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

Semi-Annual Report 6

September 29, 2022

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

Table of Contents

List of Abbreviations in this Document

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

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

Preamble

Each March and September, a semi-annual report is published to review the implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress during the first half of 2022. The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new Trueblood programs initially launched during the Phase 1 implementation of the Settlement Agreement and those operations are ongoing. Additionally, work continues to implement Phase 2 of the Settlement Agreement in the King region.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes, where possible. For this SAR, FPATH reporting includes service and referral data, and several programs (Forensic Navigator, FHARPS, and FPATH) have expanded race/ethnicity reporting. Phase 2 (King region) data has been added for CIT. Phase 2 data will be added for other programs as they become available.

Most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. 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 a few exceptions noted in the report, the data is current through June 30, 2022. It is expected that data on program participation will typically be included in the SAR after programs have been operational for at least two calendar quarters.

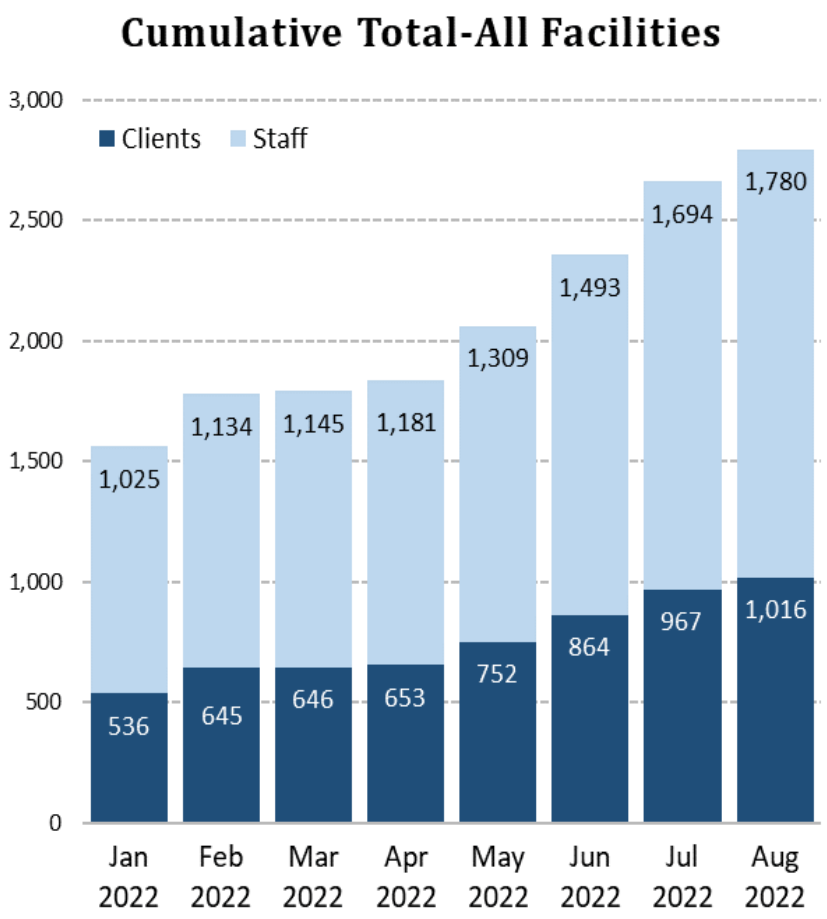
Impacts of the COVID-19 Pandemic

In March 2020, the COVID-19 pandemic began impacting Trueblood implementation efforts. The state of Washington has experienced an ongoing state of emergency since mid-March 2020, and this has affected aspects of operations and preparations for service enhancements. Initial effects included supply procurement challenges, impacts on construction, and delays to competency evaluation interviews when there was no safe way to interview a defendant. Rapid changes in the early spring and summer of 2020 required significant adaptations, and responding to COVID-19 outbreaks in many of our facilities has required additional changes since the pandemic started.

As permitted by evolving employee, client, and contractor safety considerations, the state is continuously undertaking efforts to minimize impacts to settlement activities, but impacts remain. More recently, in summer and fall 2021, the COVID-19 Delta variant intensified the pandemic's impacts, and the governor mandated that most state employees become vaccinated. Before the Delta variant could even wane, a new, more infectious but less deadly variant, Omicron, emerged placing even greater stress on our state's medical systems. Primary implementation impacts due to the Delta and Omicron variants and other COVID-19-specific systemic impacts, as well as the state's efforts to overcome those impacts, are discussed below. Additionally, the table immediately below is illustrative of the impact of the recent variants on BHA facilities. From Dec. 31, 2021 through Jan. 31, 2022, cumulative BHA COVID-19 cases increased 80 percent due to the newly dominant Omicron variant. Omicron infections have finally slowed down heading into Q3, although it and its subvariants remain the dominant strain of COVID-19.

FIGURE 1.

COVID-19 Cases All BHA Facilities
Client and Staff
AUGUST 31, 2022



Data Source: BHA 24-7 Staff-Client Counts Weekly COVID Report

Note: "All facilities" includes several BHA facilities that do not serve Trueblood clients. However, as of August 31, 2022, more than 88 percent of all COVID-19 cases involve the state hospitals or RTFs.

Workforce Challenges-Recruitment and Retention

Competing for staff talent with the private sector in the context of the ongoing pandemic leaves many positions, especially at our treatment facilities, chronically short-staffed. BHA identifies and implements creative solutions within our existing authority and partners with executive leadership, state human resources, labor, and other partners to develop and implement innovative approaches to recruiting and retaining critical staff positions. During spring and summer 2022, DSHS has taken several steps to alleviate staffing challenges. Steps taken included hiring more contractors and travel nurses, adding recruitment resources to both WSH and ESH, especially to hire nurses, partnering with the Washington State Office of Financial Management to adjust pay ranges for certain positions, expanding our successful forensic evaluator training and recruitment post-doctoral program from three-to-five interns this year, and engaging a successful demand to bargain with labor partners to allow for contract evaluations to take place until vacancies can be filled. Working toward implementing new policies and practices to attract and retain passionate, talented staff remains critical to success, and BHA will continue this critical focus into fall 2022.

National Staffing Crisis and Pandemic Staff Burnout

A new challenge is emerging in the department's efforts to operate restoration beds, and to open new restoration capacity that is currently nearing completion of construction. The nation as a whole faces an acute staffing crisis in healthcare. On May 23, 2022, the U.S. Surgeon General issued a press release summarizing a recent Surgeon General Advisory on the healthcare worker crisis:

> *Today, United States Surgeon General Dr. Vivek Murthy issued a new Surgeon General's Advisory highlighting the urgent need to address the health worker burnout crisis across the country. Health workers, including physicians, nurses, community and public health workers, nurse aides, among others, have long faced systemic challenges in the health care system even before the COVID-19 pandemic, leading to crisis levels of burnout. The pandemic further exacerbated burnout for health workers, with many risking and sacrificing their own lives in the service of others while responding to a public health crisis[1].*

Washington state, and the facilities run by the department, are not immune to these challenges. The facilities providing restoration services are currently facing acute staffing shortages. As of early September, vacancies in several critical BHA patient-centered job classes ranged from 30-40 percent. The ability to maintain current restoration capacity is at risk, and staffing new

[1] https://www.hhs.gov/about/news/2022/05/23/new-surgeon-general-advisory-sounds-alarm-on-health-worker-burnout-and-resignation.html

physical capacity is expected to be extremely challenging. To address this, the department is engaging several approaches:

1. Implemented hiring and retention incentives to keep current staff and attract new staff. The incentives are now being offered. While this is an important tool in addressing this crisis, other organizations in the private and public sphere are also using similar tactics, leading to an "arms race" in competing for the extremely limited pool of available people to hire. Additional pay raises that were previously funded became effective on July 1, 2022.

2. The department is using contract staff to fill critical vacancies and keep current capacity operating. While this is a short-term solution, the extreme cost of the contracted staff means that contract staff are not a sustainable long-term solution.

3. The department is also pursuing contract staff for vacant forensic evaluator positions. This is anticipated to increase capacity for in-jail evaluations as well as assist with completion of inpatient competency evaluations. The department also plans to request increased evaluation staff in the next legislative session.

4. The department has diversified staffing for certain functions, to use different types of credentials and staff to complete necessary work. For example, at WSH PhDs who are not licensed in Washington are working under a Washington regulatory scheme that allows them to work under supervision as an "agency affiliated counselor" to complete work within the civil center (not for class members). However, even with these efforts in place, there are simply not enough people in the nationwide employment pool. With healthcare providers across the industry facing critical shortages, those providers are engaged in similar mitigations and attempts to recruit from a limited pool of staff. Attracting new staff to department facilities often means that these staff are moving from other important mental health programs, which results in a "rob Peter to pay Paul" situation that leaves programs across the mental health system understaffed. This potentially includes and affects staffing for other Contempt Settlement Agreement programs. The department will continue with these efforts with the goal of ensuring that existing restoration capacity can operate, and that new capacity can open. However, the gravity of the current situation cannot be understated: If the available staffing does not improve, the department will not be able to keep existing beds open[2].

[2] Document 907-1. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Trueblood Quarterly Implementation Status Report, June 2022, Filed June 16, 2022, pp. 4-6.

Background

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

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

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

On Dec. 11, 2018, the Court approved a settlement agreement related to the contempt findings in this case. The Settlement Agreement is designed to move the state closer to compliance with the Court's injunction. The Settlement Agreement includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified geographic regions. The Settlement Agreement includes three initial phases of two years each and can continue to additional phases. Services and regions implemented in each phase are evaluated and continued into future phases of the settlement. Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium. Phase 1 is complete as of June 30, 2021, and Phase 2 is the current active settlement phase:

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

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

Definitions

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

Agreement: Trueblood Contempt Settlement Agreement or Settlement Agreement

Certified peer counselor or CPC: A person who self identifies as a consumer of behavioral health services, is grounded in their recovery, and who has completed the specialized state training and passed a state exam. CPCs use their personal lived experience of recovery from behavioral health challenges to build rapport, promote recovery, empower, and inspire hope to the 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: Allow unhoused or unstably housed persons in behavioral health crisis to obtain short-term housing assistance for up to 14 days post discharge from crisis triage/stabilization facilities and who have criminal court involvement or referred by law enforcement.

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

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

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

Forensic Projects for Assistance in Transition from Homelessness or FPATH: An intensive case management program that identifies people most at risk of referral for competency restoration. Individuals identified on a referral list generated by Research and Data Analysis have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those individuals most vulnerable to access housing, treatment and resources in an effort to divert them from future intersections with law enforcement. Once contacted, clients are provided wrap around services in an effort to reduce barriers to accessing care and services.

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

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

Health Care Authority or HCA: Washington State Health Care Authority

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

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

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

Residential Treatment Facilities or RTFs: (1) DSHS usage refers to an inpatient facility that treats 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 provides ongoing project monitoring analyses through monthly and semi-annual reporting. Monthly monitoring reports provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness goals, and slowing the rate of growth in competency evaluation referral volume. Most commonly, this information is available as part of the monthly reports to the court-appointed monitor and can be found on DSHS' Trueblood website[3]. Semi-annual reporting on implementation elements (e.g., FPATH and the Forensic Navigator Program) provides timely information on client engagement in implementation programs. Monitoring measures include:

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

Trueblood semi-annual dashboards contain client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for all Trueblood implementation programs but Mobile Crisis Response (see MCR section for an update on data collection). Data come from a range of sources from tools or system adaptations under continuous development. Additional program measures may be added as feasible.

RDA continues work with various teams within DSHS and HCA to establish a reliable and efficient processing system for reporting quarterly data. This requires establishing a coordinated infrastructure including, but not limited to, secure data transmission and storage; automated data error checks; a framework to download, merge, and package data; data definitions and counting rules; and validated code and templates for data analyses and reporting. Building this infrastructure is complex due to the number of data sources, different collection/reporting methods, data changes, and data quality issues. Once data and data processes are stabilized and mature (see below), the time from submission to Trueblood dashboard reporting will decrease, assuming providers submit required data in a timely manner. RDA is on track to begin quarterly reporting for programmatic use to begin in late 2022 for Forensic Navigators. Additional

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

programs will shift to quarterly reporting iteratively based on data quality, stability, and complexity of the processing. External dashboards will require additional work to ensure appropriate data protections and confidentiality requirements.

HCA continues work to identify and implement long-term data collection tools for programs, and strategies to optimize data quality and efficient sharing to support timely reporting.

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

All client-level data is aggregated and suppressed when necessary to protect individual confidentiality. Data tables in this report reflect what was possible to produce from existing data received by the report deadline. Additional data will be provided over time as both data quality improves, and the numbers served increase. This report, for example, includes King County data for Forensic Navigators, FPATH, and FHARPS.

Longer-term Impact Analyses

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

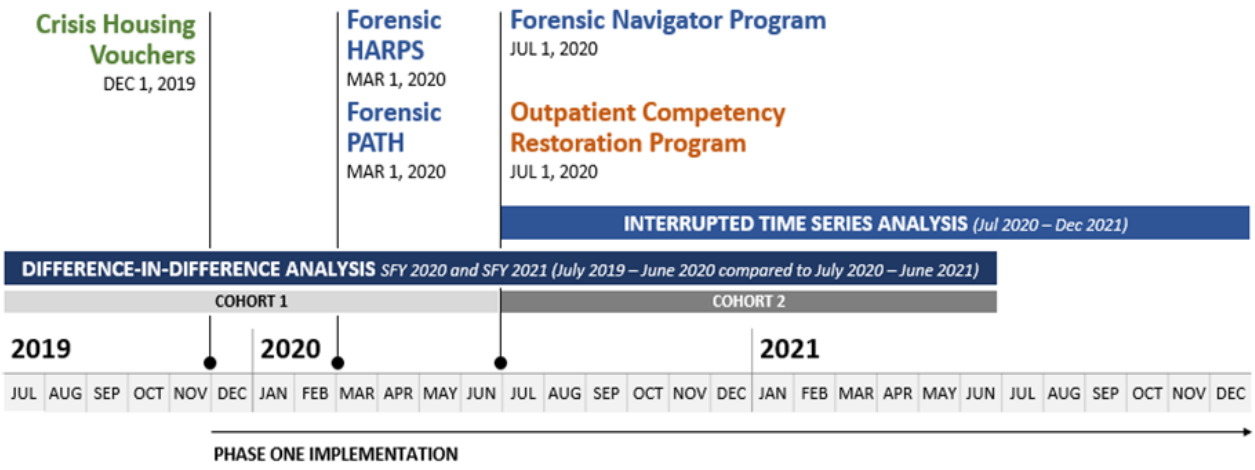
- Use of mental health and substance use disorder treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

Evaluations include assessments of the overall phased regional impact of Settlement Agreement components on outcomes through two methods: (1) an interrupted time series analysis to assess the impact of the Trueblood implementation programs on the number of competency referrals; and (2) a difference-in-difference analysis to assess impacts on behavioral health access and social outcome metrics. Findings from both methods are included in this report. Figure 2 shows the reference periods for each analysis for this report, and the following sections outline the method and findings from each approach.

FIGURE 2.

Trueblood Evaluation Reference Periods

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



Interrupted Time Series Analysis

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

The first such analysis was presented for the first nine months of implementation (July 2020 to March 2021) in the September 2021 semi-annual report. For that period, there was a small decrease in the rate of competency evaluation orders (not statistically significant) in Phase 1 regions compared to the balance of the state, no change in the rate of competency restoration orders, and no change in the rate of orders for other sub-populations (Trueblood in-jail orders and inpatient orders).

The analysis was recently updated to include data for the first 18-months of full implementation (July 2020 to December 2021). Findings include:

- Competency Evaluations – A decrease in the rate of competency evaluation orders in Phase 1 regions of 1.6 per 100,000 residents relative to the expected rate. This was significant at $p<.05$.[4]

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

- Competency Restorations – Small increase in the rate of *overall* competency restoration orders of 0.59 per 100,000 residents relative to expected, significant at p<.05.
    - There was no significant impact on restoration orders for Trueblood class members.
- Inpatient Restorations – No significant program impact on inpatient restoration orders.

This analysis will be updated periodically as data and resources allow.

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

- Mental Health Treatment: A significant increase in the rate of mental health treatment among individuals with at least one competency evaluation order in Phase 1 regions compared to the balance of the state at p<.0001.[5]
- Substance Use Disorder (SUD) Treatment: An increase in the rate of SUD treatment among those with at least one competency evaluation order and SUD treatment need in Phase 1 regions compared to balance of the state. This was approaching significance at p<.0553. When analysis was restricted to Trueblood class members (those in jail while awaiting competency services), the difference was significant at p<.05.
- No difference found between Phase 1 and the balance of state on other outcome measures, including homelessness, incarceration, state hospital admissions, emergency department visits, or hospitalizations.

This analysis will be updated periodically as data and resources allow.

Forthcoming: Individual Program Evaluation(s)
Evaluating the impact of specific Settlement Agreement components based on propensity-score matching methods were projected to be available no earlier than March 2022. This assumed sufficient study populations, with a minimum six-month follow-up period, seven months for data maturity, and at least two months for data integration, analysis, and reporting. Having recently

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

completed the first-year impacts at the aggregate level, RDA is now working to determine which is the best candidate for program-level evaluation based on number of participants, overlapping enrollment with other Trueblood programs, and available data required for the outcome period.

Implementation Plan Elements

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

Each element's report considers the following five items as they relate to the element specifically and to the Settlement Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) available data pertaining to the element. Data tables included in this report reflect data through June 30, 2022, with exceptions noted.

Competency Evaluation-Additional Evaluators

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

Current Status and Areas of Positive Impact

From July 1, 2019, to June 30, 2020, OFMHS hired 13 evaluators meeting the Settlement Agreement requirements for Fiscal Year 2020. In Fiscal Year 2021, OFMHS hired 10 additional forensic evaluators with start dates ranging from July 1, 2020, to June 1, 2021. Five of these positions were elements of the Settlement Agreement while the additional five evaluators filled pre-existing vacancies. With staff movement naturally occurring, as of Aug. 1, 2022, 66 of the 77 positions are filled. Six of the vacant positions have been filled with start dates ranging from February to August. Recruitment is occurring to fill the remaining vacancies with an emphasis on filling positions located in the east side of the state. Aided in part by OFMHS' training programs, WSH is able to staff clinical psychologists that complete the treatment reports to the court for civil commitment, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations). Staffing forensic evaluators have allowed a record number of forensic risk assessments to be completed. During the January-June 2022 reporting period, 66 FRAs have been completed. Now that there is no longer any backlog of forensic risk assessments to complete at WSH, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. Additionally, OFMHS is working with ESH to have all forensic risk assessments caught up and on the same evaluation schedule as WSH. ESH completed 14 FRAs from January-June 2022; however, due to staffing challenges, the department is currently recruiting contractors to help in meeting the June 2023 time frame to have the new system in place. This is in addition to continuing to recruit to fill vacant positions and the addition of two post-doctoral positions in the eastern region. While completion of risk assessments for the NGRI population at the state hospitals assists in vacating forensic beds that can be occupied by those in need of inpatient competency restoration services, completion of competency evaluations for class members remains prioritized over other types of evaluations, including forensic risk assessments.

Areas of Concern

In Fiscal Year 2022, Washington state had its highest number of referrals for all competency evaluations (6,491[6]) to date. Even with continued pandemic-related disruptions in services, referral levels increased dramatically by 39-percent from FY21. The previous record for competency evaluation referrals occurred in FY20 and was 4,712 referrals[7]. This growth came in spite of the 12 fine-funded contempt programs, three state-funded prosecutorial diversion programs that continued operating, and the statistically significant impact of Trueblood interventions demonstrated in the Phase 1 regions. Without these programs, demand for evaluations likely would have increased even more in the past. The arrival of COVID-19 in early winter 2020, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for months during the pandemic. Even as the criminal court system has re-opened, COVID-19 infections continue to result in decreased in-person access to clients and fewer beds to serve our clients, especially with the Delta and Omicron variants. Further, the good cause process continues to have a low response rate across the state for requests for time extensions for jail-based evaluations.

Recommendations to Address Concerns

OFMHS continues developing and implementing telehealth resources for jails throughout the state. Establishing this technology in multiple locations around the state (especially in rural areas) allows OFMHS to conduct more evaluations, thereby helping to meet court-ordered requirements, making it easier for attorneys to be present for their clients' interviews, and minimizing risks for all those involved during this pandemic. As part of this work, OFMHS continues working with IT to reorganize the telehealth committee, so that IT becomes a committee co-chair and has a more active role in the process to more immediately respond to issues in the field.

To date, OFMHS has reached out to all county jails in the state as well as tribal and municipal jails to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). Currently, additional jails with telehealth capacity on the west side of the state include the Nisqually Indian Tribe's Nisqually Corrections Center as well as city jails in Aberdeen, Forks, Issaquah, Kent, and Puyallup, and county jails in Clallam, Clark, Cowlitz, Jefferson, King (King County Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and South Correctional Entity in Des Moines), Kitsap, Mason, Pacific, Skagit, Skamania, Thurston, Wahkiakum, and Whatcom counties. Additional jails on the east side with telehealth capacity now include those in Benton, Ferry, Franklin, Grant, Kittitas, Klickitat, Okanogan, Spokane, Stevens, Walla Walla, Whitman, counties, and Yakima city jail. In addition, Airway Heights Corrections and the Colville Tribal Jail now have VTC capabilities.

[6] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2022.
[7] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2022.

Additionally, a meeting was held at the end of July 2021 with defense counsel in King County to discuss timelines for jail-based evaluations and the use of telehealth. A second meeting in late summer was held to share data on telehealth evaluations and its efficacy. Meetings will continue with King County to help improve and streamline telehealth evaluations. Ongoing ad hoc meetings with Pierce County defense counsel to maximize scheduling using a block scheduling format has allowed for evaluations to be completed in an expeditious manner.

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 3. Overall, compliance rates for jail-based evaluations remains high. In May 2022, 84 percent of evaluation orders were completed within court-ordered time limits. Ninety percent of orders in the WSH catchment area were completed within court-ordered time limits. In recent months, the compliance rate at ESH has declined. The reasons for the decline in compliance on the east side are threefold: (1) near record highs for evaluation referrals; (2) staff vacancies; and (3) scheduling issues that involved new processes and working out telehealth connectivity disruptions. To address vacancies, robust recruitment continues and recently BHA bargained to allow forensic contractors to assist in completing evaluations. Furthermore, the scheduling issues have been addressed and are monitored to ensure disruptions to the evaluation process are minimized.

The department examined the number of orders filed by the courts between January 2017 and June 2022 and projected the number of evaluation orders through June 2025 using an exponential smoothing forecast model[8]. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood Agreement and Engrossed Substitute Senate Bill 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

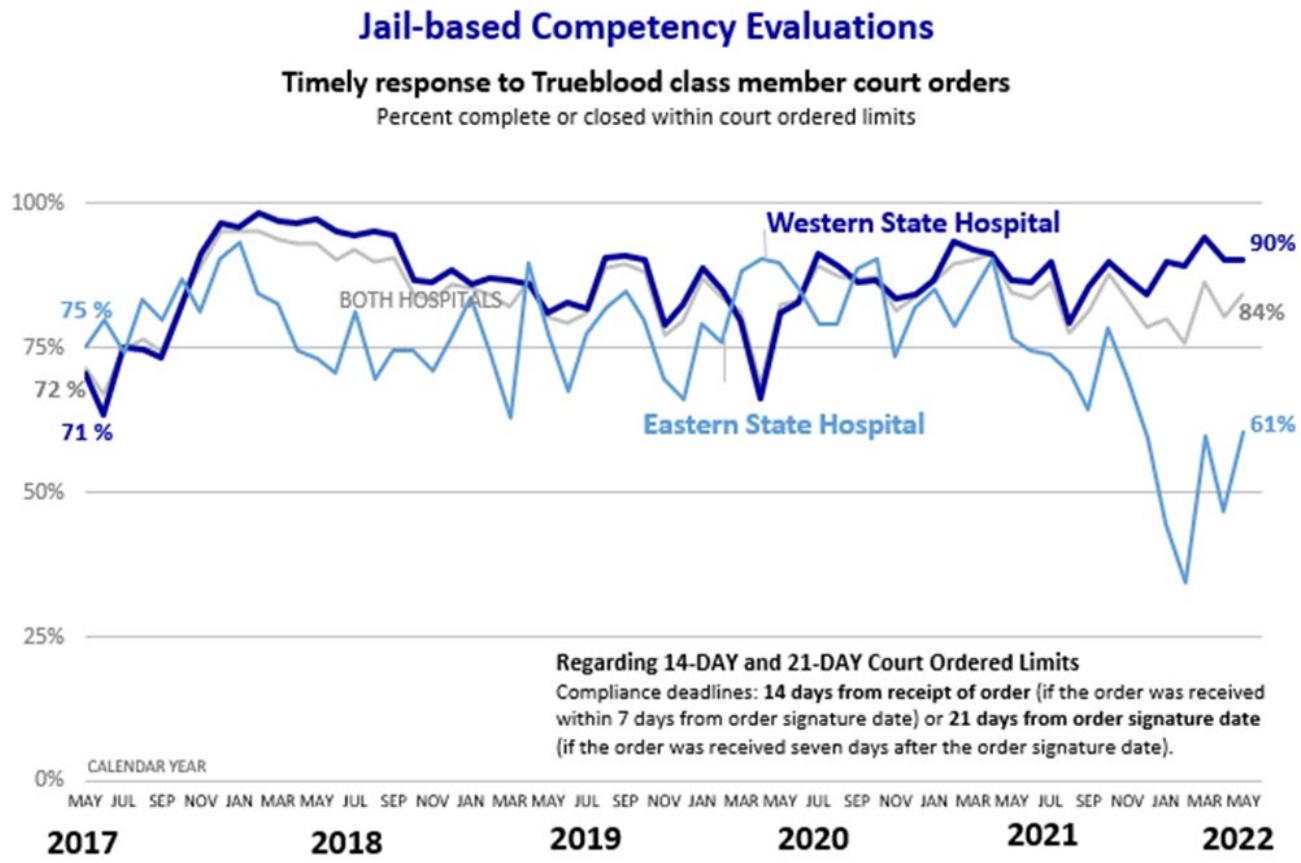
Projections indicate that the number of Trueblood evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74.0 FTE in the FY2022 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal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

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

FIGURE 3.

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.

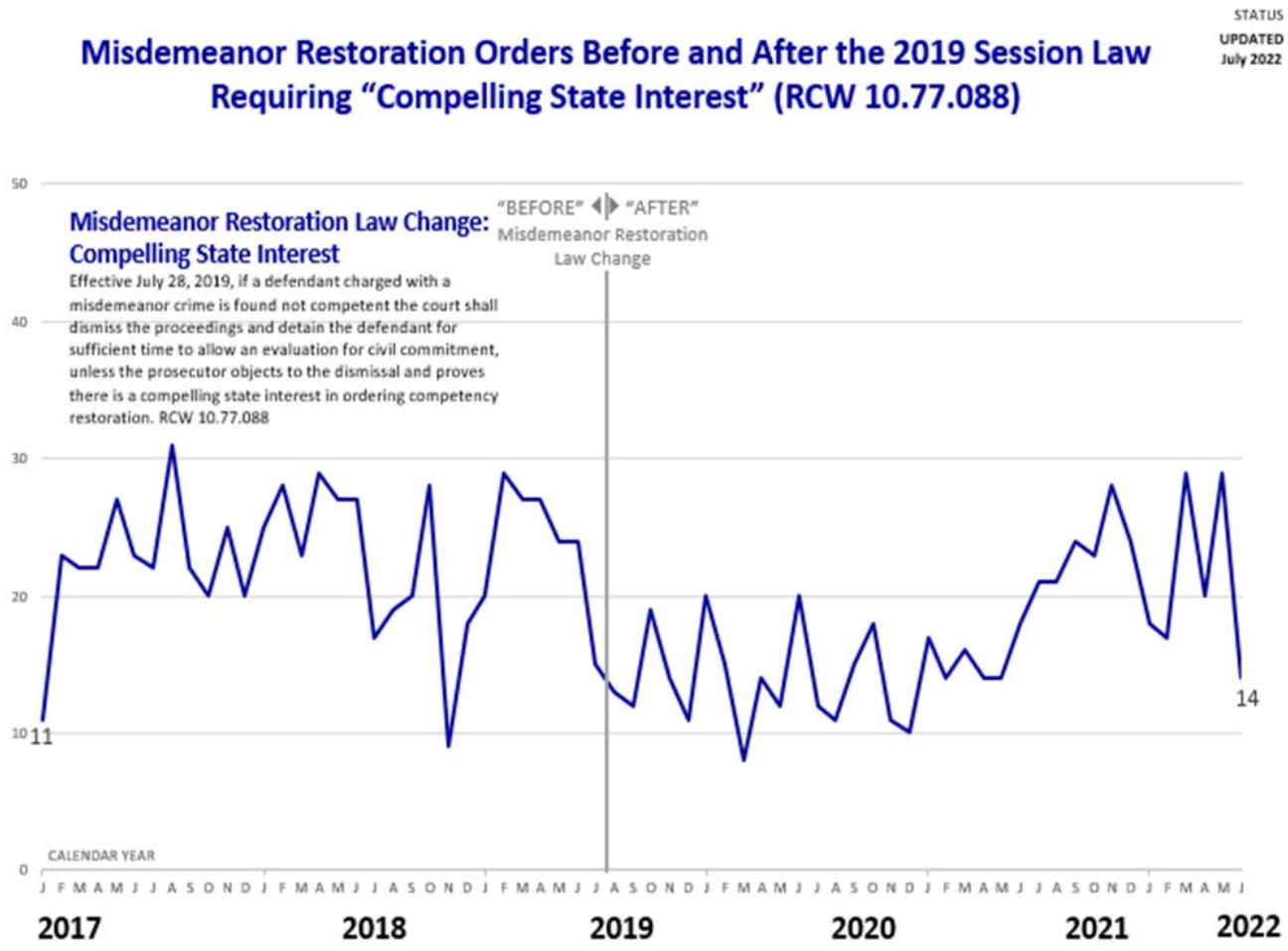
Data-Competency Restoration-Misdemeanor Restoration Orders

As part of the Settlement Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supports legislation toward this goal. ESSB 5444 was signed into law by the governor on May 9, 2019, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. The department continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088). Misdemeanor restoration orders decreased slightly after the 2019 law change, but have recently returned to a level similar to the period before the law change. During the 24-month period prior to the 2019 law change, courts issued an average of 23 misdemeanor

restoration orders per month, which decreased to an average of 15 per month during the 24-month period after the law change. However, in the past six months the average returned to 21 orders per month. In June 2022, 14 misdemeanor restoration orders were issued statewide (Figure 4). The department continues its efforts to conduct outreach to the courts that refer the highest number of misdemeanor restoration orders and remains engaged in ongoing discussions with the Court Monitor and Plaintiff's counsel about how to reduce these referrals.

FIGURE 4.

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



DATA SOURCE: Forensic Data System.

Competency Restoration-Community Outpatient Services

The Outpatient Competency Restoration Program element of the Settlement Agreement is managed by the Health Care Authority in collaboration with the Department of Social and Health Services. The department will continue providing court-ordered inpatient competency restoration services; however, HCA administers OCRP through contracted providers, an option for courts to order community-based restoration services in a less-restrictive environment for defendants with appropriate acuity levels. The intent of OCRP is to provide the most appropriate level of care to the individual, ideally closer to their home community. It is hoped that providing restoration services in a safe and cost-effective environment, while using the newly available community treatment program, will reduce the number of people wait-listed to receive competency restoration in an inpatient setting. OCRP also offers connections for individuals to receive other community-based services such as housing, vocational, and behavioral health services and supports.

Current Status and Areas of Positive Impact

OCRP continues operations in all three Phase 1 regions and all three contractors in those regions are accepting outpatient restoration orders from courts in their regions. Due to impacts from COVID-19 and workforce hiring challenges, some contractors are experiencing vacancies in their program staff, but are still meeting the needs of those enrolled in the program. HCA is working with all three contractors on ways to address the program staff vacancies. As an example, HCA is working with the contractors to provide additional funding for more competitive salaries for existing staff, along with sign on and/or retention bonuses.

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

- Publications for use with people enrolled in OCRP and stakeholder groups to ensure accurate messaging is happening regarding OCRP.

- Forensic navigators use of the OCRP transition plan with the support of other elements to provide people enrolled in OCRP with necessary information related to OCRP groups and provider's contact information.

- Quality assurance reviews are completed in all instances where a person is removed from the OCR program and returned to an inpatient restoration facility or jail to ensure policy and contract deliverables are being followed and to identify service gaps to inform program development and future success. DSHS and HCA leadership meet to review the findings and identify best practices.

- At a minimum, monthly case staffing events occur between Settlement Agreement elements to ensure communication and program coordination for people enrolled in multiple Trueblood programs.

- The OCRP administrator, in conjunction with DSHS, will be working to develop best practices for OCRP providers to restructure the Breaking Barriers Competency Restoration Program curriculum to better align with the outpatient competency restoration model.

DSHS and HCA have piloted a process that reviews OCRP orders for people who are currently receiving restoration services in a residential treatment facility and who are receiving a second competency restoration order. Forensic navigators re-assess those people for suitability for OCRP services as an alternative to completing their entire restoration treatment in an inpatient facility-based program. This provides people with the opportunity to utilize community-based resources. A flowchart and referral form were created for the RTF treatment team staff to follow when referring a person for re-assessment by a forensic navigator. This new process went live on July 5, 2022, and a patient has already been transferred under this protocol.

OCRP contractors have utilized support funds to acquire additional housing units specifically for Trueblood class members, with priority given to people enrolled in OCRP. As of December 2021, all OCRP contractors have housing units they can use specifically for people enrolled in OCRP. HCA continues working with Phase 1 OCRP contractors to increase OCRP-specific housing resources and to add master leasing. HCA and DSHS are working together to determine the appropriate methods of tracking and collecting this data.

On June 22, 2022, HCA contracted with Community House, a King County behavioral health agency, for OCRP services in the Phase 2 region. Community House has dedicated housing units for people enrolled in OCRP. HCA is meeting weekly with Community House to discuss recruitment, training, and other OCRP-related topics. These meetings will continue until OCRP is operational and accepting outpatient restoration orders from the courts in the King region. HCA is hopeful that OCRP in the King region will be operational in October 2022.

Areas of Concern

Another continued concern is consistent support for this program by system partners; however, with legislative changes that define clinical appropriateness and outreach by DSHS and HCA to the courts, these concerns could hopefully be mitigated.

Consistent support for this program by system partners remains a continued concern for HCA and DSHS. With legislative changes that define clinical appropriateness, active participation, increasing the length of competency restoration treatment for people ordered into OCRP, the ability for forensic navigators to utilize law enforcement for removals, and outreach by DSHS and HCA to the courts, these concerns could hopefully be mitigated. As a result, HCA will be updating the structure of the monthly OCRP workgroup. This will create longitudinal outreach meaning information that will be shared with all Phase 1 and 2 court partners via meetings and email, so information is not dependent on a specific court partner's attendance. HCA is also working with DSHS to update forms and documentation related to the OCR and FN programs to provider clear expectations and information to people enrolled in OCRP and associated stakeholders.

Due to legislative changes, DSHS and HCA have begun to restructure case consultations by creating case staffing, to discuss barriers and develop a plan with the hope that a removal will not be necessary. This case staffing takes place prior to a removal consultation occurring, which focuses on removing the person from OCRP. Although removals from the program do occur, DSHS and HCA continue to participate in case consultations in conjunction with the OCRP contractors, to ensure that every effort is made to support a person's success in OCRP. DSHS and HCA are reviewing common barriers for those removed from OCRP and are working to develop solutions.

Recommendations to Address Concerns

While the goal for providers is to serve people enrolled in OCRP in an in-person setting, the contractors continue to offer remote and virtual services as needed, particularly in rural communities. The OCRP contractors in each region have not identified any challenges in providing services regionwide. Appropriate referrals to community-based services and supports continues to be a focus of all OCRP teams.

DSHS and HCA will continue to engage court partners in discussions regarding the utilization of OCRP for clinically appropriate individuals. Currently, contracted agencies are included in collaboration and engagement activities in all Phase 1 regions and relationships continue to grow and develop among the programs. HCA, in partnership with DSHS, is working to engage the King region for Phase 2 implementation of OCRP. Ongoing efforts are being made to increase court personnel in the OCRP workgroup. Hopefully, by having the support and voices from the various jurisdictions in the Phase 1 and 2 regions, the number of referrals to OCRP will increase in each region.

HCA has been meeting weekly with the Phase 2 contractor to discuss OCRP services, provide technical assistance, and discuss recruitment and training, along with other OCRP related topics. The HCA OCRP administrator is working with DSHS Workforce Development to create a training plan for new OCRP staff to ensure all staff are trained in the necessary Breaking Barriers curriculum. Due to the need to hire and train staff, OCRP services are not yet live in the King region. However, HCA is hopeful that OCRP services will go live in October 2022. Once OCRP services go live in the Phase 2 region, the OCRP administrator will continue meeting with the contractor to provide technical assistance and necessary support as the program develops.

HCA has also worked with current OCRP providers to address workforce challenges. HCA has allowed one provider to use an "in-training" mechanism to hire a master's-level clinician who is working toward licensure. As previously mentioned, HCA has also provided additional funding to all Phase 1 OCRP contractors to increase staff salaries and offer sign on and/or retention bonuses. In collaboration with King County providers, a strong area of concern is hiring, and this "in-training" option may be utilized in future contracts. As of July 22, 2022, the Phase 2 OCRP contractor has posted all OCRP staff positions and has begun recruitment. If appropriate, the use of an "in-training" mechanism can be utilized by this contractor, with HCA OCRP administrator approval, to assist with the workforce challenges. As weekly meetings are taking place between

the HCA OCRP administrator and the Phase 2 contractor, the goal is to have these challenges identified early and addressed as soon as possible to prevent delay of OCRP.

Forensic navigators continue to communicate with court staff regarding the people ordered into OCRP. This allows the forensic navigators to assist with all referrals and transportation as well as release timing and program needs to ensure people can adequately connect to programs once released.

The OCRP administrator conducts removal reviews in collaboration with the assigned providers and forensic navigators. HCA and DSHS leadership meet to review the removal review findings and make recommendations for best practices in the prevention of removals or identification of commonalities among those removed. These factors may include increased experience of the programs, coordination among all the program elements, courts working with the assigned forensic navigator to order clinically appropriate people to the program, and increased case staffing prior to removal consultation for at-risk persons. HCA and DSHS leadership continue to review commonalities of people removed from OCRP and shares that information with court staff to inform the decision to order future people. Commonalities noted thus far include history of non-compliance with community-based services, program refusal upon order, medication refusal, and substance use.

Data-Competency Restoration-Community Outpatient Services

OCRP services began in Phase 1 regions on July 1, 2020. The Phase 2, King region was under contract to begin program implementation work June 2022 and began hiring and training the team. King region data was not available in time for this report.

Between July 1, 2020 and June 30, 2022, 66 clients were enrolled in OCRP Phase 1 regions: 25 in Pierce, 23 in Southwest, and 18 in Spokane (Appendix B, Table 1). Additional data by region are not reported due to the small number of cases. Across regions, most enrollments were for felony restoration orders (77 percent) and participants were mostly male (80 percent), 30-49 years old (45 percent), non-Hispanic white (68 percent), and unstably housed or homeless (61 percent).

Of the 55 people discharged (Appendix B, Table 2), 38 percent were opined competent, 25 percent had their conditional release revoked, and 14 percent had their charges dismissed. Two-thirds (67 percent) were in the community at the time of discharge, and 11 percent were admitted to inpatient services at a state hospital. Among those discharged, the average length of stay in OCRP was 69 days. This includes misdemeanor and felony orders and people discharged for any reason (e.g., those who completed the program and were opined competent, and those who were returned to jail or whose conditional release was revoked). Expanded information for length of stay will be defined and added to this report when there are sufficient cases.

Data collection transition from individual Excel trackers to the Navigator Case Management system is underway. Many OCRP data variables from the Excel trackers were added to the NCM in March 2022. Remaining variables and changes needed following implementation of 2SSB 5664

will be added in fall 2022. In the interim, providers enter data in both the Excel trackers and the NCM until all variables are available in the NCM.

Forensic Navigators

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

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

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

Current Status and Areas of Positive Impact

Forensic navigators remain in close contact with attorneys and outpatient competency restoration programs 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 facilitate eligible clients' connections to housing and recovery programs as well as to forensic peer services and case management supports even when class members are not ordered into outpatient restoration, and after the forensic navigator has been discharged and is no longer actively assigned to the client. As mentioned above, forensic navigators have also connected with both OCRP and RTFs to initiate a pilot program that works to re-assess clients on a second 90-day order, who may be suitable for community restoration. This pilot began in July 2022.

Navigators covering the Phase 2 region were hired in the second half of 2021. After being trained in the Pierce region, Phase 2 navigators began taking King region cases in January in an attempt

to shorten the communication gap before services were set to begin in spring 2022. The program staff has been essential in recruitment and further refinement of program practices.

Areas of Concern

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

Program staff continue to engage and inform prosecution, defense, and judges to develop a shared understanding of this new program. Meetings and discussions continue with prosecutors, defense, and bench in all three Phase 1 regions in partnership with HCA. While the program grows and awareness increases, outreach remains a necessity to enhance the referral process. Outreach and engagement in Phase 2 have been more consistent after learning from Phase 1 interactions. While courts, jails, and many attorneys have been understanding partners, because the program is in its infancy, defense attorneys have not allowed navigators to have client contact. As stated before, the hope is that as resources become more available to clients, that defense attorneys will enable Phase 2 staff to engage clients and provide advocacy.

DSHS and its service partners continue to work well together in order to maintain programmatic alignments. Extensive process mapping, with the use of a responsibility assignment matrix, has been completed. The value stream mapping has aided communication between the Forensic Navigator Program and partner programs OCRP, FHARPS, and FPATH. The value stream mapping process further resulted in decreased gaps within participant programs for more streamlined processes and operational efficiencies. Communication between HCA and DSHS is consistent and efficient.

Recommendations to Address Concerns

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

Data-Forensic Navigators

A total of 2,818 people were assigned a forensic navigator between July 1, 2020 (program start) through June 30, 2022 (Appendix C, Table 1). This includes 800 people in King County, where forensic navigator services started in January 2022 as part of Phase 2. The majority of people assigned a navigator were male (69 percent), over half (57 percent) were between the ages of 30 to 49, and over half (54 percent) were non-Hispanic white. Just over half (53 percent) were charged with a felony, and 47 percent were charged with a misdemeanor.

Forensic navigators worked to gather information for the courts for nearly all people assigned a navigator during the reporting period (99 percent, Appendix C, Table 2). Client meetings, interviews or observations were conducted with 51 percent of people assigned a navigator. A recommended service plan was completed for 67 percent of people. Navigators provided coordination of care for 31 percent of clients overall, and more than half in Southwest (60 percent) and Spokane (51 percent). One in four (25 percent) received a referral to other community services. Forensic navigator services in King County started prior to other Trueblood programs in the region. Navigator services and referrals are expected to improve once OCRP services begin, and the program matures.

The most common types of referrals were for other Trueblood partner programs: 16 percent received a referral to the FPATH program and 13 percent received a referral to FHARPS.

A total of 2,375 people were discharged during the reporting period, with an average length of stay in the program of 36 days (Appendix C, Table 3). About one-third (32 percent) of those were discharged with a warm handoff to provider or jail staff. Thirty percent of cases were closed because the person was determined competent, and 25 percent of cases were closed because the person was ordered by the court to receive inpatient restoration. Over one-third (35 percent) of the people 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. The program continues to make improvements to data collection and data quality. The program and data collection continue to evolve. A notable change in the coming months will be the collection of data from the Navigator Recommended Services Plan.

Competency Restoration-Ramp Down of Maple Lane RTF

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

Both facilities were scheduled to close as part of the overall integrated system changes contemplated in the Settlement Agreement. Yakima was scheduled to close by Dec. 31, 2021 but closed on Aug. 14, 2021, due to difficulty recruiting and retaining staff through December 2021. The last patient transferred out on July 26, 2021. Maple Lane has a hard closure date of July 1, 2024. The DSHS positions at Maple Lane converted to permanent status on Dec. 16, 2021, providing the staff who stay until closure layoff rights. Maple Lane's ramp down plan timeline may require updating due to this change. The director of the residential treatment facilities met June 28, 2022, with the DSHS layoff specialist and the labor relations specialist to discuss whether the current timeline for staff notifications is still accurate with all of the positions now being permanent. Minor changes were made to notify staff sooner and to provide education on the layoff process as soon as notifications are sent out. The timeline for notifications is still being finalized. As part of the Settlement Agreement, low median wait times for inpatient competency services can trigger an earlier closure. For Maple Lane, it is four consecutive months of a median wait time for admission of nine days or fewer.

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

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup is developing full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for Maple Lane. As stated above, the timelines may be impacted by the DSHS positions being converted to permanent. The meeting on June 28 was expected to clarify if changes are needed. Additional information on that meeting's outcomes will be reported at a later date. Based on the closure of the Yakima restoration program, the current plans may be adjusted to reflect lessons learned from that recent closure. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations during ramp down after the official closure notification is given. As of summer 2022, staffing remains at stable levels and within typical turnover margins. Currently, the director of RTFs is working with her chain of command to come up with both recruiting and retention strategies for the Maple Lane Competency Restoration Program. To date, two changes have been made: Recruiters have expanded where open positions are advertised, and all DSHS positions have been made permanent. The director of RTFs is currently working on how to retain staff with two other DSHS programs opening on the Maple Lane campus starting in December 2022.

Recommendations to Address Concerns

DSHS continuously monitors turnover, morale, and other factors, and actively takes steps to neutralize negative affects at Maple Lane now that Yakima has closed. Given the potential variability in closure dates due to agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient discharges. Additionally, our contract oversight of the contractor at Maple Lane will focus on the contract requirements to ensure sufficient staffing. The residential services manager works closely with the director of residential treatment facilities on staffing challenges for the DSHS side of operations at Maple Lane.

Data-Competency Restoration-Ramp Down of Maple Lane RTF

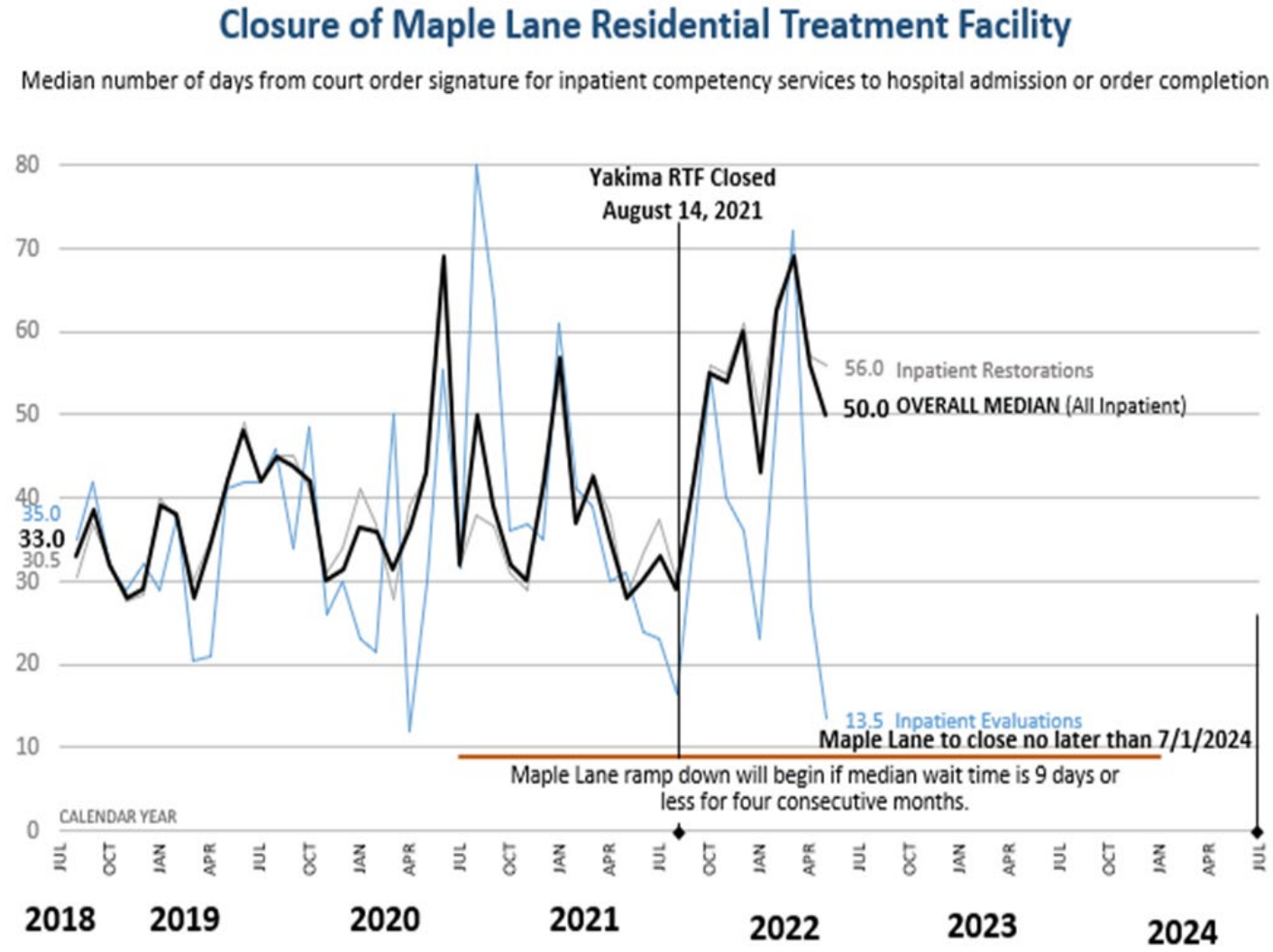
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services monthly (Figure 5). In May 2022, the median wait time for inpatient competency services was 50 days. The ramp down of Maple Lane will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 5.

Closure of Maple Lane Residential Treatment Facility

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

JULY 2022



DATA SOURCE: BHA Forensic Data System.

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

Crisis Triage and Diversion-Additional Beds and Enhancements

Trueblood Funds were provided to increase crisis bed capacity in Phase 1 and Phase 2. Crisis stabilization/crisis triage facilities are residential treatment facilities that are licensed through the Department of Health to provide short-term clinical interventions in a safe, structured environment, and to offer support and behavioral health crisis stabilization services to individuals that are experiencing a behavioral health crisis. The services provided in these facilities are short term, usually 23 hours or less but on an as needed basis, care can be extended for up to two weeks. Clinical treatment in the crisis stabilization/crisis triage facility is provided by a multi-disciplinary team of behavioral health specialists trained to provide interventions. The overall goal of care of the facility is to stabilize active symptomology and to assist in the return of the person back to their community of origin with skills or tools needed to address additional stressors. These tools can often be in the form of referrals to other skilled community providers and could entail continued outpatient services to further reduce future crisis.

In Phase 1, Trueblood enhancement funding was provided to crisis stabilization facilities for the enhancement of services and to ensure usability for individuals experiencing a mental health crisis who are interacting with law enforcement or other first responders. While an emphasis is placed on voluntary admissions, these facilities also work with first responders to accept police referrals, drop-offs, and police holds. The goal is to provide first responders and law enforcement a diversionary option from arrest, incarceration, detention, or hospitalization.

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

Current Status and Areas of Positive Impact

Additional Crisis Beds – Spokane Phase 1

HCA worked with the Department of Commerce to expand bed capacity in the Spokane region by adding 16-crisis stabilization beds and creating the Spokane Regional Stabilization Center. The SRSC was designed to provide alternative options for law enforcement and other first responders when interacting with individuals demonstrating a behavioral health crisis whose behaviors did not meet the threshold of arrest and would benefit from behavioral health support. SRSC reports that between January through March 2022, they served a total of 228 individuals. This is the first quarter that they have reported data as they opened in fall 2021.

Additional Crisis Beds – King Phase 2

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

The Department of Commerce began by issuing a procurement for two crisis stabilization facilities in King County. From this initial procurement, Commerce received two applications, and only one of the two applications was identified as a successful applicant. The successful applicant was Recovery Innovations International. RII identified that they would be constructing a facility in south King County. This project remains on target with RII having executed its contract with Commerce by June 30, 2022. Construction of this facility is expected to begin by December 2022. A joint team of state agencies including DSHS, HCA, Commerce, and the Department of Health meets with RII monthly to provide technical assistance and support. This team will continue providing support through the pre-construction, construction, and operational phases.

HCA and the Department of Commerce worked to reissue the procurement for the second crisis stabilization facility in the King region, which included arranging for additional incentives for potential contractors. To ensure more applications were received, increased marketing efforts were made, and the King County Behavioral Health Recovery Division actively engaged with and encouraged King County providers to apply. Commerce received three applications during this second procurement. On Sept. 6, 2022, Commerce announced ConnectionsWA as the grant awardee for the King region's second crisis stabilization facility. Construction of this facility is expected to begin by June 2023. Commerce reports that ConnectionsWA has been looking to renovate existing properties, which may reduce their construction schedule timeline. After ConnectionsWA is under contract with Commerce, the joint team of state agencies will schedule monthly meetings with ConnectionsWA to provide technical assistance and support throughout their pre-construction, construction, and operational phases.

Areas of Concern

The implementation plan required that two crisis stabilization facilities be under contract with the Department of Commerce by June 30, 2022, and that they begin their construction in King County by December 2022, but only one successful applicant emerged from the initial procurement. A second contractor has since been identified, but this project is now approximately six months behind its original timeline. Additionally, the second contractor has not yet obtained a physical site for construction of its facility. They plan to acquire a property to renovate.

Recommendations to Address Concerns

To address the concerns indicated above, HCA and DSHS will:

- Continue providing technical assistance and oversight to aid the contractors in meeting timelines for both crisis stabilization facility projects.

- Continue to monitor Commerce's efforts in contracting with ConnectionsWA and identifying a suitable site for their crisis stabilization facility.

- Once under contract, HCA and DSHS will jointly work to provide technical assistance to ConnectionsWA, to assist with maintaining the projected June 2023 construction start.

Current Status and Areas of Positive Impact

Crisis Enhancements

In the Phase 1 regions, the crisis stabilization facilities continue to provide crisis intervention and symptom reduction (treatment/services). The facilities have improved their discharge planning services by making referrals to community mental health agencies, FHARPS, and to substance use disorder treatment when appropriate. For example, Frontier Behavioral Health in the Spokane region has formed a partnership with the Spokane Addiction and Recovery Services to ensure that referrals to appropriate substance use disorder services are available. This was accomplished by having SPARC staff on site at the crisis stabilization facility to provide referrals and evaluations to those in need of substance use disorder services. Recovery Response Center in Pierce region identifies that they often make referrals for SUD treatment. Additional areas of positive impact include:

- The addition of new staff and the ability to use Trueblood funding for retaining current employees.
- Providing joint opportunities with law enforcement for Crisis Intervention Training.
- Scheduling open house tours of the facilities to interested community partners and law enforcement.
- Continued collaboration with local law enforcement and other first responders.
- Continuing to accept admissions while adhering to the Washington state health care COVID-19 plans.

Current Status and Areas of Positive Impact

Crisis Enhancements

For Phase 2, HCA worked collaboratively with the King County BHASO. This resulted in the development of an agreeable proposal that Trueblood funding would be used to provide enhanced crisis services in the Phase 2 region through the Downtown Emergency Service Center location as well as for the whole of the King region communities. Enhancements provided through the Phase 2 Trueblood funding included:

- The addition of new program staffers and funding for current staff retention.
- Providing technological facility updates to include communications systems and Wi-Fi services.

- Facility upgrades and environmental changes including HVAC, bathroom, security cameras, and lighting.

- Vehicle purchase to provide community outreach and transportation support for behavioral health referrals.

Areas of Concern

Two crisis stabilization facilities, Recovery Innovations International in Fife and Frontier Behavioral Health Crisis Stabilization Center Spokane, temporarily closed their doors during this reporting period. Fortunately, there were other crisis stabilization facilities in the region that were able to cover the need during the closures. Recovery Innovational International in Fife has reopened its doors and resumed services. HCA continues to be in communications with Fronter Behavioral Health regarding its plans to resume services.

The Beacon Southwest contracted facility reports that despite its attempts to admit more individuals that are law enforcement involved, the local LE has not diverted to the facility in great numbers.

Recommendations to Address Concerns

HCA worked with both regional BHASOs to develop diversion alternatives for the facilities that had to temporarily close their doors.

- Recovery Innovations International Recovery Response Center in Fife has two crisis stabilization facilities located in Pierce County. All admissions were diverted to the Parkland location until the census numbers increased to an amount that would support both facilities. RII stated that the reason for the low census was a combination of a reduction in police drop-offs due to HB 1310 and the misperception in the community that they had stopped accepting police drop-offs. Multiple meetings with RII leadership, county officials, BH-ASO and HCA staff were held to ensure that these issues were quickly resolved. RII Fife reopened its doors within two months of diversion.

- Spokane BHASO notified HCA on June 3, 2022, that Frontier Behavioral Health would be temporarily closing its doors as of June 6, 2022, as it had lost its prescribers for their Crisis Stabilization Unit and was unable to meet the medication needs of people seeking admission. HCA remains in conversation with the Spokane BHASO and is hopefully awaiting the reopening of this facilities. Crisis Stabilization Services remain available in the region because of the newly opened Trueblood-funded 16-bed crisis stabilization facility operated by Pioneer Human Services. They report that all admissions regularly admitted to Fronter Behavioral Health would be diverted to their facility.

Each contracted facility has a clause in their contract to provide community education and outreach on the availability of crisis services and to promote more public awareness of the services available at the crisis triage/stabilization facility. This information will also identify how

services can be obtained. Having strong relationships with the community is critical to ensuring they continue to receive referrals, police drop-offs and holds.

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

Data-Crisis Triage and Diversion-Additional Beds and Enhancements

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

Crisis Triage and Diversion-Residential Supports

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

Current Status and Areas of Positive Impact

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

HCA has allowed FHARPS providers to request exemptions to policy when participants are clinically unique, are engaged in the program, and might otherwise re-enter the criminal court or forensic systems if no exception is granted. These extensions allow people to access more housing voucher funds and continue to receive housing supports for longer than an initial six-month period. This often increases a participant's likelihood of obtaining permanent housing solutions, and this quarter, an additional 10 requests for exceptions to policy were approved by HCA.

FHARPS providers are engaged in multiple master leasing projects with the majority of dedicated units existing in Pierce County. Pierce County providers have access to over 60 units and the units fill quickly when units become vacant. Most participants move into master leased units from initial shelter-based placements including hotels and motels. However, some people can move directly into these units from time of enrollment, whenever units are available, which may account for a small decrease in the percentage of initial shelter-based housing placements at intake this past quarter.

FHARPS providers helped eight people move into permanent supported and/or permanent independent housing from shelter-based and/or transitional placements this quarter alone. HCA also heard from providers that there is a need for a more robust staffing model to support residents living in the master leased properties. Prior to the end of the quarter and state's Fiscal Year, HCA was able to add amendments to the FHARPS contracts providing for an additional team lead position on FHARPS teams in Phase 2. Additionally, HCA was able to provide funding for on-call staffing on nights and weekends in Phase 1 master leased properties to bolster support in the event of behavioral health crises or emergency maintenance issues that may arise outside of normal business hours.

Emergency Housing Vouchers

After a significant decrease in the use of emergency housing vouchers in Pierce County, HCA began discussions with the facility's parent company, Designated Crisis Responders, Mobile Crisis Teams, and other hourly crisis staff in the region to see if vouchers could be distributed by other means than crisis stabilization facilities. Discussions with outpatient crisis providers yielded two major responses, namely that teams either already had access to similar short-term housing supports or did not feel the scopes of their work could include referring participants to longer-term housing supports after voucher utilization. Continued technical support provided by HCA coupled with the bolstering of community partnerships between crisis stabilization facilities and local housing partners resulted in a sharp increase in utilization of crisis housing vouchers at the Crisis Recovery Center in Pierce County by the end of last quarter.

HCA distributed a discharge planner's toolkit to each of the crisis stabilization sites to enhance their knowledge of community-based supportive housing resources for the broader population of those with a clinical need. The goal was to ensure that everyone exiting these facilities who utilizes a short-term housing voucher is connected to community-based programs for ongoing support and linkage to resources even when not eligible for Trueblood programs. The discharge planner's toolkit includes an eligibility matrix that allows discharge planners to determine eligibility for housing programs including but not limited to Foundational Community Supports, PATH, Governor's Opportunity for Supportive Housing, Coordinated Entry, HARPS, and others. This may account for decreases in referrals to FHARPS teams from crisis stabilization facilities, as providers are referring participants to other programs for which they are eligible.

Crisis Housing Vouchers were distributed in Phase 2 through hourly crisis staff and assisted outpatient treatment teams beginning July 2022. HCA and King County BHASO continue to meet with other possible partners in the region who might be interested in accessing this resource, including Downtown Emergency Services Center.

Frontier Behavioral Health's Crisis Stabilization Facility temporarily closed in June 2022, and the agency's director was quick to reach out to HCA to discuss possible ways for the agency to continue to utilize crisis housing vouchers in the Spokane region. HCA agreed to allow the provider to distribute emergency housing vouchers by means of other crisis hourly staff beginning next quarter. The agency's crisis stabilization facility was one of the highest utilizers of crisis housing vouchers in the phased regions, with the Southwest region also continuing to utilize vouchers at a high rate. HCA will continue to support Frontier Behavioral Health in its efforts to transition to an outpatient model of distribution while their facility remains closed.

Areas of Concern

HCA began directly addressing the impacts of COVID-19 on FHARPS teams in October 2021 and was particularly interested in how increased COVID-19 infections in a region could affect the level of face-to-face services provided by an FHARPS team. As the number of COVID-19 cases decreased in Phase 1 regions over the last quarter, HCA saw the number of face-to-face services

increase in each of those regions. At the same time, an increase in COVID-19 cases in jails in Phase 2 has increased barriers to accessing eligible participants while in-custody.

HCA will continue to monitor the temporary closures of crisis stabilization facilities throughout the Phase 1 regions. HCA has also been able to act swiftly and work creatively with agencies to allow crisis housing vouchers to be distributed by other outpatient crisis-related teams.

Recommendations to Address Concerns

HCA will continue to communicate with FHARPS providers to address how COVID-19 infections have or could impact the level of face-to-face services provided to FHARPS participants. HCA encourages all FHARPS to follow their local public health jurisdiction's guidance. In any region where the number of COVID-19 infections and related restrictions decrease, HCA assumes the level of face-to-face services provided by FHARPS teams will increase.

HCA will continue to work with providers to distribute crisis housing vouchers in the phased regions even during temporary closures of facilities. HCA will be able to report on the successes and challenges of different modes of distribution in future SARs since providers will continue reporting utilization of these vouchers no matter the mode of distribution.

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.

Vouchers Data

The crisis stabilization and triage facilities and provider teams contracted with HCA to provide housing vouchers distributed 341 vouchers to 251 people between Dec. 1, 2019, and June 30, 2022 (Appendix D, Table 1). As mentioned earlier, some teams began distributing vouchers outside crisis facilities, so the "Voucher Disbursals by Crisis Triage and Stabilization Facilities" table was amended to "Crisis Housing Voucher Disbursals." The Phase 2 King region was ready to begin voucher distribution in June 2022. King County is excluded from the table since no vouchers had been disbursed as of June 30, 2022.

Spokane remained the lead region in voucher distributions (accounting for 52 percent of distributions and 43 percent of recipients). The total amount disbursed across Phase 1 regions was $326,038, and the average amount per recipient was $1,299. Voucher recipients leaving CS/CT facilities were there based on referrals from a number of sources including hospitals (42 percent) and self-referrals (28 percent). Due to changes in distribution process, this measure will be assessed to determine future reporting.

Overall, most voucher recipients were male (68 percent), between 30 and 39 years old (61 percent), and non-Hispanic white (68 percent).

Based on matching housing voucher and FHARPS program participant data, less than half (42 percent) were referred to FHARPS, 39 percent were enrolled, and 34 percent were housed or sheltered through FHARPS. The majority of initial housing placements through FHARPS were shelter/emergency placements (86 percent), which includes motels. Not all voucher recipients are eligible for FHARPS, and providers appear to be pre-screening cases to determine program eligibility. The implementation of the discharge planner's toolkit also assists in identifying appropriate community resources, which results in fewer referrals of ineligible people to FHARPS. This process allows FHARPS teams to focus resources on eligible cases and directs individuals to appropriate supports more quickly. Information on subsequent housing information for those receiving crisis housing vouchers is limited to those who transition to FHARPS support.

FHARPS Data

The FHARPS program expanded to Phase 2 King County region in April 2022, and data measures that met the requirement of more than 11 cases were included. A total of 1,176 people were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to June 30, 2022 (Appendix E, Table 1). Of these referrals, 712 (61 percent) were contacted[9] and 657 (56 percent) were enrolled. Enrollment rates appear to vary in part due to data entry practices. Spokane enters all referrals in the Excel trackers, while other providers may only enter referrals that result in a contact or program enrollment. HCA continues to work to ensure referrals are entered uniformly across providers.

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 53 percent of referrals. Forensic navigators made the most referrals: 22 percent overall, and 94 percent of referrals in King County region. FPATH referred 175 individuals (15 percent), and crisis stabilization and triage facilities referred 155 individuals (13 percent).

The majority of initial contacts were made by phone (55 percent). This is lower than the 67 percent in the last report, indicating that teams are utilizing other contact methods.

Two-thirds of people (68 percent) enrolled in FHARPS were male, 56 percent were between 30 and 49 years old, and 53 percent were non-Hispanic white. About one-quarter of participants (27 percent) identified as Black or African American and 10 percent as Hispanic or Latino. Individuals can identify as more than one race or ethnicity. Most people were homeless at the time of enrollment (72 percent).

[9] 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, 85 percent were housed or sheltered at least once since their enrollment (Appendix E, Table 2). About 62 percent of first housing types were emergency/shelter placements, which includes motels. This is down from 68 percent at year-end 2021. There was simultaneously an increase in transitional housing from 23 percent at year-end 2021 to 31 percent as of June 30, 2022, which coincides with an increase in the use of master leasing options by providers.

Two-thirds (67 percent) of individuals enrolled between March 1, 2020 and June 30, 2022 were discharged during the period, with an average length of support of 196 days (Appendix E, Table 3). The average total subsidy support received by those discharged was $5,881.

Among people with closed cases, 34 percent were closed due to loss of contact, 16 percent transitioned to self-support and 12 percent transitioned to other housing support. Housing status at program discharge was unknown for 33 percent of people (consistent with the loss of contact rate). One-third (33 percent, up from 30 percent at year-end 2021) were stably housed, and 15 percent were homeless.

Crisis Triage and Diversion-Mobile Crisis and Co-responders

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

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

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

Current Status and Positive Impacts

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

- The addition of certified peer counselors to each regional MCR team. Expanding mobile crisis services to include certified peer counselors will improve engagement and increase hope in individuals in crisis by modeling recovery through firsthand perspective and formal training. In their roles as a member of the mobile crisis response team, the CPC will provide emotional support, share personal experiences and knowledge, teach skills, provide practical assistance, and connect individuals with resources, and opportunities to reduce crisis situations. The CPC is expected to employ their own lived experiences to create a bond with the individual in crisis.

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

The enhancements in the three Phase 1 regions were funded to provide a timelier response for individuals in the community who were experiencing a crisis and to work collaboratively with law enforcement, co-responders, and other first responder teams to accept referrals and thereby divert from arrest. Trueblood funded MCR enhancements during the Phase 1 schedule have included:

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

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

- Frontier Behavioral Health's MCR reports that they continue to focus on referrals from law enforcement, the jail, and other first responders while also offering crisis intervention services for other Trueblood programs at FBH. FBH reports that its MCR services have developed a targeted approach for working with Trueblood class members and other individuals who may have had law enforcement/criminal justice system contact as they work to explore possible diversion strategies. FBH reports that their MCR services are available for outreach to rural county clients and that they often work in partnership with other Trueblood programs as needed to the betterment of the individual in crisis. FBH reports that they often attend coordination meetings with other Trueblood programs where MCR services are discussed and how these services may complement each other. As FBH's current MCR supervisor also serves as the supervisor of Trueblood Forensic PATH program, natural coordination of services will occur.

- Frontier reports that it receives police reports for follow up, including 911 and crime check calls that are more appropriate for mental health response over law enforcement. Staff also receive referrals from the co-responder team to follow up with people to ensure they are accessing the resources and referrals provided. Frontier's MCR team has been able to build a good working relationship with the local law enforcement in Spokane.

- 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 and actively works to provide community outreach and education to promote awareness for the MCR program in Spokane County.

- Adams County has developed a paper referral process to enable law enforcement agencies to send the names of individuals in the community they encounter who could use their services. The MCR and client care coordinator collaboratively make efforts to contact these individuals and provide enhanced MCR services. Adams County Integrated Health Care Services is creating a linkage to requested/necessary resources in the community for families 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. The goal of Adams County IHCS's MCR team is to provide services to all individuals to increase MCR services and public awareness to the community.

Pierce Region

Pierce Beacon contracts for MCR services in the Pierce region with MultiCare Behavioral Health's mobile outreach crisis team provides for crisis outreach services.

- MOCT reports that they increased their follow-up services from 311 (Q3 January-March 2022) people seen to 338 Q4 April-June 2022) people seen. Thereby, assisting an additional 23 residents in Q4.

- The response times for face-to-face outreach increased from 79 minutes to an average of 97 minutes from Jan-Mar 2022 (Q3). This can be attributed to gaps in staffing during the graveyard shifts. These open positions have since been filled.

- MOCT reports that their DCR response time average was 182 minutes, which is 10 minutes below the stated goal of 192 minutes.

- MOCT reports that while they are responding to all rural areas in Pierce, they are also expanding the outreach services to provide more face-to-face meetings in the rural communities.

- MOCT reports that they continue to meet individuals in the field and have worked to get them either into crisis beds or to make appointments for follow-up services. These steps are being taken to avoid hospital admissions.

- MOCT reports ongoing and regularly scheduled monthly meetings with first responders to enhance their services. They are also reporting ongoing training in crisis intervention training with law enforcement and with East Pierce and Central Pierce fire departments.

- MOCT is continuing efforts for coordinated communication with the tribes as well as with their law enforcement partners. Reporting that they have received community referrals from some of the staff employed by Kwawachee Tribal Health Center at the Puyallup Tribe.

- MOCT also continues to also engage on a regular basis with community hospitals, evaluation and treatment centers, and local community behavioral health providers to be seen as a partner for the betterment of the residents of the region.

Southwest Region
Beacon contracts for MCR services in the southwest region. Three community agencies providing mobile crisis services: Sea Mar Adult Mobile Crisis Intervention in Clark County, Comprehensive HealthCare in Klickitat County, and Skamania County Community Health in Skamania County.

- Sea Mar reports that with its current staffing structure it has been able to successfully maintain its goal of expanding MCR service hours. The Trueblood enhancement funds provide SeaMar with the ability to increase staffing to additional hours in Clark County.
    - In the Q3 report covering January-March 2022, they reported that they are able to provide services from 8 a.m. to 12 a.m. daily. Sea Mar reports that the service goals are to expand hours to 24/7/365 by the end of 2022.
- Skamania reports that with the hiring of their two positions, a 0.35 MHP and a 0.35 peer counselor, they have been able to expand their MCR services by offering more diverse follow-up and outreach to individuals who have had law enforcement involvement by providing co-responders/first responders with another option for a less restrictive intervention: a referral rather than arresting, placing a hold on someone, or taking them to the hospital. Skamania reports that the sheriff's office has utilized this service over the past months as a resource when they were unable to hold someone for mental health reasons and they are utilizing this service to submit referrals for individuals when a family member is concerned about safety when it has not been appropriate for law enforcement to intervene.

In Phase 2, the King County BHASO is going to enhance their existing mobile crisis response system by adding four new position types to their current staffing structure. Those positions include:

- Program coordinator
- Dispatchers
- Peer/supervisor
- Training/supervisor

<u>Areas of Concern</u>
HCA, the Accountable Communities of Health, and WASPC are exploring strategies to transport individuals from rural areas who are experiencing a mental health crisis.

Recommendations to Address Concerns

To address the transportation concerns, HCA, through its misdemeanor diversion funds, has provided WASPC funding for rural regions for safe/secure transportation of people in a behavioral health crisis to crisis triage/stabilization facilities, evaluation and treatment facilities, and secure withdrawal management facilities.

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

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

Collecting the required data for enhancing the Trueblood MCR services has been an evolving endeavor. To collect the requested data, HCA created rules that were too narrowly focused to capture anything other than that information needed for Trueblood elements and specific to the phases where service was contracted. As the BHASOs, who provide oversight of crisis services, worked to change their reporting structure to meet the objectives of the contract deliverables, it became apparent that mobile crisis response was implemented in multiple ways across the state.

The multiple ways that mobile crisis response was being implemented became apparent when reviewing data received from the BHASOs showed inaccurate time stamps, duplication of services, and difficulty in discerning services provided (this was especially apparent in regions where MCR and DCR services were performed by the same staffer who had multiple roles and responsibilities).

While HCA has made substantial progress in correcting records received and adding validation to the data ingestion process, this will not solve the issue that the original rules that were put in place only reflected one model of mobile crisis response and does not reflect the multiple ways that mobile crisis response is performed.

The state has invested significant resources into improving mobile crisis services. These investments include a whole new team at HCA. The goal is for the coordinated efforts of this team to result in improved data beginning in early 2023. This data will be assessed to determine what can be reported moving forward, in addition to the response time data already contemplated. When data is of sufficient quality and quantity, the number of interventions, individual characteristics of those served, and average response time will be reported (see Table 1). The table may be revised following data assessment. WASPC is responsible for collecting/reporting co-responder's data.

TABLE 1. **PRELIMINARY EXAMPLE**

Mobile Crisis Response Interventions and Client Characteristics

	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 Behavioral Health Data System[10]

[10] Table 1 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 Contempt Settlement Agreement, the state created a new program modeled after the federally funded traditional PATH program. FPATH teams provide assertive outreach and engagement to a by-name list, receive referrals from other Trueblood Settlement elements, and provide intensive case management services to those they enroll. On a monthly cadence, RDA identifies people with two or more competency evaluation orders in the last two years who have higher risk of future intersection with the criminal court system. The FPATH Program Administrator sends the teams a prioritized list so that outreach and engagement efforts are focused on individuals who have the highest barriers, such as people who live in rural counties, have four or more competency evaluation referrals, or experience homelessness.

FPATH teams, within community behavioral health agencies, include enhanced certified peer counselors who have experience working with people experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years. FPATH teams use assertive outreach to connect with, engage, and assist people in getting connected to community supports including housing, transportation, health care, and behavioral health services. People court-ordered for forensic navigator/outpatient competency restoration refer eligible people to FPATH for intensive case management services.

Current Status and Areas of Positive Impact

FPATH teams continue their efforts to outreach and engage eligible people. In the Phase 2 region, the FPATH teams are making inroads with accessing jails in the King County region. They have had the most success when outreaching at smaller jails and/or partnering with forensic navigators.

In March 2022, all FPATH teams across the state met for the first annual FPATH meeting. The meeting was held virtually and was an opportunity for the teams to connect and learn with and from one another. The teams learned about the Settlement Agreement, reflected on the successes of the program, and looked toward the future of the program. One key takeaway from the meeting was the need to create more opportunities for FPATH teams to connect with another.

In April, HCA started facilitating two FPATH learning collaboratives, one for direct service staff and another for program supervisors and leads. The learning collaboratives meet once a month. Team members are also being encouraged to connect with each other outside of HCA facilitated meetings.

HCA has recognized that there is a lot that the teams can learn from one another. For example, the team in the Southwest region is the top performing program for engaging and enrolling eligible people in FPATH. This team regularly participates in the FPATH learning collaboratives and shares strategies for engaging and enrolling eligible people with teams across the state. Additionally, HCA will facilitate site visits across FPATH teams in which programs can share successful practices with one another.

At the end of March 2022, FPATH services began in the King region. Services are being provided by Community House Mental Health Agency and Telecare Corporation. These teams are meeting regularly to coordinate services, ensure there is not duplication, and share resources. They are also participating in twice monthly coordination calls with the King FHARPS team and forensic navigators.

Areas of Concern

At the beginning of April 2022, Comprehensive Life Resources, an FPATH service provider in the Pierce region, notified HCA that it was not interested in renewing its contract for the FPATH program. HCA immediately reached out to Greater Lakes Mental Health to talk about expanding its FPATH program. GLMH agreed to expand, and will be adding two case managers, one certified peer counselor, and one FPATH program team lead. HCA has been working directly with both agencies to ensure continuity of care for people enrolled in FPATH in Pierce County.

Workforce shortages and turnover continues to be an area of concern amongst the teams. The workforce shortage, especially in outreach positions, was a concern expressed by both providers in the King region. That said, both teams were able to hire enough staff to start services in March. By the end of June, both teams were nearly fully staffed.

Recommendations to Address Concerns

HCA worked with Comprehensive Life Resources on transferring engaged and/or enrolled people to Greater Lakes Mental Health. Greater Lakes Mental Health established a plan for working with transferred people and started connecting with them in mid-June. HCA, RDA, and the Department of Commerce worked together to ensure that the transfer of data between the two agencies was done as smoothly as possible.

Previously identified issues with data quality have improved. FPATH teams are utilizing weekly HCA IT office hours to address issues that come up in the data validation process. Data quality has benefited from a monthly HMIS error list created by RDA. Teams are addressing data quality issues on a routine basis.

In order to address work force shortages, teams in all regions are reevaluating their recruitment practices, including looking at new platforms to post their jobs, and attending career fairs in their region. Several teams have implemented a recruitment and retention bonus for new hires. Additionally, HCA was able to increase funding for all teams in the Phase 1 regions, making it possible for all of the teams to keep up with the wage increases needed to retain staff.

By the end of April 2022, the HCA FPATH program administrator was able to complete site visits with all Phase 1 teams. The site visits provided an opportunity to meet the teams, learn about how they structure their programs, and troubleshoot questions in-person. HCA will conduct site visits with teams in King region in the coming months.

Data-Crisis Triage and Diversion-FPATH

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

The FPATH program began March 1, 2020 in Phase 1 regions, and April 1, 2022 in the Phase 2 region. Between March 1, 2020 and June 30, 2022, 1,770 people were referred to the program across all regions (Appendix F, Table 1). HCA has asked providers to focus outreach efforts on a subset of these people based on housing status (prioritizing unstably housed and homeless), number of referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 844.

Of all people on the referral list, FPATH providers attempted to contact 875 (49 percent), and successfully contacted 520 (29 percent). As of June 30, 2022, a total of 299 people (17 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Of these, the majority were male (77 percent) and between 30 and 49 years old (58 percent). More than half of enrollees (66 percent) were homeless, while 21 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Of the Phase 1 regions, Southwest enrolled the largest proportion of those on their referral list (35 percent), while the Pierce region enrolled 12 percent and Spokane enrolled 20 percent. Southwest has historically had the highest enrollment numbers of the Phase 1 regions, but also tends to have less individuals on their referral list. The Phase 2 region has had 15 enrollees since April 1, 2022, which was approximately nine percent of its referral list.

Among all individuals discharged from the FPATH program through June 30, 2022, the average length of stay in the FPATH program was 234 days. People in the Southwest region had the longest length of stay at 299 days, while the Pierce region had the shortest at 185.5 days. The Phase 2 providers have not discharged anyone from their FPATH programs yet (Appendix F, Table 1).

Services

There have been 6,339 service encounters between FPATH providers and participants over the duration of the program, with an average of 3.1 services per participant, per month (Appendix F, Table 2). Individuals enrolled in the Pierce region had an average of 2.9 service encounters per month, while those in the Spokane region had an average of 3.1. Participants in the Southwest region had the highest average of 3.5 service encounters per month. The average number of service encounters per person, per month in the Phase 2 region was 2.7 (73 total encounters). Across all FPATH regions, the most common service encounter was case management (1.4 per month, on average), followed by outreach services (0.7 per month) (Appendix F, Table 2).

Over the past quarter (April 1-June 30, 2022), the number of service encounters per person, per month was higher than average across all Phase 1 regions. The Pierce region, for example, provided an average of 4.0 services per person, per month (compared to 2.9, cumulatively). The Spokane region provided an average of 5.8 services per person, per month (3.1, cumulatively), while Southwest provided an average of 4.0 services per person, per month (3.5, cumulatively) (table not pictured due to low cell counts). This indicates that service encounters are increasing as the FPATH programs continue to mature and evolve.

Referrals

Of the 299 FPATH enrollees, 187 (62.5 percent) had received at least one referral through June 30, 2022 (Appendix F, Table 2). The Spokane region provided the most referrals, with 75 percent of participants having at least one. Nearly 60 percent of program participants in the Pierce region had at least one referral, as well as 62 percent of the Southwest region.

The most common referral throughout all Phase 1 regions was FHARPS housing, with 29 percent of all enrollees receiving at least one referral. Community mental health was another common referral, with one-quarter of enrollees receiving at least one referral (Appendix F, Table 2). Due to low enrollment numbers, and to protect participant confidentiality, referral information for Phase 2 FPATH enrollees is not available as of June 30, 2022.

Education and Training – Crisis Intervention Training

For Phase 1 regions through June 30, 2022, the Criminal Justice Training Commission has completed twenty-three 40-hour courses for law enforcement and certified peace officers, with eight of these occurring since January 2022. Within these classes, CJTC has trained law enforcement officers, mental health professionals, dispatchers, co-responders, military police, and corrections officers. As of June 30, 2022, 968 law enforcement officers have received the training. As of June 30, 2022, every agency in the Phase 1 region has met the 25 percent goal. Now that the 25 percent goal was met, Phase 1 regions will shift to a maintenance schedule that includes two-to-three 40-hour classes annually in each region. The Spokane region already has a scheduled a class for this fall.

CJTC also developed and deployed a webinar-style 8-hour course, specifically to meet the needs of correctional agencies. CJTC conducted 21 of these classes in the first half of 2022. In addition to the earlier traditional courses and the addition of Clark County's 40-hour program, 854 corrections officers have received at least the minimum eight-hour CIT for corrections training. The Lincoln and Skamania counties sheriff's departments cross-train all of their corrections officers as 911 dispatchers. Those officers took the eight-hour 911 CIT training.

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

CJTC collaborated with the state 911 office for delivery of the eight-hour CIT course for dispatchers. The telecom/911 training was reformatted to a hybrid course compromised of four hours of static online training and a follow-up four-hour instructor-led webinar course. It was also found that several telecom training programs already included the eight-hour CIT materials. Several of these programs applied and were granted equivalency status. To date, 443 dispatchers have received the full eight-hour training, and 100 percent of dispatchers in the Phase 1 regions have completed the training.

In Phase 2, King County has been running a robust 40-hour CIT program for several years. Because of this, of the 3,161 certified peace officers in King County, 1,405 have already completed the training (44 percent). However, not every agency has 25 percent of their officers trained yet. Forty-eight officers remain to be trained to bring every King County agency up to the minimum requirement. King County has eight of the 40-hour CIT courses scheduled for the second half of 2022.

King County has six correctional agencies encompassing 769 correctional officers. To date, 279 officers have completed the required 8-hour CIT for corrections training. These courses have been offered exclusively in an interactive webinar format and will continue to be for at least the next six months.

King County has 429 Telecom/911 dispatchers. Of these, 330 (77 percent) have completed either the hybrid 4-hour static/4-hour webinar or an equivalent training. At least two of the webinar courses are scheduled each month and the static course can be taken at any time as a prerequisite.

Areas of Concern

The current training environment continues to present significant challenges. The pandemic and resulting vaccine requirements had a significant impact on staffing levels across the board. The CJTC has doubled the number of basic law enforcement academies, and there remains a four-month wait for entry. Every law enforcement, corrections, and telecom agency is working short staffed. Some are staffed as much as 25 percent below their allotted positions. When an agency cannot cover their active shifts, it is difficult to encourage them to create a larger deficit by sending an officer to 40 hours of training. In addition to the student issues, CJTC is also experiencing instructor shortages. The vaccine mandate and tight labor market have impacted the ability to conduct classes.

Recommendations to Address Concerns

CJTC continues to increase communication and to work with individual agencies to find ways to get students into classes. For example, two agencies sent their academy graduates directly to a 40-hour training before they even were placed on their schedules to begin field officer training. The CIT for Corrections 8-hour course is being offered occasionally on swing shift and on weekends. CJTC is hiring and training new instructors for several blocks of instruction and continue to offer quality training by excellent instructors.

Data-Education and Training-CIT

Phase 1

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

Appendix G, Figure 1 displays training completion rates for each individual law enforcement agency in Phase 1. As of June 30, 2022, all 55 (100 percent) law enforcement agencies met or exceeded the 25-percent benchmark. Large agencies had higher training completion rates (48 percent, overall) than small agencies (36 percent) in all three regions (Appendix G, Table 7).

As shown in Appendix G, Table 1, 27 percent of officers were trained in the Pierce region, compared to 58 percent in the Southwest region, and 55 percent in the Spokane region. Previously, these rates were 19 percent, 56 percent, and 53 percent, respectively (see March 2022 semi-annual report). Washington State Patrol units in the Phase 1 regions have demonstrated a training rate of 27 percent, up from 19 percent in December 2021 (see March 2022 semi-annual report).

The Settlement Agreement also requires 911 dispatchers and correctional officers in the Trueblood Phase 1 regions to complete an eight-hour CIT course by June 30, 2021. As of June 30, 2022, all Phase 1 911 dispatchers had completed CIT training, with completion rates of 100 percent (Appendix G, Table 2). In addition, 90 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 83 percent in the Southwest region to nearly 98 percent in the Pierce region (Appendix G, Table 3).

Phase 2

Appendix G, Figure 2 displays the training completion rates for the law enforcement agencies in Phase 2, which began July 1, 2021. As of June 30, 2022, 17 of the 28 (61 percent) law enforcement agencies were meeting or exceeding the 25 percent benchmark, with an overall training completion rate of 44 percent (Appendix G, Table 4). These training rates remain stable as compared to December 2021 rates (see March 2022 semi-annual report). Washington State Patrol units in Phase 2 had a training completion rate of 21 percent. Similar to Phase 1, large law enforcement agencies had higher training completion rates than small and medium sized agencies (Appendix G, Table 8).

Approximately 77 percent of 911 dispatchers and 36 percent of correctional officers in King County had competed the eight-hour CIT course by June 30, 2022 (Appendix G, Tables 5 and 6). Dispatchers and correctional officers in the Phase 2 region have until June 30, 2023, to meet the 100 percent training requirement.

The Settlement Agreement also states that the 25 percent training target should prioritize agencies that serve areas with higher population densities. As of June 30, 2022, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (Southwest 65 percent and Spokane 63 percent) than the Pierce region (26 percent, Appendix G, Table 7). In the Phase 2 region, large agencies with higher population densities had higher training completion rates (47 percent) than medium and small agencies (36 percent and 30 percent, respectively, Appendix G, Table 8).

Education and Training – Technical Assistance for Jails

DSHS' Jail Technical Assistance program provides training and information to jails across the state to support jail staff in working effectively with persons who live with mental illness.

The Jail Technical Assistance team worked 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's completion occurred on May 14, 2020, prior to the June 1, 2020 deadline. It is now available on the DSHS website[11] and has served as a support document for trainings on the topics it covers.

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plan have been delivered. Webinar-based trainings continue monthly. Many of the training topics have been identified through input from participants attending prior events and providing feedback on additional trainings that would be useful. Jail site visits provide an additional source to identify other topics of interest to jail personnel and their stakeholders.

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. Previously purchased licenses for a suite of authoring tools intended to create more engaging and interactive online learning experiences, has allowed JTA staff to design and publish unique training content specific to stakeholders needs. During summer 2021, JTA staff, along with DSHS Workforce Development staff, engaged with psychology and nursing leadership within the King County Jail to identify training topics of particular interest for jail staff. Over the fall and winter, these staff have followed up by designing a training series that has since been completed and offered to King County Jail staff for initial feedback. It is currently being posted online to offer the training series which will be made available to jails and interested stakeholders statewide. A central focus of this JTA training will be to increase jail staff's understanding of competency to stand trial, and how competency

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

evaluations, competency restoration treatment and associated court activities interface with their daily work.

There has been a significant increase in the use of videoconferencing software to conduct forensic evaluations remotely. The use of videoconferencing has been an effective adaptation to the limitations imposed by COVID-19 on in-person evaluations. It has also helped improve the efficiency with which competency evaluations can be completed. Members of the JTA team have been centrally involved in providing guidance and technical assistance statewide in support of this transition to increased online forensic evaluations at jails throughout the state. OFMHS is in the process of standing up a telehealth committee and JTA staff have been identified to serve as co-lead for this effort. There will be several subcommittees, to include forensic evaluators and IT, to ensure reliable service and delivery. DSHS continues to provide support for jail-based competency evaluations to be completed via videoconferencing. More than 50 locations statewide are now using videoconferencing to complete more than 212 competency evaluations per month.

During FY22, as COVID-19 restrictions began to ease, staff were able to resume in-person visits to jails. This engagement with jails statewide has centered on a semi-structured interview designed to gather further information regarding practices across jails in four key areas of mental health work:

- Initial screening to identify possible mental illness
- Mental health assessment
- Capacity to provide mental health treatment within jails; and
- Continuity of care for people upon discharge from jail.

In addition to gathering information on the topics listed above, visits have also included discussion of challenges and identification of best practices. A site visit report has been documented for each facility. To date, FY22 jail visits have been conducted at the following jails:

South County Corrections Entity (SCORE CITY Jail)	City of Hoquiam	City of Aberdeen
King County Downtown Adult Detention Center	Maleng Regional Justice Center	Cowlitz County Jail
Lewis County Jail	Chehalis Tribal Jail	Olympia City Jail
Mason County Jail	Kitsap County Jail	Grays Harbor Jail
Wahkiakum County Jail	Pierce County Jail	Skamania County Jail
Clark County Jail	Pacific County Jail	Snohomish County Jail
Thurston County Jail	Island County Jail	Skagit County Jail
Whatcom County Jail	Yakima County Jail	Kittitas County Jail
Stevens County Jail	Jefferson County Jail	Clallam county Jail
Forks City Jail	Klickitat County Jail	Franklin County Jail
Benton County Jail	Grand County Jail	Chelan County Jail
Walla Walla County Jail	Columbia County Jail	Garfield County Jail
Asotin County Jail	Spokane County Jail	Lincoln County Jail
Pen Oreille County Jail	Ferry County Jail	Okanagan County Jail
Yakima City Jail	Adams County Jail	Whitman County Jail

Areas of Concern

A continuing area of focus is regional awareness of the JTA program. Although the foundation of the program has been established and a communications plan created, program awareness, as well as attendance (by jail staff, etc.) at trainings offered by the JTA team could be enhanced. To address this, beginning in July 2021, the JTA team implemented a method of tracking the number of participants in each JTA monthly webinar. The team is also consulting with DSHS information technology staff to seek more ways of tracking the number of visits to materials on the JTA website. By gathering this information, the team aims to identify opportunities for expanding the reach of our training and technical assistance efforts. As of July 2022, the number of participants in our monthly JTA training events has steadily increased. We are continuing to work to expand the number of people who participate in these events. Since July 2021, we have begun tracking who is attending the trainings and requesting that participants complete a brief survey after each training to help us better understand what participants are finding of interest. The OFMHS Workforce Development administrator and JTA staff gave a presentation at the fall 2021 WASPC Conference, which included information about the monthly JTA training events and information on how to join them. We are also developing new trainings that we hope will help stimulate additional interest in the monthly training events.

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. To date, the number of survey responses has been relatively small. However, that small sample of survey results has indicated that participants find the trainings to be well designed and delivered. Survey responses also indicate that participants find the training topics to be relevant to the needs of jail staff.

Recommendations to Address Concerns

JTA staff have accelerated an awareness campaign through increased jail site visits and taking part in engagement at opportunities such as the WASPC spring conference. These interactions provide additional avenues to solicit information regarding JTA needs.

As information is gathered regarding the strengths and challenges of mental health work in jails through the visits mentioned above, it is recommended to build upon the bank of current resources by providing additional materials that are implementation ready. For example, through conversations with our workforce partners, many would clearly benefit from materials that could be downloaded and used, such as screening instruments, discharge planning templates, and many other relevant templates, tools, and instruments. Additionally, many would benefit from the availability of model policies and procedures developed by other jurisdictions that have addressed the needs of forensically-involved persons with mental health conditions.

Data-Jail Technical Assistance

Effective July 1, 2021, the Jail Technical Assistance team implemented a method to accurately track participation in the monthly JTA training webinars and staff track telehealth data as part of the telehealth committee.

Enhanced Peer Support

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

Current Status and Areas of Positive Impact

HCA, in partnership with OFMHS, developed a continuing education training titled *The Intersection of Behavioral Health and the Law* that provides a foundational overview of the forensic mental health system. This training was developed for certified peer counselors who work on Trueblood-related services as well as other professionals who work within the forensic mental health system. The IBHL curriculum and the complimentary online training are currently available to learners through a learning management system. This training focuses on the components of the legal system and how they intersect with the behavioral health system. Professionals in the legal and forensic mental health systems also learn about the impacts and effectiveness of peer support services.

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

It is important to note that these virtual trainings were designed to maximize learner engagement, provide an interactive learning experience, and comply with Section 508 ensuring accessibility to all learners accessing the trainings through the learning management system. Section 508 of the Rehabilitation Act of 1973 ensures that people who are living with disabilities have equal access to government information contained on information and communications technology, thereby, ensuring access to government employment programs and services to which all citizens are entitled.

The subject matter expert who co-created the *Enhancing Your Cultural Intelligence* training also facilitated a train-the trainer event for this diversity, equity, and inclusion training in February 2022. This two-day train-the-trainer event had a strong focus on how to most effectively present the content and how to manage learning environments with learners who have varying levels of experience and understanding of topics related to diversity, equity, and inclusion. Since this event, the EPS program continues to bring this group of trained trainers together monthly to discuss the content and prepare to present the training to learners in-person, when it is deemed safe to do so.

Certified peer counselors on Trueblood program teams and court-funded diversion programs continue to come together quarterly for the Trueblood CPC Learning Community. CPCs from teams across the state are in attendance, including CPCs working in the King region. Recent Trueblood CPC Learning Community topics of discussion included, but are not limited to, connecting with people who are in the state hospitals, how to bridge the voluntary nature of receiving peer support services with mandatory program participation, accessing the *Intersection of Behavioral Health and the Law* and *Enhancing Your Cultural Intelligence* trainings through the learning management system, and professional development opportunities offered by the HCA Peer Support Services team. Additionally, the learning community provided technical assistance, resourcing, and networking for CPCs on Trueblood program teams and court-funded diversion programs throughout Washington state.

Certified peer counselors working on Trueblood program and court-funded diversion program teams were invited by the EPS program to participate on formal panels to inform others of the work that CPCs are doing and to speak to the power of peer support services. In March 2022, a panel of CPCs on Trueblood program and court-funded diversion program teams work was featured in the jail technical assistance program's monthly webinar, highlighting the support that they offer to people who are incarcerated and near release for the jail staff and jail leadership that were in attendance. Another panel of CPCs was invited by the EPS program to speak to members of the Trueblood General Advisory Committee about the work that they are doing to connect with people who are in jail and to bridge supports and services in the community.

Traditionally, people with criminal court involvement have been reluctant to move forward to become certified peer counselors because of the possibility that 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. As these changes are being realized, workforce opportunities are slowly expanding for individuals with lived criminal court and behavioral health experiences. As a result, the EPS program had been working in collaboration with the HCA Peer Support program and the Department of Corrections to offer the 40-hour certified peer counselor certification training to people who are currently incarcerated, affording them an opportunity to share their story and recovery story through employment as certified peer counselors when they re-enter the community. Furthermore, the EPS program lead applied for and was invited to join The National Justice-Involved Peer Support Council, a group that facilitates networking and mutual learning focused on peer support that is provided within jails, prisons, and post-incarceration. This council will meet weekly with the support of Doors to Wellbeing, a SAMHSA-funded national consumer technical assistance center of the Copeland Center for Wellness and Recovery.

Areas of Concern

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

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails. The EPS program has connected with jail staff and DOC administrators to provide education about peer support services and the role of unique role certified peer counselors. Certified peer counselors have continued to find success in entering the jails by working directly with the sergeant on duty. The Enhanced Peer Services Program administrator is working to bring together practices that have led to success in entering the jails in an effort to operationalize certified peer counselors entering the jails.

Data-Enhanced Peer Support

Beginning February 2022, data collection around completion of the online trainings offered by the Enhanced Peer Support program has been captured by a learning management system that registers individual users and tracks each user's completion of trainings. Between February and June 2022, 68 certified peer counselors, including those from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions, have completed *The Intersection of Behavioral Health and the Law* online training. Between March 2022 and June 2022, 101 certified peer counselors, including those from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions have completed *Enhancing Your Cultural Intelligence* online training.

Workforce Development

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

The WFD team has been involved in a range of initiatives. In previous reports, WFD described progress on a comprehensive training plan to provide guidance in the scope, process, and focus of training provided by WFD. In January 2021, OFMHS finalized the *Forensic Workforce Development and Jail Technical Assistance Training Plan*. This document helps define the parameters of the WFD team's functions within the broader workforce development system in the state of Washington.

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 increase awareness of and to stimulate interest in the field, and to provide information about the training and qualifications required. Six brochures were finalized in March 2021. These "Career Pathway" brochures illustrate the educational pathways for forensic behavioral health careers in psychology, social work, peer counseling, mental health counseling, nursing, and psychiatry.

Current Status and Areas of Positive Impact

One of the recommendations that Groundswell Consulting Services provided regarding workforce development was to "increase basic forensic literacy." In early 2022, the workforce development team worked with Washington state K-12 school districts and skill centers to distribute these career pathway brochures. The goal of this effort is to lead to students developing an interest in possible careers working at the intersection of behavioral health and the law.

Another significant effort during FY22 has been to develop an online training series specifically designed to address the previously identified need to enhance basic forensic literacy. Workforce development staff worked in partnership with leadership staff at the King County Jail to craft an outline of the topics to be covered in this training series. Based on that consultation, workforce development staff created a five-module online training series that covers:

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

5. Continuity of care

Each of these online training modules is 30 minutes or less. They provide learners with a foundational understanding of our state's forensic mental health system, with a particular emphasis on competency to stand trial and factors related to the Settlement Agreement. This series is being offered to strategic partners and workforce development staff continue to collect feedback to refine and keep the training current. This training series will be used to accomplish the strategic goal of enhancing basic forensic literacy for a variety of system partners. To that end, the training will be made available at no cost to all jail staff statewide, educational partners, service providers, and any/all partners in implementation of Settlement Agreement endeavors. The online training series will be available to all state employees through the state's Learning Center. It will also be available to anyone outside of state government via the OFMHS workforce development website, to include prosecutors, defenders, judges, behavioral health providers, law enforcement, and to our partners in the field of education. Additionally, during FY22, workforce development staff began the application process for making continuing education credits available for people who complete the online training series.

As a result of FY22 work, an online training series on trauma-informed approaches is now available to state-employed staff and any other interested parties online at no cost, through a partnership between DSHS and HCA. Additionally, workforce development staff lead the trauma-informed care workforce development subcommittee in an intensive effort to embed trauma-informed principles into all DSHS forensic mental health facilities, starting with a pilot project at Western State Hospital.

In June 2021, WFD staff completed the workforce report, *The Washington State Forensic Mental Health Workforce: Assessing the Need and Target Areas for Training, Certification, and Possible Degree Programs*. This report was distributed to the executive committee and to key and interested legislators. This workforce report analyzed the need and target areas for additional training, certification, and degree programs; examined the availability of those programs in and outside of Washington; assessed the statewide workforce needs of the Trueblood programs over the next 10 years; and included recommendations detailed by high, medium, and low cost and by long-, medium-, and short-term recommendations for future action. WFD staff continue to work on strategies to implement these recommendations.

WFD continues to build on partnerships and opportunities for collaboration. Some examples are WFD staff's active engagement with the Workforce Training and Education Coordinating Board workgroups, the King County Competency Continuum Workgroup, the Washington State Association of Sheriffs and Police Chiefs, the Trauma Informed Care Committee, and with the Health Care Authority's Division of Behavioral Health and Recovery. In FY22, workforce development staff created a survey to learn more about the perspectives of prosecutors, defense counsel, and judges regarding the continuing increase in demand for pretrial competency services. A total of 279 respondents returned completed surveys. A key finding resulting from this survey identified

opportunities for DSHS to help address important training needs for our legal partners. Workforce development staff have presented the survey results and proposed next steps to the executive leadership team of DSHS' Behavioral Health Administration. Future steps will include sending a report on the survey results to all those who received it, and conducting follow-up focus groups to engage further with survey respondents.

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

Additionally, the workforce development team has developed and deployed a Curriculum Review Committee in adherence to OFMHS' policy, 11.08 Training. Designated staff review all internal and external OFMHS training material and make required and/or recommended changes to the author. Training material is tracked and once finalized, placed in a training repository for future use.

Areas of Concern

The WFD team is on track to complete all required Phase 2 element tasks on time or ahead of schedule. COVID-19 impacts remain an area of concern. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. However, the use of videoconferencing for online interaction and other available means allows us to engage our partners and continue working to provide education and training to prepare people to enter and successfully work in this field. In addition, a broad challenge regarding workforce development is ongoing statewide workforce shortages within the field of mental health.

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 reach our audiences more effectively. The WFD team continues to use Articulate software to create online trainings to supplement limited in-person offerings.

Data-Workforce Development

In preparing the Forensic Workforce Report, the OFMHS workforce development team surveyed state staff to learn the numbers and types of staff identified in each contract that is related to operationalizing Phase 1 of the Settlement Agreement. WFD then used population data to make

estimates of how many staff, of which types, would be required to implement the Settlement Agreement statewide. This methodology informed some estimates of forensic workforce needs. Thus far, available workforce data from existing sources are not sufficiently specific to the forensic mental health field to support reliable analysis of specific workforce needs. Consultation with RDA and members of state workforce development organizations has been initiated and will continue.

Conclusions

Behavioral health transformation is well underway in Washington state. The two-year designated implementation period for Phase 1 of the Settlement Agreement concluded on June 30, 2021, and along with continuing to serve Trueblood class members and other eligible clients in the 10 counties that comprise the three Phase 1 regions, most Trueblood programming in the Phase 2 King region is operational. Phase 2 began on July 1, 2021 and continues through June 30, 2023.

Excitement over Phase 1's successful implementation and recent progress on Phase 2 implementation remains tempered, however, by the challenges faced with the COVID-19 pandemic and resulting workforce challenges. In late fall 2021, just as it seemed the most severe Delta variant wave of the pandemic was concluding, the Omicron variant emerged as the most rapidly infectious variant to date, but also as an overall less deadly form of COVID-19. Omicron, severely impacted operations in January and February 2022, but its impacts, although waning over time, continued to be felt in Trueblood implementation throughout Q2 2022.

The COVID-19 pandemic continues to place significant constraints on daily life and normal operations of the state's behavioral health system. State and local providers continue to contend with a nationwide behavioral health workforce shortage as well as a behavioral health workforce that has been stretched thin and burnt out by the demands of the pandemic, with many vacancies still left to fill. COVID-19-related impacts to Trueblood initiatives are ongoing, and additional impacts could emerge, efforts to mitigate the effects notwithstanding. Criminal courts have begun processing significant case backlogs built up during the pandemic. In part, these backlogs have fueled record high demand for evaluation services during FY22.

The state remains committed to implementing the elements of the Settlement Agreement and continuing to improve those elements already established in Phase 1. Phase 1 programs continue to gain experience serving their clients and recently implemented Phase 2 programming is rapidly gaining experience in the field and benefiting from the knowledge gained during Phase 1. When the next semi-annual report is published in late March 2023, HCA and the department will be almost two years into implementing Phase 2 programming in the King region.

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

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

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

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

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

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

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

Trueblood *Implementation Plan:* *www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/*Trueblood*/2019*Trueblood*/679_1_Exhibit A_FinalPlan.pdf*

Trueblood *August 2022 Progress Report for the Court Monitor and Appendices A-L:*

August | Appendix A-G | Appendix H | Appendix I | Appendix J | Appendix K | Appendix L

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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

Appendix B-OCRP Dashboard

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

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

REPORTING PERIOD
Cumulative: July 1, 2020 to June 30, 2022

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

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TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	66	100.0%	25	100.0%	23	100.0%	18	100.0%
Among Enrolled Clients…								
RESTORATION ORDER TYPE (unduplicated)								
Felony	51	77.3%						
Misdemeanor	15	22.7%						
GENDER								
Female	13	19.7%						
Male	53	80.3%						
AGE GROUP								
18-29 yrs	21	31.8%						
30-49 yrs	30	45.5%						
50+ yrs	15	22.7%						
RACE/ETHNICITY*								
Non-Hispanic White	45	68.2%						
Black, Indigenous, and People of Color	21	31.8%						
HOUSING STATUS AT PROGRAM ENROLLMENT								
Stably Housed	16	24.2%						
Unstably Housed	40	60.6%						
Homeless	9	13.6%						
Unknown	1	1.5%						

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

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

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

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)								
Enrolled	66	100.0%	25	100.0%	23	100.0%	18	100.0%
Active	11	16.7%						
Discharged	55	83.3%						
Among Discharged Clients…								
DISCHARGE REASON								
Charges Dismissed	8	14.5%						
Opined Competent	21	38.2%						
Opined Not Competent	4	7.3%						
Opined Not Restorable	1	1.8%						
Returned to Jail	3	5.5%						
Inpatient Medical Care	0	0.0%						
Inpatient Civil Psychiatric Care	2	3.6%						
Revoked Conditional Release	14	25.5%						
Death	0	0.0%						
Missing/Unknown	2	3.6%						
DISCHARGE LOCATION								
Community	37	67.3%						
Residential Treatment Facility	1	1.8%						
State Hospital	6	10.9%						
Jail	5	9.1%						
Unknown	6	10.9%						
LENGTH OF STAY								
Average Length of Stay in Program (days)	69	N/A						

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

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 sections are suppressed to protect confidentiality.

OCRP Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase 1 regions: Pierce, Southwest, Spokane.
Phase 1 Regions	Phase 1 regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Individuals assessed and enrolled into OCRP during the reporting period.
Restoration Order Type	Restoration order type, based on most serious charge of first competency period orders (including concurrent orders). An individual with both a misdemeanor and felony competency restoration order is counted as a felony restoration order.
Misdemeanor	Restoration order with one or more misdemeanor charges as specified in RCW 9a.20.
Felony	Restoration order with one or more felony charges as specified in RCW 9a.20.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Black, Indigenous, and People of Color categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was unreported.
Housing Status at Program Enrollment	Self-reported housing status at time of program enrollment.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
DISCHARGE TABLE, Cumulative	
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.
Discharge Reason	Reason the program ended for participant. Providers are limited to one dropdown option. Table reflects this selection.
Charges Dismissed	Participant charges were dismissed by court order; program has no legal authority to retain participant in the program.

Opined Competent	Evaluator opined the participant competent to stand trial.
Opined Not Competent	Evaluator opined the participant not competent to stand trial but possibly restorable.
Opined Not Restorable	Evaluator opined the participant not competent to stand trial and not restorable.
Returned to Jail	Participant returned to jail and there is no expectation that they would return to the program. Used if 'returned to jail' was the only reason for program end.
Inpatient Medical Care	Participant admitted to a medical hospital due to a serious medical condition (e.g., liver transplant) and there is no expectation the participant will return, or participant did not return from a Leave of Absence for inpatient medical care.
Inpatient Civil Psychiatry Care	Participant admitted voluntarily or involuntarily to an inpatient psychiatric facility (community or state hospital) due to grave disability and/or danger to self or others (e.g., participant is at risk of suicide or homicide) with no expection the participant will return, or participant did not return from a Leave of Absence for inpatient psychiatric care.
Revoked Conditional Release	Court revoked conditional release order.
Death	Participant passed away while in the program.
Missing/Unknown	Discharge reason is sometimes unknown by providers at time of discharge and left blank in excel trackers. Providers are encouraged to update this field when a reason is determined.
Discharge Location	Location of participant at time of program end.
Community	Participant was not in a facility at the time of discharge. Some participants may be pending inpatient treatment.
Residential Treatment Facility	Maple Lane, Yakima, and Fort Steilacoom competency restoration facilities.
State Hospital	Western and Eastern State Hospitals.
Jail	County, city, or tribal jail facility.
Unknown	Discharge location unknown.
Length of Stay	Length of stay at time of program end.
Average Length of Stay in Program (days)	The average (mean) length of stay, in days, from the most recent OCRP enrollment date to OCRP discharge date, among participants discharged. Leaves of absence from the program are excluded.

Appendix C-Forensic Navigator Dashboard

Forensic Navigator Dashboard

Forensic Navigator Program

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2022

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

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TABLE 1.

Forensic Navigator Enrollment and Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	2,854	100%	952	100%	415	100%	659	100%	828	100%
Forensic Navigator Assigned	2,818	99%	947	99%	413	100%	658	100%	800	97%
Among Clients Assigned a Forensic Navigator…										
CLIENT STATUS (on last day of reporting period)										
Active	443	16%	93	10%	51	12%	68	10%	231	29%
Pre-Competency Hearing	422	15%	83	9%	44	11%	64	10%	231	29%
OCRP Enrolled	17	1%	--	--	--	--	--	--	0	0%
Post-OCRP (Coordinated Transition)	4	0%	--	--	--	--	--	--	0	0%
Discharged	2,375	84%	854	90%	362	88%	590	90%	569	71%
GENDER										
Female	615	22%	208	22%	80	19%	158	24%	169	21%
Male	1,932	69%	676	71%	310	75%	485	74%	461	58%
Unknown	271	10%	63	7%	23	6%	15	2%	170	21%
AGE GROUP										
18-29	645	23%	230	24%	121	29%	151	23%	143	18%
30-49	1,617	57%	523	55%	219	53%	365	55%	510	64%
50+	556	20%	194	20%	73	18%	142	22%	147	18%
RACE/ETHNICITY*										
American Indian or Alaskan Native	44	2%	28	3%	--	--	--	--	--	--
Asian	69	2%	24	3%	--	--	--	--	29	4%
Black or African American	535	19%	249	26%	56	14%	47	7%	183	23%
Hispanic or Latino	56	2%	13	1%	--	--	--	--	22	3%
Native Hawaiian or Pacific Islander	40	1%	35	4%	--	--	--	--	0	0%
White Only, Non-Hispanic	1532	54%	464	49%	257	62%	475	72%	295	37%
Other Race	43	2%	--	--	--	--	--	--	29	4%
Unknown	567	20%	131	14%	69	17%	113	17%	254	32%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
MOST SERIOUS CURRENT CRIMINAL CHARGE										
Felony	1,487	53%	553	58%	250	61%	419	64%	265	33%
Misdemeanor	1,330	47%	394	42%	163	39%	238	36%	535	67%
Unknown	1	0%	--	--	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM INTAKE										
Stably Housed	413	15%	141	15%	91	22%	127	19%	54	7%
Unstably Housed	270	10%	136	14%	56	14%	54	8%	24	3%
Homeless	601	21%	183	19%	163	39%	170	26%	85	11%
Unknown	1,534	54%	487	51%	103	25%	307	47%	637	80%

DATA SOURCE: Navigator Case Management System and Forensic Data System.

NOTES: See 'Definitions' for more detailed information on each reporting category. All individuals in Phase 1 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. Counts and percentages may not sum due to unreported data and/or rounding.

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

TABLE 2.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
POPULATION										
Active Clients (at any point during reporting period)	2,818	100%	947	100%	413	100%	658	100%	800	100%
Avg Daily Navigator Caseload (most recent quarter of reporting period)	24	N/A	24	N/A	26	N/A	20	N/A	25	N/A
Among Active Clients (at any point during the reporting period)…										
FORENSIC NAVIGATOR SERVICES										
Assisting Clients with Attending Classes and Appointments	42	1%	18	2%	12	3%	12	2%	0	0%
Attending Competency Hearing	727	26%	179	19%	292	71%	254	39%	--	--
Client Meeting, Interview, and/or Observation	1,430	51%	542	57%	298	72%	421	64%	169	21%
Client Support-Network Interactions	175	6%	61	6%	--	--	74	11%	--	--
Completed Recommended Services Plan	1,886	67%	658	69%	306	74%	496	75%	406	51%
OCRP Compliance Monitoring	69	2%	22	2%	30	7%	--	--	--	--
Contact with Client's Attorney or Prosecutor	2,309	82%	826	87%	306	74%	545	83%	632	79%
Coordination of Care	870	31%	241	25%	249	60%	334	51%	46	6%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	315	11%	44	5%	156	38%	115	17%	0	0%
Information Gathering	2,787	99%	941	99%	412	100%	656	100%	778	97%
Medication Monitoring	101	4%	--	--	74	18%	18	3%	0	0%
Outreach Services - Attempted Contact	557	20%	163	17%	89	22%	280	43%	25	3%
Outreach Services - Client Contact	348	12%	--	--	112	27%	197	30%	--	--
Post-OCRP Client Check-in (up to 60 days)	16	1%	--	--	--	--	--	--	0	0%
Post-OCRP Coordinated Transitions	12	0%	--	--	--	--	--	--	0	0%
Referral to Services	701	25%	210	22%	115	28%	288	70%	88	11%
REFERRALS										
Adult Protective Services	1	0%	0	0%	0	0%	--	--	--	--
Community Outpatient Mental Health Services	190	7%	19	2%	25	6%	146	35%	0	0%
Designated Crisis Responder Referral	3	0%	0	0%	--	--	--	--	0	0%

EBT/ABD (Food/Cash Benefits)	65	2%	--	--	--	--	61	15%	0	0%
Educational Services	18	1%	0	0%	0	0%	18	4%	0	0%
Employment Assistance	36	1%	0	0%	--	--	--	--	0	0%
Forensic HARPS Services	356	13%	140	15%	67	16%	83	20%	66	8%
Forensic PATH Services	447	16%	161	17%	75	18%	149	36%	62	8%
Home and Community Services	80	3%	0	0%	--	--	--	--	0	0%
Housing Services (Non-HARPS)	93	3%	--	--	--	--	87	21%	0	0%
Job Training	11	0%	0	0%	0	0%	11	3%	0	0%
Medical Insurance Services	32	1%	0	0%	--	--	--	--	0	0%
Other Community Based Resource	116	4%	20	2%	--	--	82	20%	--	--
Primary Health Care/Dental Care	11	0%	0	0%	--	--	--	--	0	0%
SSI/SSDI	47	2%	0	0%	--	--	--	--	0	0%
Substance Use Disorder Treatment	120	4%	--	--	--	--	112	27%	0	0%
Supported Employment	7	0%	0	0%	--	--	--	--	--	--
VA Benefits	3	0%	--	--	0	0%	--	--	0	0%

DATA SOURCE: Navigator Case Management System and Forensic Data System.

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
CLIENTS DISCHARGED										
Clients Discharged During the Reporting Period	2,375	100%	854	100%	362	100%	590	100%	569	100%
Clients Discharged with Warm Hand-Off to Provider or Jail Staff	758	32%	271	32%	117	32%	279	47%	91	16%
Among Clients Discharged…										
DISCHARGE REASON										
Charges Dismissed	328	14%	102	12%	32	9%	49	8%	145	25%
Civil Conversion - Removal from OCRP	4	0%	--	--	0	0%	--	--	0	0%
Client Death	3	0%	0	0%	--	--	--	--	0	0%
Client Determined Competent	724	30%	307	36%	129	36%	159	27%	129	23%
Dismiss & Refer (to DCR)	145	6%	67	8%	--	--	--	--	39	7%
Diversion Program(s)	3	0%	0	0%	--	--	--	--	0	0%
Felony (72-Hour) Civil Conversion	19	1%	--	--	--	--	11	2%	--	--
Inpatient Restoration	601	25%	279	33%	119	33%	95	16%	108	19%
Not Restorable - Developmental Disability	5	0%	--	--	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	5	0%	--	--	--	--	--	--	0	0%
Order Canceled or Withdrawn	62	3%	12	1%	--	--	--	--	33	6%
Re-Arrest	1	0%	--	--	0	0%	0	0%	--	--
Refused Forensic Navigator Services	58	2%	17	2%	--	--	28	5%	--	--
Released From Jail on Personal Recognizance (PR)	386	16%	54	6%	20	6%	209	35%	103	18%
Successful OCRP Completion - Coordinated Transition Completed	18	1%	--	--	--	--	--	--	0	0%
Successful OCRP Completion - Summary of Treatment Completed	0	0%	0	0%	0	0%	0	0%	0	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	13	1%	--	--	--	--	--	--	0	0%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started January 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
LENGTH OF STAY										
Average Length of Stay in Forensic Navigator Program (days)	35.9	N/A	32.3	N/A	46.3	N/A	41.9	N/A	28.6	N/A

DATA SOURCE: Navigator Case Management System and Forensic Data System.

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

Forensic Navigator Program Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and Phase 2 regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County
Southwest Region	Clark, Klickitat, and Skamania Counties
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
Phase 2 Region	Phase 2 region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is 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 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. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
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, Cumulative	
Avg Daily Caseload	The average daily caseload per Forensic Navigator during the reporting period's most recent quarter.
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.
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	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 Referral	Forensic Navigator referred client to the Designated Crisis Responders.
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, Cumulative	
Discharged with Warm Hand-Off to Provider or Jail Staff	When a Forensic Navigator interacts with service providers or correctional staff to move a client from the Forensic Navigator Program to a jail, community mental health agency, hospital, Residential Treatment Facility, or other forensic service. Occurs if client had a Forensic Navigator assigned, a competency hearing took place, and that client is not ordered to the OCRP.
Discharge Reasons	The reason Forensic Navigator services ended and the individual was discharged from the program.
Charges Dismissed	The criminal charges associated with the order for competency services were dismissed.
Client Death	Client deceased.
Client Determined Competent	Client found competent by the court.
Dismiss and Refer (to DCR)	Charges were dismissed and the client was referred by the court to the Designated Crisis Responders for evaluation.
Diversion Program(s)	Client ordered by court into diversion program (e.g. prosecutorial diversion program).
Felony (72-Hour) Civil Conversion	The court ordered a forensic to civil conversion commitment (72 Hour Felony) at the initial competency hearing.
Civil Conversion - Removal from OCRP	The court ordered a forensic to civil conversion commitment (72 Hour Felony/Misdemeanor Evaluation) after the client had been ordered to OCRP.
Inpatient Restoration	Client ordered by court into state psychiatric hospital for inpatient restoration services.
Not Restorable - Developmental Disability	Navigator services ended because the level of the client's disability indicated to the court that the client could not be restored.

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

Appendix D-Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Crisis Housing Voucher Disbursals

CUMULATIVE UPDATE

Beginning December 2019, Washington State Health Care Authority contracted funds for select crisis triage and stabilization facilities. The intent of the program was to provide crisis housing vouchers for persons leaving a facility without housing. To better meet community needs, contracts were expanded to allow teams to distribute vouchers outside crisis triage and stabilization facilities. 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. Vouchers were available in the Phase 2 region (King County) in June 2022. No King County data were available at the time of this report.

REPORTING PERIOD
Cumulative: December 1, 2019 to June 30, 2022

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

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TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Vouchers Disbursed	341	100%	37	10.9%	128	37.5%	176	51.6%
Recipients (unduplicated)	251	100%	37	14.7%	106	42.2%	108	43.0%
Total Amount Disbursed	$326,038	N/A	$35,588	N/A	$139,411	N/A	$151,039	N/A
Average Amount Per Recipient	$1,299	N/A	$962	N/A	$1,315	N/A	$1,399	N/A
FACILITY REFERRAL SOURCE								
Crisis Call Center	2	0.8%						
Family/Friend	3	1.2%						
Hospital	109	43.4%						
Mobile Crisis Response	10	4.0%						
Designated Crisis Responder	19	7.6%						
Tribe or Indian Healthcare Provider	0	0.0%						
Emergency Responder	2	0.8%						
Other Healthcare Provider	16	6.4%						
Law Enforcement (Police, Co-Responders)	13	5.2%						
Court/Criminal Justice Referred	0	0.0%						
Self	75	29.9%						
Other	2	0.8%						
GENDER								
Female	75	29.9%						
Male	170	67.7%						
Other/Unknown	6	2.4%						
AGE GROUP								
18-29	40	15.9%	--	--	--	--	19	17.6%
30-49	152	60.6%	18	48.6%	66	62.3%	68	63.0%
50+	59	23.5%	11	29.7%	27	25.5%	21	19.4%
RACE/ETHNICITY*								
Non-Hispanic White	172	68.5%	22	59.5%	83	78.3%	67	62.0%
Black, Indigenous, and People of Color	69	27.5%	15	40.5%	23	21.7%	31	28.7%
Unknown	10	4.0%	--	--	--	--	--	--

	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	105	41.8%	23	62.2%	27	25.5%	55	50.9%
Contacted by FHARPS Staff	97	38.6%	22	59.5%	22	20.8%	53	49.1%
Enrolled in FHARPS	97	38.6%	22	59.5%	22	20.8%	53	49.1%
Housed or Sheltered by FHARPS	85	33.9%	19	51.4%	20	18.9%	46	42.6%
Among Individuals Housed or Sheltered by FHARPS…								
FIRST FHARPS HOUSING TYPE**								
Permanent	3	3.5%	--	--	--	--	--	--
Transitional	9	10.6%	--	--	--	--	--	--
Shelter/Emergency	73	85.9%	17	89.5%	--	--	41	89.1%
Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%

DATA SOURCES: Excel trackers submitted by each contracted provider to the Washington State Health Care Authority.

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 sections and cells with '--' are suppressed to protect confidentiality.

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

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

Crisis Housing Voucher Definitions

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

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

Appendix E-FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

Forensic Housing and Recovery Through Peer Services, is designed to provide residential 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. FHARPS services began in the Phase 2 region (King County) in April 2022.

REPORTING PERIOD

Cumulative: March 1, 2020 to June 30, 2022

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

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TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started March 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	1,176	100%	548	100%	225	100%	352	100%	51	100%
Contacted	712	61%	343	63%	192	85%	160	45%	17	33%
Enrolled	657	56%	326	59%	162	72%	155	44%	14	27%
Among Referred Individuals…										
REFERRAL SOURCE*										
Trueblood Partner Programs	618	53%	220	38%	--	--	238	64%		
Forensic Navigator	*262*	*22%*	*86*	*16%*	--	--	*70*	*20%*		
Forensic PATH	*175*	*15%*	*76*	*14%*	*16*	*7%*	*83*	*24%*		
OCRP	*5*	*0%*	--	--	--	--	--	--		
Crisis Stabilization Center	*155*	*13%*	*48*	*9%*	*35*	*16%*	*72*	*20%*		
Mobile Crisis Response	*1*	*0%*	--	--	--	--	--	--		
Co-Response Team	*20*	*2%*	--	--	--	--	--	--		
Behavioral Health Facility - Outpatient	225	*19%*	96	*18%*	90	*40%*	--	--		
Inpatient Facility	45	*4%*	25	*5%*	--	--	--	--		
Family/Self	49	*4%*	31	*6%*	--	--	--	--		
Other	240	*20%*	177	*32%*	--	--	45	*13%*		
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT*										
Phone	391	55%	206	60%	151	79%	--	--		
Court	2	0%	--	--	--	--	--	--		
Hotel/Motel	24	3%	21	6%	--	--	--	--		
Jail	84	12%	--	--	33	17%	23	14%		
Crisis Stabilization Center	66	9%	14	4%	--	--	52	33%		
Behavioral Health Facility - Outpatient	70	10%	46	13%	--	--	--	--		
Inpatient Facilty	12	2%	--	--	--	--	--	--		
Shelter	5	1%	--	--	--	--	--	--		
Street/Encampment	3	0%	--	--	--	--	--	--		
Temporary Residence	4	1%	--	--	--	--	--	--		
Other	52	7%	32	9%	--	--	--	--		

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started March 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	219	33%	113	35%	47	29%	45	29%	14	6%
Discharged (during reporting period)	438	67%	213	65%	115	71%	110	71%	0	0%
GENDER										
Female	198	30%	--	--	--	--	--	--	N/A	N/A
Male	449	68%	214	66%	114	70%	--	--	N/A	N/A
Other/Unknown	10	2%	--	--	--	--	--	--	N/A	N/A
AGE GROUP										
18-29	152	23%	83	25%	--	--	--	--	N/A	N/A
30-49	367	56%	154	47%	--	--	104	67%	N/A	N/A
50+	138	21%	89	27%	--	--	--	--	N/A	N/A
RACE/ETHNICITY**										
American Indian or Alaska Native	55	8%	27	8%	15	9%	--	--	N/A	N/A
Asian	11	2%	--	--	--	--	--	--	N/A	N/A
Black or African American	175	27%	122	37%	--	--	24	15%	N/A	N/A
Hispanic or Latino	66	10%	34	10%	17	10%	--	--	N/A	N/A
Native Hawaiian or Pacific Islander	10	2%	--	--	--	--	--	--	N/A	N/A
White Only, Non-Hispanic	347	53%	144	44%	--	--	105	68%	N/A	N/A
Other Race	36	5%	--	--	22	14%	0	0%	N/A	N/A
Unknown	0	0%	--	--	--	--	--	--	N/A	N/A
HOUSING STATUS AT PROGRAM ENROLLMENT*										
Unstably Housed	188	29%	71	22%	--	--	--	--	N/A	N/A
Homeless	470	72%	256	79%	--	--	--	--	N/A	N/A

DATA SOURCE: FHARPS Excel trackers submitted by each provider to the Washington State Health Care Authority.

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

*Sum of breakouts by type exceeds the number of referrals and/or enrollments due to provider data entry errors. Corrections will be reflected in future data.

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

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started March 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	657	100%	326	100%	162	100%	155	100%	14	100%
Housed or Sheltered	556	85%	297	91%	--	--	127	82%	--	--
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies Only	6	1%								
Support Services and Subsidies	651	99%								
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	36	6%	--	--	--	--	--	--		
Transitional	172	31%	109	37%	34	28%	--	--		
Shelter/Emergency	343	62%	164	55%	--	--	98	77%		
Other	5	1%	--	--	--	--	--	--		

DATA SOURCE: FHARPS Excel trackers submitted by each provider to the Washington State Health Care Authority.
NOTES: See 'Definitions' for more detailed information on each reporting category. Counts and percentages may not sum due to unreported data and/or rounding. Greyed out sections and cells with '--' are suppressed to protect confidentiality.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started March 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS										
Enrolled	657	100%	326	100%	162	100%	155	100%	14	100%
Active (on last day of reporting period)	219	33%	113	35%	47	29%	45	29%	14	100%
Discharged (during reporting period)	438	67%	213	65%	115	71%	110	71%	0	0%
Among Individuals Discharged…										
SUBSIDY										
Average Total Subsidy Since Enrollment	$5,881	N/A	$6,288	N/A	$6,424	N/A	$4,337	N/A	N/A	N/A
DISCHARGE REASON										
Transitioned to Other Housing Support	54	12%	43	0%	0	0%	11	0%	N/A	N/A
Received Maximum Subsidy	*16*	*4%*	--	--	--	--	--	--	N/A	N/A
Did Not Receive Maximum Subsidy	*38*	*9%*	--	--	--	--	--	--	N/A	N/A
Transitioned to Self-Support	69	16%	40	19%	--	--	--	--	N/A	N/A
Admitted to a Facility	27	6%	11	*5%*	--	--	--	--	N/A	N/A
Received Maximum Assistance (no transition)	52	12%	26	12%	15	13%	11	10%	N/A	N/A
Withdrew	45	10%	14	7%	11	10%	20	18%	N/A	N/A
Loss of Contact	148	34%	57	27%	50	43%	41	37%	N/A	N/A
Served by Another FHARPS Team	1	0%	--	--	--	--	--	--	N/A	N/A
Other	42	10%	22	10%	--	--	--	--	N/A	N/A
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	196	N/A	191	N/A	208	N/A	193	N/A	N/A	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	143	33%	89	42%	32	28%	22	20%	N/A	N/A
Unstably Housed	28	6%	--	--	--	--	--	--	N/A	N/A
Homeless	67	15%	38	18%	--	--	--	--	N/A	N/A
In a Facility	56	13%	--	--	--	--	29	26%	N/A	N/A
Unknown	144	33%	51	24%	52	45%	41	37%	N/A	N/A

DATA SOURCE: FHARPS Excel trackers submitted by each provider to the Washington State Health Care Authority.

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

FHARPS Definitions

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

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

Appendix F-FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

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 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. FPATH services began in the Phase 2 region (King County) in April 2022.

REPORTING PERIOD

Cumulative: March 1, 2020 to June 30, 2022

Prepared by Washington State Department of Social and Health Services
Research and Data Analysis Division
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Contents

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION										
Number on Referral List	1,770	100%	922	100%	248	100%	437	100%	163	100%
Attempted Contacts	875	49%	421	46%	127	51%	321	73%	6	4%
Contacted	520	29%	160	17%	124	50%	214	49%	22	13%
Enrolled	299	17%	109	12%	86	35%	89	20%	15	9%
PRIORITIZED POPULATION										
Prioritized Referral List	844	48%	466	51%	96	39%	229	52%	53	33%
Attempted Contacts	488	58%	267	57%	50	52%	169	74%	2	4%
Contacted	261	31%	92	20%	54	56%	109	48%	6	11%
Enrolled	162	19%	65	14%	39	41%	55	24%	3	6%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	155	52%	49	45%	42	49%	49	55%	15	100%
Discharged	144	48%	60	55%	44	51%	40	45%	0	0%
Average Length of Stay in Program (days)	234.3	N/A	185.5	N/A	298.9	N/A	236.5	N/A	N/A	N/A
DISCHARGE REASON										
Successful Exit	30	21%	12	20%	--	--	--	--	N/A	N/A
Loss of Contact	66	46%	35	58%	--	--	--	--	N/A	N/A
Needs Could Not Be Met By Program	5	3%	--	--	--	--	--	--	N/A	N/A
Withdrew	8	6%	--	--	--	--	--	--	N/A	N/A
Incarceration	13	9%	--	--	--	--	--	--	N/A	N/A
Admitted to Hospital	3	2%	--	--	--	--	--	--	N/A	N/A
Death	4	3%	--	--	--	--	--	--	N/A	N/A
Other	15	10%	--	--	--	--	--	--	N/A	N/A
GENDER										
Female	64	23%	--	--	--	--	22	25%	--	--
Male	215	77%	84	81%	--	--	67	75%	--	--
Unknown	20	7%	--	--	--	--	0	0%	--	--

AGE GROUP										
18-29	85	28%	32	29%	22	26%	--	--	--	--
30-49	173	58%	53	49%	--	--	59	66%	--	--
50+	41	14%	24	22%	--	--	--	--	--	--
RACE/ETHNICITY*										
American Indian or Alaskan Native	13	4%	--	--	--	--	--	--	--	--
Asian	5	2%	--	--	--	--	--	--	--	--
Black or African American	55	18%	26	24%	17	20%	--	--	--	--
Hispanic or Latino	28	9%	--	--	11	13%	--	--	--	--
Native Hawaiian and Other Pacific Islander	4	1%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	126	42%	--	--	48	56%	42	47%	--	--
Other Race	10	3%	--	--	--	--	--	--	--	--
Unknown	77	26%	39	36%	--	--	30	34%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	30	10%	--	--	--	--	11	12%	--	--
Unstably Housed	62	21%	--	--	20	23%	25	28%	--	--
Homeless	198	66%	80	73%	54	63%	53	60%	11	73%
Unknown	9	3%	--	--	--	--	0	0%	--	--
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	35	24%	19	32%	--	--	--	--	N/A	N/A
Unstably Housed	5	3%	--	--	--	--	--	--	N/A	N/A
Homeless	19	13%	16	27%	--	--	--	--	N/A	N/A
In a Facility	21	15%	--	--	--	--	--	--	N/A	N/A
Unknown	64	44%	20	33%	28	64%	16	40%	N/A	N/A

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

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

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

TABLE 2.

Forensic PATH Services

CUMULATIVE: March 1, 2020 - June 30, 2022

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS										
Total Forensic PATH Service Encounters	6,339	N/A	2,652	N/A	1,590	N/A	2,024	N/A	73	N/A
Average Service Encounters (per participant, per month)	3.1	N/A	2.9	N/A	3.5	N/A	3.1	N/A	2.7	N/A
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach Services	0.7	N/A	0.4	N/A	0.5	N/A	1.2	N/A	0.3	N/A
Re-engagement	0.1	N/A	0.0	N/A	0.1	N/A	0.2	N/A	0.0	N/A
Screening	0.3	N/A	0.5	N/A	0.1	N/A	0.1	N/A	0.2	N/A
Clinical assessment	0.0	N/A	0.0	N/A	0.1	N/A	0.0	N/A	0.1	N/A
Habilitation/Rehabilitation	0.1	N/A	0.0	N/A	0.3	N/A	0.0	N/A	0.0	N/A
Community Mental Health	0.2	N/A	0.1	N/A	0.6	N/A	0.0	N/A	0.0	N/A
Substance Use Treatment	0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
Case Management	1.4	N/A	1.5	N/A	1.3	N/A	1.5	N/A	2.0	N/A
Residential Supportive Services	0.2	N/A	0.2	N/A	0.3	N/A	0.0	N/A	0.1	N/A
Other	0.0	N/A	0.0	N/A	0.0	N/A	0.1	N/A	0.0	N/A
Among Enrolled Individuals…										
REFERRALS - *Number of participants with at least one referral*										
Any Referral	187	62.5%	65	59.6%	53	61.6%	67	75.3%	--	--
Referral Type										
Community Mental Health	76	25.4%	33	30.3%	23	26.7%	--	--	--	--
Substance Use Treatment	38	12.7%	11	10.1%	--	--	19	21.3%	--	--
Primary Health/Dental Care	37	12.4%	--	--	--	--	23	25.8%	--	--
Job Training	3	1.0%	--	--	--	--	--	--	--	--
Educational Services	3	1.0%	--	--	--	--	--	--	--	--
FHARPS Housing	87	29.1%	32	29.4%	--	--	30	33.7%	--	--
Permanent Housing (non-FHARPS)	18	6.0%	15	13.8%	--	--	--	--	--	--
Temporary Housing (non-FHARPS)	37	12.4%	26	23.9%	--	--	--	--	--	--
Other Housing Services (non-FHARPS)	56	18.7%	21	19.3%	30	34.9%	--	--	--	--

Housing Services (pre-August 2021)	39	13.0%	--	--	--	--	29	32.6%	--	--
Income Assistance	14	4.7%	--	--	--	--	--	--	--	--
Employment Assistance	15	5.0%	--	--	--	--	--	--	--	--
Medical Insurance	0	0.0%	--	--	--	--	--	--	--	--
Other	24	8.0%	--	--	--	--	16	18.0%	--	--

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

NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality.

FPATH Definitions

Variable Name	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and Phase 2 regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County
Southwest Region	Clark, Klickitat, and Skamania Counties
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties
Phase 2 Region	Phase 2 region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County
ENROLLMENT TABLE , Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated, meaning if a person is referred or enrolled more than once in Forensic PATH during a reporting period, the most recent case information is included.
Number on Referral List	Number of individuals who appeared on the Forensic PATH eligibility list during the reporting period. Eligibility criteria include having two or more competency evaluation referrals in the past 24 months.
Number on Prioritized Referral List	Number of individuals who appeared on the prioritized Forensic PATH eligibility list during the reporting period. Eligibility is prioritized based on the number of referrals for competency evaluation, county of residence, and housing status.
Attempted Contacts	Individuals 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.
Discharge Reason	Reason a participant is no longer enrolled in the Forensic PATH program.
Successful Exit	Participant has been successfully transitioned into services (e.g., outpatient mental health, employment, housing, substance use treatment).
Loss of Contact	The Forensic PATH worker has not had any contact with the participant for at least 60 days (excludes cases where client transitioned to other outpatient services or self-withdrew).
Needs Could Not Be Met By Program	Participant's needs were unable to be met by services or referrals from the Forensic PATH program.
Withdrew	Participant decided they no longer wanted Forensic PATH services or support, ability to support self is unknown.
Incarceration	Participant is no longer in the Forensic PATH program due to incarceration.
Admitted to Hospital	Participant is no longer in the Forensic PATH program as a result of being admitted to a state psychiatric hospital or residential competency restoration facility.
Death	Participant is no longer in the Forensic PATH program due to death.
Other	Participant was exited for reason(s) not listed above.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.

Race/Ethnicity	Race and Ethnicity information is based on an individual's self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
Housing Status at Program Exit	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program end.
SERVICES TABLE, Cumulative	
Program Totals	Program totals regarding services provided during the reporting period.
Total Forensic PATH Service Encounters	Sum of all Forensic PATH service encounters during the reporting period.
Average Service Encounters (per individual, per month)	The average number of service encounters (per individual, per month) experienced by Forensic PATH program participants during the reporting period.
Forensic PATH Services	The primary service provided to the individual during the contact with the Forensic PATH worker/team, including the following options:
Outreach Services	Providing outreach and engagement services to individuals on the Forensic PATH eligibility list.
Re-engagement	Service that involves engaging with a Forensic PATH-enrolled individual who is disconnected from Forensic PATH services.
Screening	An in-person process during which a preliminary evaluation is made to determine a person's needs and how they can be addressed through the Forensic PATH Program.
Clinical Assessment	A clinical determination of psychosocial needs and concerns.
Habilitation/Rehabilitation	Services that help a Forensic PATH individual learn or improve the skills needed to function in a variety of activities of daily living.

Community Mental Health	A range of mental health and/or co-occurring services and activities provided in non-institutional settings to facilitate an individual's recovery. Note: This category does not include case management, alcohol or drug treatment, habilitation, or rehabilitation, as they are standalone services with distinct definitions.
Substance Use Treatment	Preventive, diagnostic, and other services and supports provided for people who have a psychological and/or physical dependence on one or more substances.
Case Management	A collaboration between a service recipient and provider in which advocacy, communication, and resource management are used to design and implement a wellness plan specific to a Forensic PATH-enrolled individual's recovery needs.
Residential Supportive Services	Services that help Forensic PATH-enrolled participants practice the skills necessary to maintain residence in the least restrictive community-based setting possible.
Other	Other services that are not covered in the above options.
Referrals	Referrals provided by Forensic PATH for services outside of the program.
Total Number of Referrals	Sum of all referrals received by Forensic PATH participants during the reporting period.
Referral Type	The primary referral made from the following options: (Note: Number represents the number of individuals referred in the reporting period. Percent represents the percentage of active participants in the reporting period who received the referral.)
Community Mental Health	A range of mental health and/or co-occurring services and activities provided in non-institutional settings to facilitate an individual's recovery. Note: This category does not include case management, alcohol or drug treatment, habilitation, or rehabilitation, as they are standalone services with distinct definitions.
Substance Use Treatment	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers preventive, diagnostic, and other services and supports for individuals who have psychological and/or physical problems with use of one or more substances.
Primary Health/Dental Care	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers physical and/or dental health care services.
Job Training	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that helps prepare an individual to gain and maintain the skills necessary for paid or volunteer work.
Educational Services	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers academic instruction and training.
FHARPS Housing	Connecting the Forensic PATH participant to an FHARPS provider that offers assistance with attaining and sustaining living accommodations.
Permanent Housing (non-FHARPS)	Connecting the Forensic PATH participant to a non-FHARPS housing agency, organization, or service that offers residence in a stable setting where length of stay is determined by the individual or family without time limitations, as long as they meet the basic requirements of tenancy.
Temporary Housing (non-FHARPS)	Connecting the Forensic PATH participant to a non-FHARPS housing agency, organization, or service that offers shelter in a time-limited setting.
Other Housing Services (non-FHARPS)	Connecting the Forensic PATH participant to other non-FHARPS housing services not listed above, that offer assistance with preparing for and attaining living accommodations.
Housing Services (pre-August 2021)	Housing service referral categories used prior to the implementation of updated housing referrals in August 2021.
Income Assistance	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers benefits that provide financial support.
Employment Assistance	Connecting the Forensic PATH participant to an appropriate agency, organization, or service that offers assistance designed to lead to compensated work.
Other	Connecting the Forensic PATH participant to any other agencies, organizations, or services not listed above.

Appendix G-Crisis Intervention Training Dashboard

CIT Dashboard

Crisis Intervention Training

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2022

Prepared by Washington State Department of Social and Health Services
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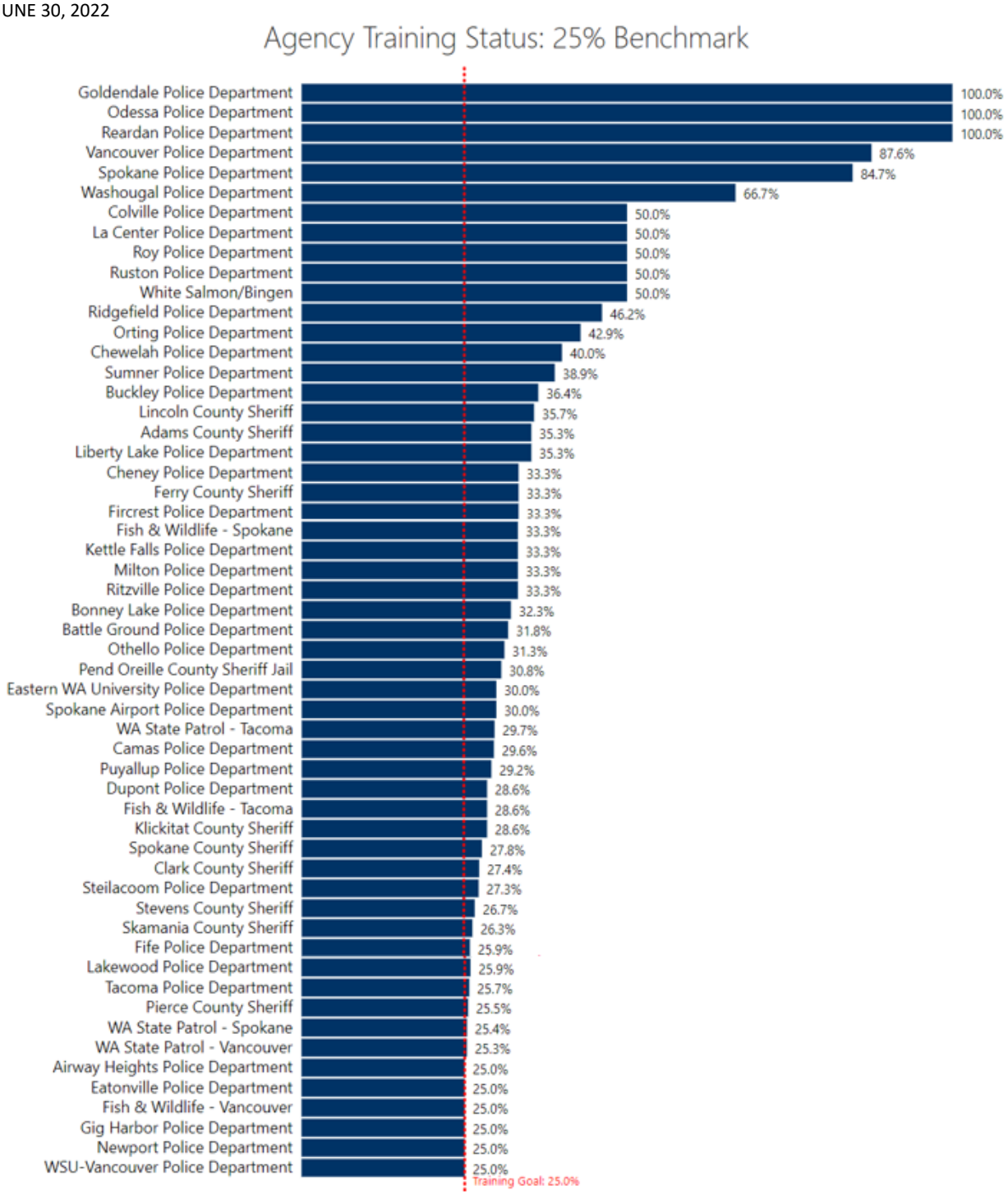
Contents

Figure 1.

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

JUNE 30, 2022



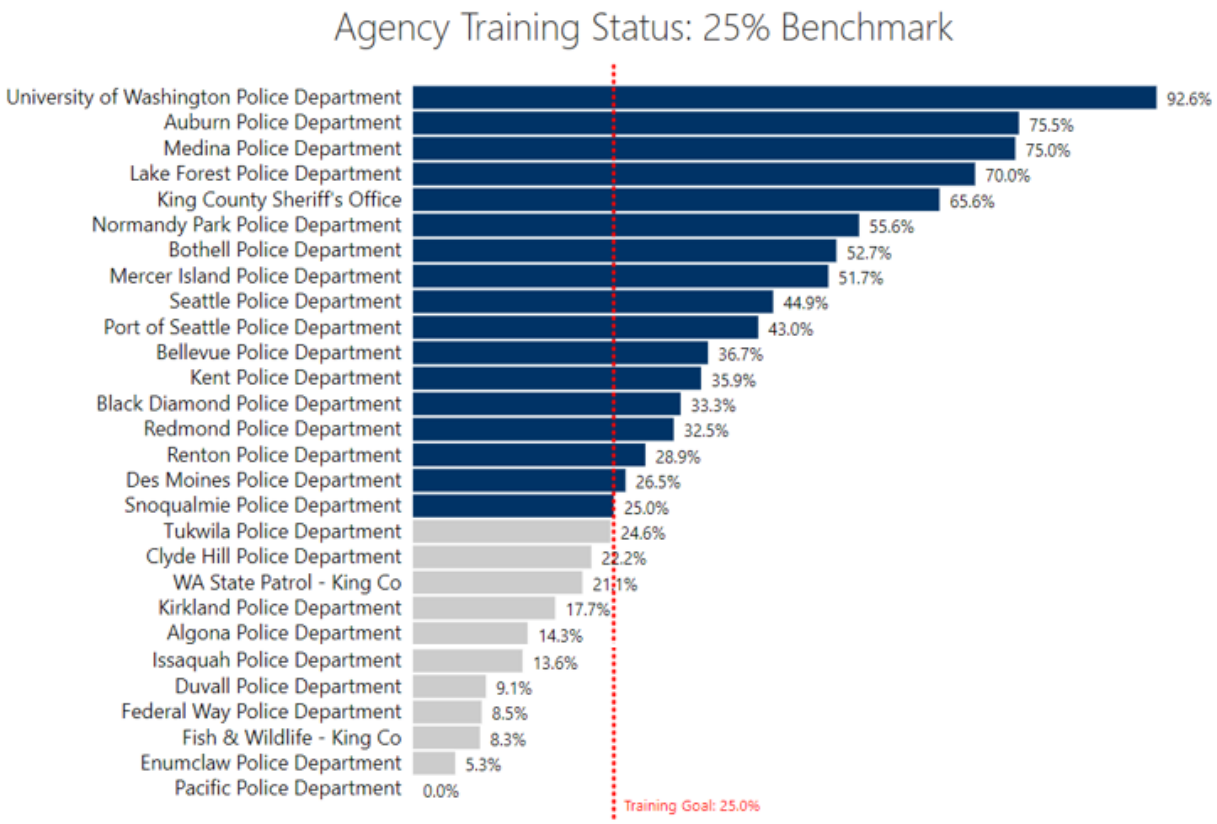
*Percent of officers who have received 40 hours of Crisis Intervention Training.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

JUNE 30, 2022



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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 1.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Phase 1 Region

JUNE 30, 2022

Region	# of Officers	# of Officers Trained	% Trained
⊞ Fish & Wildlife - Phase 1	27	8	29.6%
⊞ Pierce Region	901	244	27.1%
⊞ Southwest Region	450	262	58.2%
⊞ Spokane Region	719	395	54.9%
⊞ WA State Patrol - Phase 1	220	59	26.8%
Total	**2,317**	**968**	**41.8%**

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.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 2.

Crisis Intervention Training Program Measures
Number of Dispatchers Trained by Phase 1 Region

JUNE 30, 2022

Region	# of Dispatchers	# of Dispatchers Trained	% Trained
⊞ **Pierce Region**	**135**	**135**	**100.0%**
⊞ **Southwest Region**	**81**	**81**	**100.0%**
⊞ **Spokane Region**	**175**	**175**	**100.0%**
⊞ **WA State Patrol - Phase 1**	**52**	**52**	**100.0%**
Total	**443**	**443**	**100.0%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

Crisis Intervention Training Program Measures
Number of Corrections Officers Trained by Phase 1 Region

JUNE 30, 2022

Region	# of Officers	# of Officers Trained	% Trained
⊞ Pierce Region	276	269	97.5%
⊞ Spokane Region	283	249	88.0%
⊞ Southwest Region	178	147	82.6%
Total	**737**	**665**	**90.2%**

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 4.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Phase 2 Region

JUNE 30, 2022

Region	# of Officers	# of Officers Trained	% Trained
⊞ Fish & Wildlife - Phase 2	12	1	8.3%
⊞ King Region	3,021	1,377	45.6%
⊞ WA State Patrol - Phase 2	128	27	21.1%
Total	**3,161**	**1,405**	**44.4%**

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.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 5.

Crisis Intervention Training Program Measures
Number of Dispatchers Trained by Phase 2 Region

JUNE 30, 2022

Region	# of Dispatchers	# of Dispatchers Trained	% Trained
⊞ **King Region**	**415**	**325**	**78.3%**
⊞ **WA State Patrol - Phase 2**	**12**	**2**	**16.7%**
Total	**427**	**327**	**76.6%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 6.

Crisis Intervention Training Program Measures
Number of Corrections Officers Trained by Phase 2 Region

JUNE 30, 2022

Region	# of Officers	# of Officers Trained ▼	% Trained
⊞ King Region	769	279	36.3%
Total	**769**	**279**	**36.3%**

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 7.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Phase 1 Region and Agency Size

JUNE 30, 2022

Region	Pierce Region			Southwest Region		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained
⊞ Large	578	148	25.6%	318	208	65.4%
⊞ Medium	208	58	27.9%	49	15	30.6%
⊞ Small	115	38	33.0%	83	39	47.0%

Continued below

Spokane Region			WA State Patrol - Phase 1			TOTAL - ALL REGIONS		
# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	**# of Officers**	**# of Officers Trained**	**% Trained**
524	331	63.2%				**1,420**	**687**	**48.4%**
30	8	26.7%	220	59	26.8%	**507**	**140**	**27.6%**
165	56	33.9%				**390**	**141**	**36.2%**

NOTE: Eight trained officers from the Washington Department of Fish & Wildlife are not pictured in the above table.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 8.

Crisis Intervention Training Program Measures
Number of Law Enforcement Officers Trained by Phase 2 Region and Agency Size

JUNE 30, 2022

Region	Fish & Wildlife - Phase 2			King Region		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained
⊞ Large				2,405	1,159	48.2%
⊞ Medium				501	181	36.1%
⊞ Small	12	1	8.3%	115	37	32.2%

Continued below

WA State Patrol - Phase 2			TOTAL - ALL REGIONS		
# of Officers	# of Officers Trained	% Trained	**# of Officers**	**# of Officers Trained**	**% Trained**
128	27	21.1%	**2,533**	**1,186**	**46.8%**
			501	**181**	**36.1%**
			127	**38**	**29.9%**

DATA SOURCE: Washington State Criminal Justice Training Commission.