Community Outpatient Mental Health Services	Forensic Navigator referred client to Community Outpatient Mental Health Services.
Designated Crisis Responder (DCR) Referral	Forensic Navigator referred client to the Designated Crisis Responders (DCRs)
EBT/ABD (Food/Cash Benefits)	Forensic Navigator aided the client in applying for or reestablishing EBT/ABD (Food/Cash Benefits).
Educational Services	Forensic Navigator aided the client in obtaining educational services (e.g. classes, school, technical).
Employment Assistance	Forensic Navigator aided the client in obtaining employment/vocational services.
Forensic HARPS Services	Forensic Navigator referred client to Forensic HARPPS Services.
Forensic Path Services	Forensic Navigator referred client to Forensic PATH Services.
Home and Community Services	Forensic Navigator referred client to Home and Community Services.
Housing Services (Non-HARPS)	Forensic Navigator aided the client in applying for or reestablish Housing Services (Non-HARPS).
Job Training	Forensic Navigator aided the client in obtaining job training (e.g. classes, school, technical).
Medical Insurance Services	Forensic Navigator referred client to Medical Insurance Services.
Other Community Based Resource	Forensic Navigator referred client to Other Community Based Resource.
Primary Health Care/Dental Care	Forensic Navigator aided client is establishing or reestablishing Primary Health Care/Dental Care.
SSI/SSDI	Forensic Navigator aided the client in applying for SSI/SSDI.
Substance Use Disorder Treatment	Forensic Navigator aided the client in establishing or reestablishing Substance Use Disorder Treatment.
Supported Employment	Forensic Navigator aided the client in obtaining supported employment (e.g. classes, school, technical).
VA Benefits	Forensic Navigator aided the client in obtaining Veterans Services and/or benefits.
DISCHARGE TABLE	
Discharge Reasons	The reason Forensic Navigator services ended and the individual was discharged from the program.
Charges Dismissed	The criminal charges associated with the order for competency services were dismissed.
Client Death	Client deceased.
Client Determined Competent	Client found competent by the court.
Dismiss and Refer (to DCR)	Charges were dismissed and the client was referred by the court to the Designated Crisis Responders for evaluation.
Diversion Program(s)	Client ordered by court into diversion program (e.g. prosecutorial diversion program)
Felony (72-Hour) Civil Conversion	The court ordered a forensic to civil conversion commitment (72 Hour Felony) at the initial competency hearing.

Civil Conversion - Removal from OCRP	The court ordered a forensic to civil conversion commitment (72 Hour Felony/Misdemeanor Evaluation) after the client had been ordered to OCRP.
Inpatient Restoration	Client ordered by court into state psychiatric hospital for inpatient restoration services.
Not Restorable - Developmental Disability	Navigator services ended because the level of the client's disability indicated to the court that the client could not be restored.
Not Restorable - Pre-Hearing/OCRP	Navigator services ended at the pre-hearing stage because prior findings of not restorable indicated to the court that the client could not be restored. Or the client was evaluated for competency to stand trial while in OCRP and was determined by the court to be not restorable.
Order Canceled or Withdrawn	The court order for competency services was canceled or withdrawn.
Re-arrest	Individual re-arrested and unable to continue Forensic Navigator Program services.
Refused Forensic Navigator Services	Individual refused Forensic Navigator Program services prior to the initial competency hearing.
Released from Jail on Personal Recognizance (PR)	Individual released from jail at, before or after the initial competency evaluation order, but prior to the initial competency hearing or finding, and the Forensic Navigator completed all steps in the associated warm hand-off as documented in the Forensic Navigator Desk Manual.
Successful OCRP Completion - Coordinated transition completed	Individual ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator completed a coordinated transition for the client from OCRP to community behavioral health services.
Successful OCRP Completion - Summary of treatment completed	Individual was ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator did not complete a coordinated transition for the client from OCRP to community behavioral health services, but did complete a summary of treatment.
Violation of OCRP Conditions of Participation/Court Ordered CR	Individual violated OCRP conditions of participation and/or conditions of release, and was removed from OCRP.
Length of Stay	
Average Length of Stay in Program (days)	The average number of days from the date the Forensic Navigator was assigned to the date the individual was discharged from the program.

Appendix C – Crisis Housing Vouchers

Crisis Housing Vouchers

Voucher Disbursals by Crisis Triage and Stabilization Facilities

QUARTERLY UPDATE

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

REPORTING PERIOD

Cumulative: December 1, 2019 to December 31, 2020

Prepared by Washington State Department of Social and Health Services
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Contents

TABLE 1.

Crisis Triage and Stabilization Facility Housing Vouchers

CUMULATIVE: December 1, 2019 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Vouchers Disbursed	89	100%	20	22%	13	65%	56	63%
Recipients (unduplicated)	64	100%	--	--	--	--	--	--
Total Amount Disbursed	$ 80,250	N/A	$ 21,111	N/A	$ 14,800	N/A	$ 44,339	N/A
Average Amount Per Recipient	$ 1,254	N/A	$ 1,056	N/A	$ 1,480	N/A	$ 1,304	N/A
FACILITY REFERRAL SOURCE								
Crisis Call Center	1	2%						
Family/Friend	1	2%						
Hospital	29	45%						
Mobile Crisis Response	6	9%						
Designated Crisis Responder	0	0%						
Tribe or Indian Healthcare Provider	0	0%						
Emergency Responder	1	2%						
Other Healthcare Provider	6	9%						
Law Enforcement (Police, Co-Responders)	12	19%						
Court/Criminal Justice Referred	0	0%						
Self	6	9%						
Other	2	3%						
GENDER								
Female	17	27%						
Male	46	72%						
Other/Unknown	1	2%						
AGE GROUP								
18-29	11	17%						
30-49	33	52%						
50+	19	30%						
Unknown	1	2%						
RACE/ETHNICITY								
Non-Hispanic White	40	63%						
Minority	24	38%						
Unknown	0	0%						

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Voucher Recipients…								
FORENSIC HARPS (FHARPS) STATUS								
Referred to FHARPS	59	92%						
Contacted by FHARPS staff	59	92%						
Enrolled in FHARPS	59	92%						
Housed or sheltered by FHARPS	51	80%						
Among Individuals Housed or Sheltered by FHARPS…								
FIRST FHARPS HOUSING TYPE								
Permanent	0	0%						
Transitional	1	2%						
Shelter/emergency	49	96%						
Other	1	2%						

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

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

Crisis Triage and Stabilization Facility Housing Voucher Definitions

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

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

Appendix D – FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

QUARTERLY UPDATE

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

REPORTING PERIOD

Cumulative: March 1, 2020 to December 31, 2020

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

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Referred	611	100%	277	100%	126	100%	208	100%
Contacted	355	58%	168	61%	107	85%	80	38%
Enrolled	319	52%	159	57%	84	67%	76	37%
Among Referred Individuals…								
REFERRAL SOURCE								
Trueblood partner programs	267	44%	123	*44%*	33	*26%*	111	*53%*
Forensic Navigator	*79*	*13%*	*40*	*14%*	*13*	*10%*	*26*	*13%*
Forensic PATH	*73*	*12%*	*39*	*14%*	--	--	--	--
OCRP	*0*	*0%*	*0*	*0%*	*0*	*0%*	*0*	*0%*
Crisis Stabilization Center	*97*	*16%*	--	--	--	--	*44*	*21%*
Mobile Crisis Response	*0*	*0%*	*0*	*0%*	*0*	*0%*	*0*	*0%*
Co-Response Team	*18*	*3%*	--	--	--	--	--	--
Behavioral Health Facility - Outpatient	131	21%	33	12%	71	56%	27	13%
Inpatient Facility	30	5%	--	--	--	--	--	--
Family/Self	40	7%	--	--	--	--	--	--
Other	143	23%	83	30%	15	12%	45	22%
Among Contacted Individuals…								
LOCATION OF INITIAL CONTACT								
Phone	263	74%	133	79%	106	99%	24	30%
Court	0	0%	0	0%	0	0%	0	0%
Hotel/Motel	1	0%	--	--	--	--	--	--
Jail	20	6%	--	--	--	--	--	--
Crisis Stabilization Center	44	12%	11	7%	0	0%	33	41%
Behavioral Health Facility - Outpatient	4	1%	--	--	--	--	--	--
Inpatient Facilty	9	3%	--	--	--	--	--	--
Shelter	2	1%	--	--	--	--	--	--
Street/encampment	0	0%	0	0%	0	0%	0	0%
Temporary Residence	2	1%	--	--	--	--	--	--
Other	10	3%	--	--	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Enrolled Individuals…								
PARTICIPANT STATUS (on last day of reporting period)								
Active	163	51%	69	43%	50	60%	44	58%
Discharged	156	49%	90	57%	34	40%	32	42%
GENDER								
Female	114	36%	59	37%	30	36%	25	33%
Male	201	63%	97	61%	54	64%	50	66%
Other/Unknown	4	1%	--	--	--	--	--	--
AGE GROUP								
18-29	73	23%	41	26%	19	23%	13	17%
30-49	181	57%	75	47%	56	67%	50	66%
50+	61	19%	--	--	--	--	--	--
Unknown	4	1%	--	--	--	--	--	--
RACE/ETHNICITY								
Non-Hispanic White	179	56%	66	42%	56	67%	57	75%
Minority	121	38%	78	49%	28	33%	15	20%
Unknown	19	6%	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT								
Unstably Housed	72	23%	28	18%	27	32%	17	22%
Homeless	246	77%	130	82%	57	68%	59	78%
Unknown	1	0%	--	--	--	--	--	--

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

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

-- Cells suppressed due to small n's.

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	319	100%	159	100%	84	100%	76	100%
Housed or Sheltered	267	84%	136	86%	71	85%	60	79%
Among Enrolled Individuals…								
SERVICES PARTICIPANT AGREED TO								
Subsidies only	16	5%	--	--	--	--	--	--
Support Services and Subsidies	303	95%	148	93%	84	100%	71	93%
Among Housed/Sheltered Individuals…								
FIRST HOUSING TYPE								
Permanent	16	6%	--	--	--	--	--	--
Transitional	51	19%	27	20%	--	--	--	--
Shelter/emergency	193	72%	96	71%	44	62%	53	88%
Other	7	3%	--	--	--	--	--	--

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

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

-- Cells suppressed due to small n's.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - December 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)	319		159		84		76	
Enrolled	319	100%	159	100%	84	100%	76	100%
Active on last day of reporting period	163	51%	69	43%	50	60%	44	58%
Discharged during reporting period	156	49%	90	57%	34	40%	32	42%
Among Individuals Discharged…								
SUBSIDY								
Average total subsidy since enrollment	$ 4,928	N/A	$ 4,864	N/A	$ 5,643	N/A	$ 4,412	N/A
DISCHARGE REASON								
Transitioned to other housing support	23	15%						
Received maximum subsidy	*7*	4%						
Did not receive maximum subsidy	*16*	10%						
Transitioned to self-support	16	10%						
Admitted to a facility	5	3%						
Received maximum assistance (no transition)	26	17%						
Withdrew	15	10%						
Loss of contact	54	35%						
Served by another FHARPS team	1	1%						
Other	16	10%						
LENGTH OF SUPPORT								
Average Length of Stay in Program (days)	127	N/A	120	N/A	123	N/A	151	N/A
HOUSING STATUS AT DISCHARGE								
Stably Housed	43	28%						
Unstably Housed	7	4%						
Homeless	37	24%						
In a facility	13	8%						
Unknown	56	36%						

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

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

FHARPS Definitions

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

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

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

Appendix E – FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

QUARTERLY UPDATE

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

REPORTING PERIOD

Cumulative: March 1, 2020 to December 31, 2020

Prepared by Washington State Department of Social and Health Services
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Contents

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: MARCH 1, 2020 - DECEMBER 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Number on Referral List	752	100%	464	100%	117	100%	171	100%
Number on Prioritized Referral List	372	49%	225	48%	50	43%	97	57%
Attempted Contacts	415	55%	203	44%	81	69%	131	77%
Contacted	208	28%	74	16%	55	47%	79	46%
Enrolled	102	14%	42	9%	41	35%	19	11%
Among Enrolled Individuals…								
Client Status								
Active (on last day of reporting period)	87	85%	29	69%	39	95%	19	100%
Discharged	15	15%	--	--	--	--	--	--
Average Length of Stay in Program (days)	131		128		151		n/a	
Gender								
Female	23	23%	--	--	--	--	--	--
Male	77	77%	35	83%	31	78%	11	61%
Unknown	2	2%	--	--	--	--	--	--
Age Group								
18-29	34	33%	16	38%	--	--	--	--
30-49	56	55%	19	45%	26	63%	11	58%
50+	12	12%	--	--	--	--	--	--
Race/Ethnicity								
Non-Hispanic White	42	41%	--	--	20	49%	--	--
Minority	44	43%	--	--	16	39%	--	--
Unknown	16	16%	--	--	--	--	--	--
Housing Status at Program Enrollment								
Stably Housed	16	16%	--	--	--	--	--	--
Unstably Housed	23	23%	--	--	--	--	--	--
Homeless	58	57%	26	62%	23	56%	--	--
Unknown	4	4%	--	--	--	--	--	--
Housing Status at Program Exit								
Stably Housed	1	7%	--	--	--	--	-	-
Unstably Housed	5	33%	--	--	--	--	-	-

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Homeless	8	53%	--	--	--	--	-	-
In a Facility	0	0%	--	--	--	--	-	-
Unknown	1	7%	--	--	--	--	-	-

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

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

FPATH Definitions

Variable name	DEFINITION
Total - All Regions	**Includes all Phase One Regions: Pierce, Southwest, Spokane.**
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County
Southwest Region	Clark, Klickitat, and Skamania Counties
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties
ENROLLMENT TABLES , Quarter and Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated, meaning if a person is referred or enrolled more than once in FPATH during a reporting period, the most recent case information is included.
Number on Referral List	Number of individuals who appeared on the Forensic PATH eligibility list during the reporting period. Eligibility criteria include having two or more competency evaluation referrals in the past 24 months.
Number on Prioritized Referral List	Number of individuals who appeared on the prioritized Forensic PATH eligibility list during the reporting period. Eligibility is prioritized based on meeting any of the following criteria: (1) having 4 or more competency evaluation referrals in the previous 24 months; (2) residing in a rural county; or (3) having any of the following housing statuses: City/County Jail, Emergency Housing/Shelter, Homeless, Unstably Housed, or living in an institution.
Attempted Contacts	Individuals with an attempted (unsuccessful) contact during the reporting period.
Contacted	Individuals successfully contacted by the program during the reporting period.
Enrolled	Individuals who have agreed to formally accept Forensic PATH services and referrals, and were enrolled into the program during the reporting period.
Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Minority categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Minority	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was unreported.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.

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