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

Semi-Annual Report 5

March 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
SUD-substance use disorder
VTC-video technology conferencing
WASPC-Washington Association of Sheriffs and Police Chiefs
WSH-Western State Hospital

Preamble

This is the March 2022 semi-annual report. The SAR is published in March and September each year through the duration of implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress during the second half of 2021. The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new Trueblood programs initially launched during the Phase 1 implementation of the Settlement Agreement and in addition to ongoing Phase 1 operations, work is being done 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 County) data has been added for CIT. Phase 2 data will 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 Dec. 31, 2021. 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

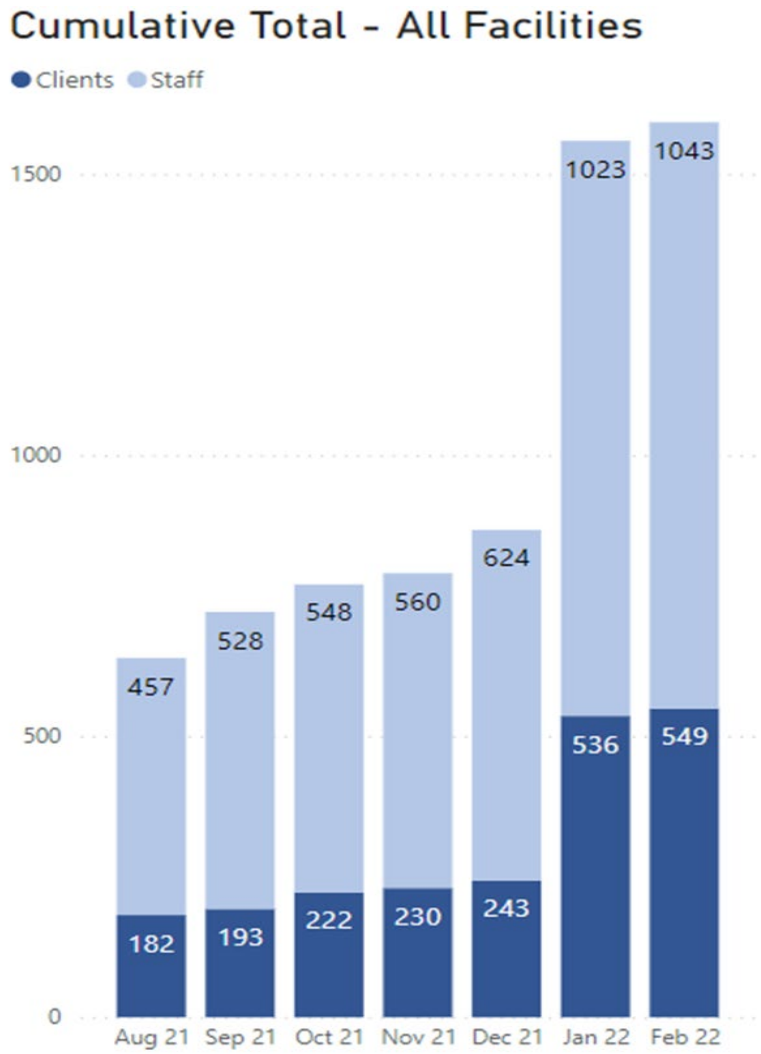
BHA facilities. From Dec. 31, 2021 through Jan. 31, 2022, cumulative BHA COVID-19 cases increased 80 percent due to the newly dominant Omicron variant.

FIGURE 1.

COVID-19 Cases All BHA Facilities

Client and Staff

FEBRUARY 1, 2022



Data Source: BHA Cumulative Cases By Facility By Month: https://app.powerbigov.us/view?r=eyJrIjoiYjRkNDQwODktMjM2ZC00OGJlLTg4OGUtYzYzZGNjZjZmMDNiIiwidCI6IjExZDBlMjE3LTI2NGUtNDAwYS04YmEwLTU3ZGNjMTI3ZDcyZCJ9

Note: All facilities include several BHA facilities that do not serve Trueblood clients. However, as of Feb. 1, 2022, more than 80 percent of all COVID-19 cases involve the state hospitals or RTFs.

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 phases of two years each and can be expanded to include additional phases. Services and regions implemented in each phase are evaluated and continued into future phases of the settlement. Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium. Phase 1 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 quarterly 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[1]. Quarterly reporting on implementation elements (e.g., FPATH and the Forensic Navigator Program) provides timely information on client engagement in implementation programs. Monitoring measures to be tracked will 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 quarterly dashboards will be produced containing client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for the elements listed below. Data come from a range of sources, and largely from tools or system adaptations still under development. Additional program measures may be added as feasible. HCA is working to identify and implement long-term data collection tools for programs, as well as strategies to optimize data quality, and efficient sharing, to support timely reporting. Programs designated for this quarterly dashboard include:

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

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

- Crisis housing vouchers

Compliance with Crisis Intervention Training targets are also monitored through the quarterly dashboard. MCR has a preliminary dashboard and other programs are presented in the appendices of this report.

Quarterly reporting timeline: Available program data are currently reported on a semi-annual basis through the SAR. RDA is working with various teams within DSHS and HCA to establish a reliable and efficient data processing system for reporting quarterly data. This requires establishing a coordinated infrastructure including, but not limited to, secure data transmission and storage; automated data error checks; a framework to download, merge, and package data; data definitions and counting rules; and validated code and templates for data analyses and reporting. Building 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 that data providers submit required data in a timely manner. The goal is for quarterly reporting to begin later in 2022. Programs will shift to quarterly reporting based on data quality, stability and complexity of the processing. King County providers (Phase 2) are expected to be added to program reporting within two quarters of program providers submitting complete data.

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

All client-level data is aggregated to protect client confidentiality and suppression guidelines are being followed. Data tables included in this report reflect what was possible to produce from existing data received by the report deadline. Draft tables reflect what is anticipated to be ready in future reports. Additional data will be provided over time as both data quality improves, and the numbers served increase. This report, for example, includes expanded FPATH data and additional race and ethnicity categories for FPATH, FHARPS, and Forensic Navigators.

Longer-term Impact Analyses

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

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

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

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

Timeline

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

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

2. Impacts on behavioral health access and social outcome metrics will require significantly more time to measure. These measures are produced on a global scale for all Medicaid beneficiaries and require a 12-month measurement window, seven months of data maturity[2], one month of global measure production and testing, and one month for analysis of results for the Trueblood population. Analysis of first-year impacts (through the period ending June 30, 2021) has begun. Timeline to completion is contingent on data availability (data on key outcomes through June 30 are not yet available). Findings will be shared with stakeholders when available, and a summary will be included in the next SAR.

3. Preliminary estimates of 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. Like item #2 above, this work is also contingent on updated data on key outcomes. After the aggregate outcomes in bullet #2 are completed,

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

RDA will assess whether specific program analyses will be possible given overlapping program enrollment, the number of participants enrolled, and available data for the follow-up 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) data pertaining to the element. As previously described, data for new programs takes time to mature. Data tables included in this report reflect data through Dec. 31, 2021, with exceptions noted. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served in the new Trueblood programs increase.

Competency Evaluation-Additional Evaluators

The Settlement Agreement 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 Feb. 1, 2022, 66 of the 74 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 two remaining vacancies. OFMHS completed jail-based competency evaluations within 14 days for 85 percent[3] of clients from January through November 2021. Aided in part by the OFMHS training programs, WSH is able to staff clinical psychologists that complete the treatment reports to the court for civil commitment, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations). Staffing forensic evaluators have allowed a record number of forensic risk assessments to be completed. During the July-December 2021 reporting period, 63 FRAs have been completed. Now that there is no longer any backlog of forensic risk assessments to complete, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. 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.

[3] *Table 8. Class member status at WSH and ESH (totals)-Jail-based competency evaluations.* July 2021-December 2021, Mature Data. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Final Monthly Report to the Court Appointed Monitor. Feb. 28, 2022, p. 21.

Areas of Concern

In Fiscal Year 2021, Washington state had its second highest number of referrals for all competency evaluations (4,686[4]) to date. While there was a slight decrease in all referrals, levels remained near record highs despite shutdowns due to the pandemic and even though 12 fine-funded contempt programs and three state-funded prosecutorial diversion programs were operating. Without these programs, demand for evaluations likely would have increased even more in the past and even during the pandemic. The arrival of COVID-19 in late winter 2020, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for months during the pandemic. Even as the criminal court system has re-opened, COVID-19 infections continue to result in decreased in-person access to clients and fewer beds to serve our clients, especially with the Delta and Omicron variants. Furthermore, 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 to work in 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, make it easier for attorneys to be present for their clients' interviews, and minimize risks for all those involved during this pandemic.

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 city jails in Aberdeen, Kent, and Issaquah, Puyallup, and county jails in Skagit, King (King County Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and South Correctional Entity in Des Moines), Skamania, Kitsap, Thurston, Mason, Pacific, Jefferson, Wahkiakum, Whatcom, Clallam, Cowlitz, and Clark counties.

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

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.

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

Furthermore, DSHS will work with the Legislature supporting several initiatives related to Trueblood such as clarifying HCA's role in outpatient restoration, addressing the good cause exception process, and providing more clarity around record access by forensic evaluators. Once any changes are passed by the legislature and signed into law, DSHS and HCA will implement these updates to the law during the time frame dictated by the bill. Internally, the department worked with our information technology team to complete development of a real-time report tracker database for evaluators across the state to allow for the ability to shift resources as needed that was released on Jan. 20, 2022.

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 2.

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

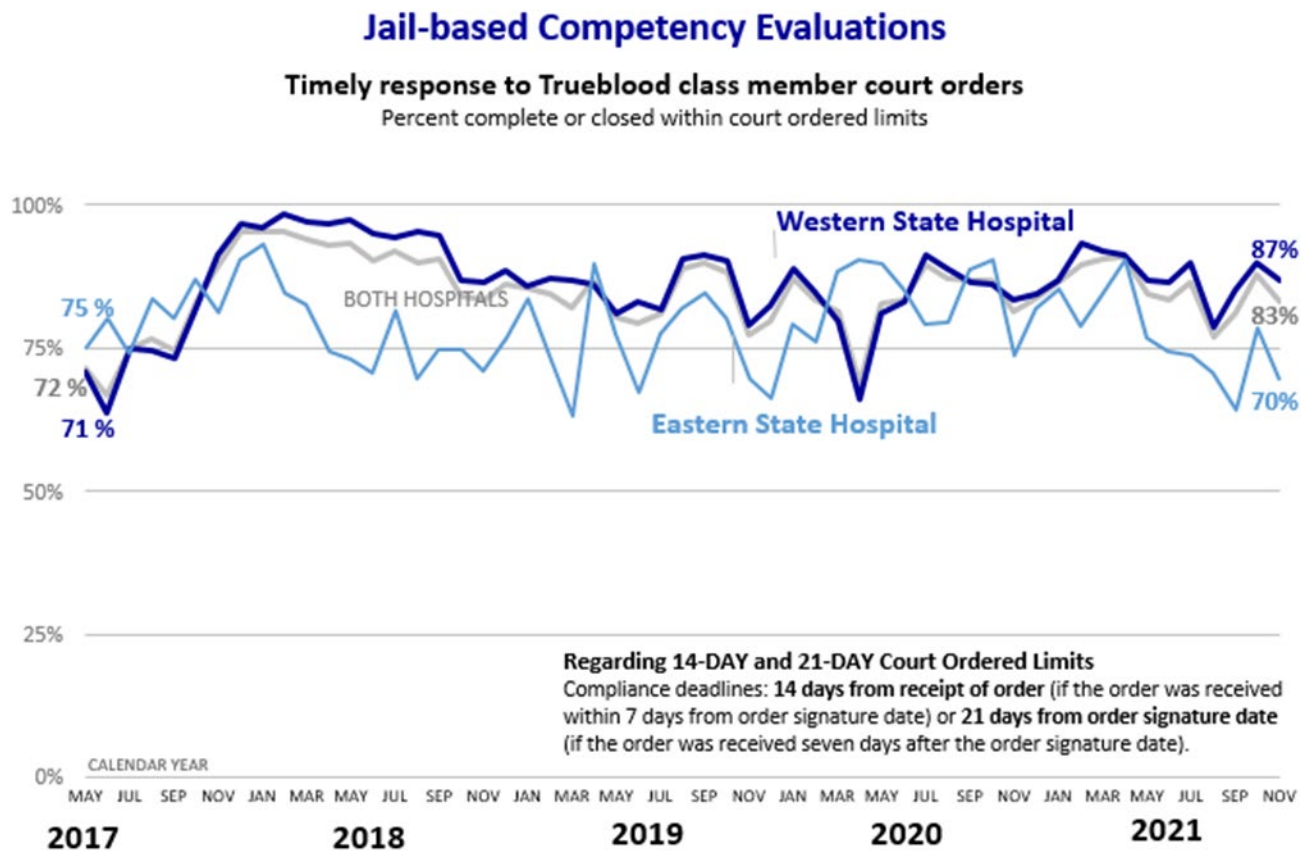
Projections indicate that the number of evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74.0 FTE in the FY2022 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes,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

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

FIGURE 2.

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.

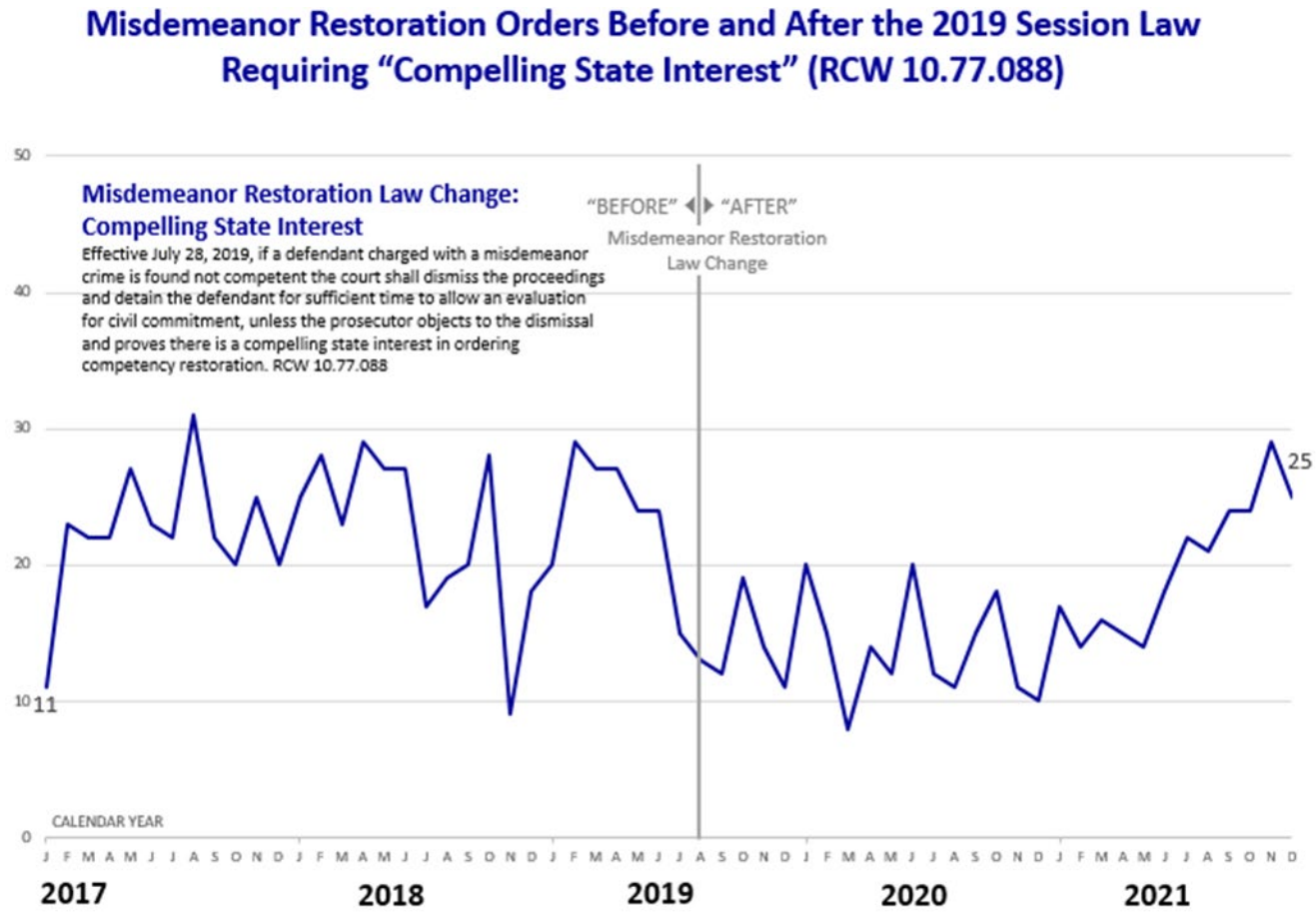
Data-Competency Restoration-Misdemeanor Restoration Orders

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 an average of 23 orders per month. In December 2021, 25 misdemeanor restoration orders were issued statewide (Figure 3).

FIGURE 3.

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. DSHS 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.

Current Status and Areas of Positive Impact

OCRP is operational in all three Phase 1 regions and all three contractors 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.

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

- Publications for use with participants and stakeholder groups to ensure accurate messaging is happening regarding OCRP.
- The OCRP transition plan is being utilized by forensic navigators with the support of other elements to provide participants with necessary information related to OCRP groups and contact information of providers.
- 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 shared participants.
- The OCRP administrator, in conjunction with DSHS, will be working together to restructure the Breaking Barriers Competency Restoration Program curriculum to better align with the outpatient competency restoration model.

DSHS and HCA are drafting a proposal that reviews OCRP orders for people who are currently receiving restoration services in a residential treatment facility, who are receiving a second

competency restoration order and assessing those people for suitability for OCRP services as an alternative to completing their entire restoration in an inpatient facility-based program. This would provide people with the opportunity to utilize community-based resources. OCRP contractors have utilized client support funds to acquire additional housing units specifically for Trueblood class members, with priority given to OCRP participants. As of December 2021, all OCRP contractors have housing units that they can use specifically for OCRP participants.

Areas of Concern

A single provider was identified in each Phase 1 implementation region. This could be problematic for the more rural regions, although the provider contracts require services be available to the entire region. If problems arise with the contractor, a new procurement would be required. People within multiple county regions may find transportation to the OCRP services challenging; however, the volume of OCRP orders from participating courts is not sufficient to warrant additional contracted providers at this time.

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.

Removal rates have been continuously reviewed since inception of the program, and efforts continue to identify best practices to prevent removals. Although removals from the program do occur, DSHS and HCA have and will continue to participate in case consultations in conjunction with the OCRP contractors to ensure that every effort is made to support client success in OCRP.

Recommendations to Address Concerns

The providers continue to offer remote and virtual services to individuals in rural communities, as needed, with the goal of serving individuals in person as much as possible. 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, contractor agencies are included in collaboration and engagement activities in all Phase 1 regions and relationships are being developed among the programs. HCA, in partnership with DSHS, is working to engage King County for Phase 2 implementation of OCRP. Staff from the King County Prosecuting Attorney's Office and staff from the King County Department of Public Defense participate in the planning and implementation of OCRP in King County. Since March 2020, both HCA and DSHS have been participating in the King County Competency Continuum workgroup, which includes membership from King County law enforcement, defense counsel, prosecution, judges, county staff, and advocates. HCA and DSHS have met with specific partner groups to include each regional Accountable Community of Health, Kent Municipal Court, Spokane County Office of

Public Defense, Pierce County Criminal Justice Steering Committee, Washington District Court Judges Association, Spokane County Prosecuting Attorney's Office, and DSHS forensic evaluators.

From July-December 2021, HCA engaged in conversations with licensed community behavioral health agencies to identify interest in contracting to provide OCRP services in King County under contract. In some instances, multiple conversations were had with these providers to answer their questions and discuss any concerns. Initially, no King County licensed community behavioral health agencies expressed interest in becoming an OCRP contractor. HCA then engaged in contract negotiations with a national provider. After two months of intense contract negotiations, HCA determined that it was not in the best interest of Washington State to continue contract negotiations with this national provider. HCA next asked the King County BHASO for their assistance in identifying current King County licensed community behavioral health agencies who may be interested in contracting for OCRP. Based on the King County BHASO recommendations, HCA has begun targeted outreach to find an OCRP contractor in King County.

During the January-March 2022 time period, HCA has met with two behavioral health agencies and discussed the OCR program. One of these providers reported that they are unable to take on OCRP due to commitments to implement multiple programs; however, they did report that they are interested in discussing OCRP in the future. The other provider has reported that they are interested in implementing OCRP in King County. In March, HCA had a second meeting with this provider, where discussion regarding OCRP and potential barriers to providing the OCR services occurred. The provider will be submitting a copy of their budget proposal to HCA and another meeting will be scheduled in March or April. If this provider does contract for OCRP, there will be a delay in OCRP services in King County as the provider would need to staff the program. Although HCA will not meet the target date of March 31, 2022, for OCRP services to begin in Phase 2, a plan for standing up OCRP services in Phase 2 is being developed.

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. In collaboration with King County providers, a strong area of concern is hiring, and this "in-training" option may be utilized in future contracts.

Forensic navigators continue to engage court staff in discussion about communicating who is being ordered into OCRP so that a forensic navigator can assist with all referrals and transportation as well as release timing and program needs to ensure people can adequately connect to programs once released.

Removal reviews are conducted by the OCRP administrator in collaboration with the assigned providers and forensic navigators. HCA and DSHS leadership meet 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 consultation for at-risk participants. The state continues to review commonalities of people who have been removed and share that information with court staff to inform the decision to order future participants. Commonalities noted thus far include history of non-compliance with community-based services, program refusal upon order, and medication refusal.

Data-Competency Restoration-Community Outpatient Services

OCRP services began on July 1, 2020. Between July 1, 2020 and Dec. 31, 2021, 46 clients were enrolled in OCRP (Appendix B, Table 1). Most enrollments were for felony restoration orders (83 percent) and participants were mostly male (85 percent), 30-49 years old (44 percent), non-Hispanic white (65 percent), and unstably housed or homeless (80 percent).

Of the 36 people discharged (Appendix B, Table 2), 39 percent were opined competent and 28 percent had their conditional release revoked. About two-thirds of those (67 percent) were in the community at the time of discharge, and 1 in 6 (17 percent) were admitted to inpatient services at a state hospital or residential treatment facility. At this time, data by region are not reported due to the small number of cases.

Program data is from interim Microsoft Excel data trackers and adjustments are underway to collect some information through the Navigator Case Management system. Program and data collection continue to evolve.

Forensic Navigators

DSHS' Forensic Navigator Program seeks to divert forensically involved criminal defendants out of jails and inpatient restoration settings, and into community-based restoration and treatment settings. Program participants are assigned a forensic navigator at the time the court orders a competency evaluation. For participants deemed not competent to stand trial and determined clinically appropriate for outpatient competency restoration, courts may elect to grant conditional release, 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 utilize client-reported information and gather records from OFMHS, jails, behavioral health agencies, and other agencies, as well as from registries and databases to assist in fully informing the court in its determination of clinical appropriateness for outpatient restoration. Navigators may also gather substance abuse disorder information and seek information from family and other sources when the client has signed a release of information.

If the court finds that a client is suitable for outpatient competency restoration and agrees to order the client to outpatient restoration, forensic navigators continue to work with these participants. At this point, forensic navigators assist those clients in maintaining compliance with any conditions of release, assisting clients to attend their outpatient competency restoration classes, and encouraging their adherence to prescribed medications. Forensic navigators also work closely with OCRP, FHARPS, FPATH, and community-based mental health providers to coordinate continuity of care across all providers and programs. If the client is not ordered into outpatient restoration, navigators attempt to complete warm 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 have also been in close contact with attorneys and outpatient competency restoration programs and have referred program participants to outpatient forensic service providers in the three Phase 1 regions. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators have continued to facilitate connections for eligible clients to housing and recovery programs as well as to forensic peer services and case management supports even when class members are not ordered into outpatient restoration, and after the forensic navigator has been discharged and is no longer actively assigned to the client.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one that primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not extend to a larger group of people for whom competency to stand trial has been raised,

particularly those for whom a competency evaluation is ordered at or after their release from jail. Thus far, forensic navigators have also been serving those 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 are ongoing and discussions continue with prosecutors, defense, and bench in all three Phase 1 regions in partnership with HCA. While the program is growing and awareness is increasing, the outreach remains a necessity to enhance the referral process. Outreach and engagement in Phase 2 have been more productive as we have grown our understanding due to Phase 1 interaction. Courts, jails, and attorneys have been more responsive, but because the program is in its infancy, it remains to be seen if responsiveness will translate in sustainable communication.

As with any new program, there have been lessons learned in what works for these programs to interface smoothly. DSHS and its service partners are working well together in order to iron out these programmatic alignments. Extensive process mapping, with the use of 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 VSM process further resulted in decreased gaps within participant programs for more streamlined processes and operational efficiencies. Communication with HCA and DSHS has increased and is helping processes to happen more consistently and efficiently.

Recommendations to Address Concerns

Continue to focus forensic navigator time and resources primarily on Trueblood class members who are awaiting forensic evaluation or restoration services in jail while simultaneously serving those who may not meet the definition of class member. In the Pierce and Spokane regions, caseload prioritization requires focus on class members. We will continue to conduct focused outreach to the courts on this topic in each region indicating the willingness of the program to continue to provide warm 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 1,541 people were assigned a forensic navigator between July 1, 2020 (program start) through Dec. 31, 2021 (Appendix C, Table 1). The majority of people assigned a navigator were male (74 percent), half (54 percent) were between the age of 30 to 49, and over half (60 percent) were non-Hispanic white. Over half (61 percent) were charged with a felony, and 39 percent were charged with a misdemeanor.

Forensic navigators worked to gather information for the courts for nearly all individuals assigned a navigator during the reporting period (over 99 percent, Appendix C, Table 2). Client meetings, interviews or observations were conducted with over half (62 percent) of the people assigned a navigator. A recommended service plan was completed for 69 percent of people. Navigators provided coordination of care for 38 percent of clients overall, and more than half in Southwest (59 percent) and Spokane (55 percent). About one in four (28 percent) received a referral to other community services. The most common types of referrals were to other Trueblood partner programs; 19 percent received a referral to the FPATH program and 14 percent received a referral to FHARPS.

A total of 1,387 people were discharged during the reporting period, with an average length of stay in the program of 36 days (Appendix C, Table 3). More than one-third (35 percent) of those were discharged with a warm handoff to provider or jail staff. One-third (34 percent) of cases were closed because the person was determined competent; 28 percent of cases were closed because the person was ordered by the court to receive inpatient restoration. One-third (32 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.

Competency Restoration-Ramp Down of Maple Lane RTF

DSHS opened two competency 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 close as part of the overall integrated system changes contemplated in the Contempt Settlement Agreement. Yakima was scheduled to close by Dec. 31, 2021, but closed on Aug. 14 due to difficulty recruiting and retaining staff through December 2021. The last patient was transferred out on July 26, 2021. Maple Lane has a hard closure date of July 1, 2024. The DSHS positions at the Maple Lane Program were converted to permanent status on Dec. 16, 2021; this will give the staff who stay until closure layoff rights. The timeline in the ramp down plan for Maple Lane may need to be updated due to this change. The director of the residential treatment facilities met March 10, 2022, with the DSHS layoff specialist to discuss whether the current timeline for staff notifications is still accurate with all of the positions now being permanent. 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 March 10 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 the recent closure. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations during ramp down after the official closure notification is given. At this time, staffing remains at stable levels and within typical turnover margins. Currently, the director of RTFs is working with her chain of command to come up with both recruiting and retention strategies for the Maple Lane Competency Restoration Program. 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 is continuously monitoring turnover, morale, and other factors, and is actively taking 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 is discharged. Additionally, our contract oversight of the contractor at Maple Lane will focus on the contract requirements to ensure sufficient staffing. The residential services manager will work closely with the director of residential treatment facilities on staffing challenges for the DSHS side of operations at Maple Lane.

Data-Competency Restoration-Ramp Down of Maple Lane RTF

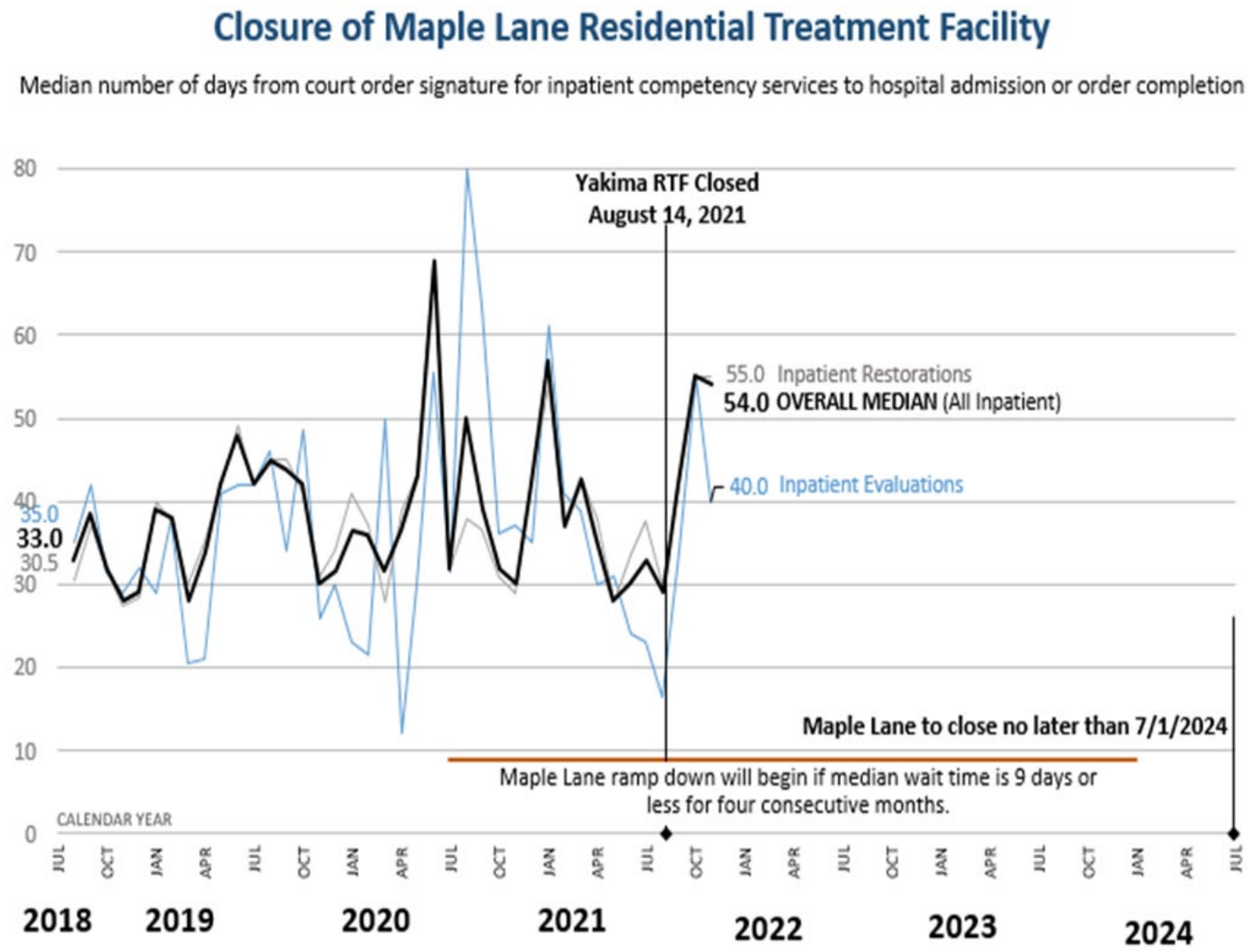
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services on a monthly basis (Figure 4). In November 2021, the median wait time for inpatient competency services was 54 days. The ramp down of Maple Lane will begin if median wait times reach nine days or less for four consecutive months. Per the Settlement Agreement, the facility will close by July 1, 2024, regardless of wait times.

FIGURE 4.

Closure of Maple Lane Residential Treatment Facility

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

JANUARY 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

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

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

Current Status and Areas of Positive Impact

Additional Crisis Beds

HCA worked with Department of Health, Department of Commerce, DSHS and the Washington Association of Sheriffs and Police Chiefs on a weekly basis to address concerns and mitigate barriers or obstacles which affected the successful completion and opening of the 16-bed facility in Spokane County. With a concerted effort to offer timely interventions and assist with navigating agency roadblocks, speedy responses have been achieved. This multiagency collaboration has proven successful to fast-track licensing and certification processes. According to the Spokane project team, this joint effort has been the most beneficial impact to their completion of the project overall. Developing a construction matrix to create a timeline for completion for all construction related projects which were visible and open to all members of the team. This matrix was individualized per operation by area of subject matter experts with HCA and DSHS providing overall oversight.

In August 2021, HCA secured funding for its Spokane-area contractor, Pioneer Human Services to cover staffing costs including funding to provide incentives for hiring staffers and bonuses for retaining workers. Funds were also provided to assist with ramp-up of service cost.

As additional concerns were identified, HCA aided in finding solutions. To address concerns regarding serving rural counties and transportation needs, HCA, through its contracts with WASPC, began conversations which allowed Trueblood misdemeanor funds provided to WASPC be used funding to purchase, two new Honda Odyssey vans for PHS. The use of these vans would be used to address transportation concerns and support people from rural counties to seek crisis services and to return to their county of origin once stabilization services are complete.

By tightly managing this schedule, the facility received its certification of occupancy on Aug. 11, 2021, had a ribbon-cutting ceremony on Sept. 13, 2021, and began admissions of guests into the facility on Oct. 12, 2021.

Crisis Enhancements

HCA contracts with licensed community behavioral health facilities in each of the three Phase 1 regions. Funds provided in these contracts, are intended to enhance the facility's ability to provide services for the stabilization of individuals experiencing a behavioral health crisis. Services provided to this acute populations are diversionary and are intended to intervene and decrease arrest by allowing a community-based site that will allow for increase police drop-offs, referrals, and holds. Enhancement examples included funding for startup:

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

Funding has continued post startup to these facilities to maintain the sustainability of the services offered and better support individuals entering the facility. This funding has included salary enhancements, which is used for both retention and recruitment of staff as well as to maintain the safety of the milieu.

Additional facilities in the Phase 1 region have come online since the last reported SAR to include the newly created Parkland Recovery Response Crisis Stabilization center in the Pierce region, which began admissions on Aug. 18, 2021. Additionally, in the Spokane region, the Spokane's Regional Stabilization Center, which was in part funded through Trueblood funding, began admitting people on Oct. 12, 2021. The addition of these two resources in the Phase 1 regions will help support the people living there and should be a welcomed community resource for law enforcement and other first responders seeking diversion options rather than arrest or unneeded hospitalization for people who experience a behavioral health crisis. Each agency that receives enhancement funds in the Phase 1 regions report continued efforts to increase its relationship with law enforcement to receive referrals, drop-offs and holds.

HCA continues to work with the King County BHASO on its proposal for how to enhance crisis services in the Phase 2 region.

Areas of Concern

The facilities have expressed challenges in serving clients in a congregate setting during COVID-19 pandemic. The contracted CS/CT facilities who have received crisis enhancements have expressed the importance of making connections with community behavioral health agency if enrolled and working with community support systems to ensure that a "warm handoff" is successful.

Recommendations to Address Concerns

To address the concerns about serving individuals in a congregate setting during the pandemic, the facilities report making changes to meet the Department of Health guidelines. These include reducing the number of people confined to the space due to physical distancing requirements and other changes in procedures meant to lessen the potential for disease spread.

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

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. The department will assess the feasibility of determining the impact of additional beds and services from other Trueblood efforts. Data on crisis housing vouchers distributed by crisis triage and stabilization facilities is included in the Crisis Triage and Diversion-Residential Supports section and (Appendix D).

Crisis Triage and Diversion-Residential Supports

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

Current Status and Areas of Positive Impact

FHARPS teams receive referrals from forensic navigators, Outpatient Competency Restoration Programs, Forensic PATH, other outpatient behavioral health agencies, family members, and self-referrals. At least 75 percent of the FHARPS teams are comprised of certified peer counselors. They enroll, house, and provide targeted supports and housing voucher subsidies to people who have had engagement with the forensic mental health system. FHARPS teams work with eligible people to assist in obtaining immediate, transitional, and more permanent housing options. While working with people to obtain and maintain housing, 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.

FHARPS teams provide monthly data reports. HCA provided technical assistance and individual provider instruction on how to submit data through an automated process and began automated data validation for each of the FHARPS teams in 2021. Providers continue to submit data to HCA in a timely manner, so HCA can track participant initial engagement, housing subsidy utilization, and housing placements.

HCA identified early in the program that some people need more than the six months of supports and housing voucher subsidies. HCA has allowed FHARPS providers to request exemptions to policy when participants demonstrate this need. Exemptions are approved when participants are clinically unique, engaged in the program, and might otherwise re-enter the criminal court or forensic systems if no exception is granted. Since initiating this process, HCA has approved over 35 requests for extensions.

Each of the Phase 1 FHARPS providers is now engaged in some form of a master leasing project and has less need to rely on temporarily placing participants in hotels and motels. The two FHARPS providers in Pierce County have leased a total of five properties with shared living spaces, kitchens, bathrooms, and 30 total private bedrooms. One of the providers in Pierce County has also begun providing on-call staffing on weekends to attend to behavioral health crises that may arise outside of normal business hours. Each of these homes has served as a central place where multiple participants can access residential supports simultaneously, including resource acquisition and peer counseling.

In the Spokane Region, FHARPS has entered into an agreement with a low-barrier housing provider to retain two units in a multi-family housing program that includes both studios and

one-bedroom apartments and offers supportive housing services onsite. This FHARPS provider is looking to expand into other master leasing projects or agreements with local agencies and is being provided continued technical support by HCA to facilitate progress.

The FHARPS provider in the Southwest Region has acquired two tiny homes, which will be made available to FHARPS participants. These tiny homes are not exclusively reserved for FHARPS participants and are not retained with housing subsidy dollars; however, Columbia River Mental Health Services states FHARPS participants will always be considered for placement in these domiciles over and above hotels/motels especially when participants express a desire to live in a tiny home.

Emergency Housing Vouchers

HCA noticed a significant decrease in the use of Emergency Housing Vouchers in Pierce County and conducted an in-person site visit with the crisis stabilization facility in that region. The purpose of this visit was to assess the reasons for the significant decrease in voucher use, to address any new barriers to voucher use, and offer targeted technical support to increase voucher use. The facility cited multiple reasons. including fewer people using the facility, a decrease in law enforcement drop-offs when cases of COVID increased in their region, and staff turnover in management as well as direct service staff, which resulted in confusion about how to access housing vouchers. While HCA is dedicated to increasing the use of housing vouchers at the current crisis stabilization facility, HCA has also begun discussions with the facility's parent company and management, to see if vouchers could be used at another crisis stabilization facility in the Pierce region.

HCA created and distributed a discharge planner's toolkit to each of the four 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, Project for Assistance in Transition from Homelessness, Governor's Opportunity for Supportive Housing, Coordinated Entry, HARPS, and others.

Areas of Concern

The effects of COVID-19 continue to directly affect FHARPS providers and their participants. Several FHARPS team members and FHARPS participants have tested positive for COVID-19 during this last quarter, and some were required to quarantine. Multiple community-based service providers have temporarily closed when increased numbers of their staff contracted the virus resulting in barriers to FHARPS team members aiding participants in accessing some community-based resources. HCA began directly addressing the impacts of COVID-19 on FHARPS teams in October 2021. HCA 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 in that region. HCA also planned in-person site visits to FHARPS providers in the Phase 1 regions, but travel requests were postponed due to increased cases of COVID-19 and the spread of the Omicron variant.

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. We encourage all FHARPS to follow their local public health jurisdiction guidance. HCA assumes that in any region where the number of COVID-19 infections and related restrictions decrease the level of face-to-face services provided by FHARPS teams ought to increase.

As part of an effort by HCA to continue to support providers, HCA is creating guidelines for use of housing subsidies. Sections of these guidelines will pertain to the appropriate use of motels, hotels, and other shelter-based strategies when necessary, and will also include examples of successful master leasing projects. The guidelines should be completed this year.

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. The program and data improvements continue to evolve.

Vouchers Data

The crisis stabilization and triage facilities contracted to provide housing vouchers distributed 280 vouchers to 211 people between Dec. 1, 2019, and Dec. 31, 2021 (Appendix D, Table 1). Spokane distributed the majority of vouchers (52 percent). As noted above, HCA is working with the current Pierce County provider to increase use of housing vouchers. The total amount disbursed was $268,712, and the average amount per recipient was $1,274. 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). There may be variation in how providers interpret/report a ”self-referral.” HCA plans to clarify that this means the person did not learn of the facility services from any other entity, not whether they presented themselves for intake voluntarily.

Overall, most voucher recipients were male (66 percent), between 30 and 39 years old (59 percent), and non-Hispanic white (69 percent). Since March 1, 2020 (when FHARPS began), some voucher recipients were referred to FHARPS, where they may be eligible for additional support.

Based on matching housing voucher and FHARPS program participant data, less than half (46 percent) were referred to FHARPS, 43 percent were enrolled, and 38 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 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 is a positive development, as FHARPS teams can reduce time spent on ineligible cases, and eligible people will receive needed supports — whether though FHARPS or another housing program — more quickly. Housing information from other sources is not available.

FHARPS Data

A total of 920 people were referred for FHARPS services from March 1, 2020, to Dec. 31, 2021 (Appendix E, Table 1). Of these referrals, 538 (58 percent) were contacted[6] and 493 (54 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 track referrals outside the primary Excel data collection and enter referrals that result in a contact and/or program enrollment. HCA will work to ensure referrals are entered uniformly across providers.

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 51 percent of referrals. Crisis stabilization and triage facilities referred 149 people. In the Spokane Region, CS/CT facilities made up 23 percent of referrals, and 38 percent of initial contacts by FHARPS staff occurred at CS/CT facilities in the region. "Other" referral source makes up 21 percent of referrals, and 31 percent in Pierce County. The use of "Other" will be discussed in the training refresher. HCA may consider additional categories if merited.

The majority of initial contacts were made by phone (67 percent); this rate was highest in the Southwest Region (93 percent). Two-thirds of people (68 percent) enrolled in FHARPS were male, 56 percent were between 30 and 49 years old, and 54 percent were non-Hispanic white. Program numbers are now large enough to provide additional race and ethnicity information. Note that the sum of the categories will exceed the number of participants since individuals can identify as more than one race or ethnicity. About one-quarter of participants (24 percent) identified as Black or African American and 11 percent as Hispanic or Latino. Most people were homeless at the time of enrollment (74 percent).

Of those enrolled, 99 percent opted to receive housing support services and subsidies, and 83 percent were housed or sheltered during the reporting period (Appendix E, Table 2). About 68 percent of first housing types were emergency/shelter placements, which includes motels. More than six in 10 (67 percent) people enrolled between March 1, 2020, and Dec. 31, 2021, were

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

discharged during the period, with an average length of support of 177 days (Appendix E, Table 3). The average total subsidy support received by those discharged was $5,343.

Among people with closed cases, 34 percent were closed due to loss of contact, 13 percent transitioned to other housing support, 13 percent received the maximum subsidy without transition to other program support, and 12 percent transitioned to self-support. Housing status at program discharge was unknown for 36 percent of people (consistent with the loss of contact rate), 30 percent were stably housed, and 16 percent were homeless.

Data quality improvement efforts continue. Additional details will be provided as data matures and improves.

Crisis Triage and Diversion-Mobile Crisis and Co-responders

In Washington, mobile crisis response services are provided statewide 24 hours per day, 365 days per year, under HCA's contracts with regional behavioral health administrative service organizations. MCR is an integral part of the regional behavioral health crisis system and is designed to provide community-based services to 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. The goals of these services are engagement, symptom reduction, and stabilization. In some large rural communities, MCR services are provided by designated crisis responders, while other communities are served by dedicated crisis interventionists. According to contract, MCR teams are required to meet a response time of two hours or less. Based on community discussions with the three Phase 1 regions, the majority of MCR teams report that they are responding within 90 minutes. For the Phase 2 implementation, HCA is currently in contract negotiations with the King County BHASO regarding their proposal for MCR enhancements.

Current Status and Positive Impacts

Under the Trueblood implementation plan, HCA sought to enhance the regional MCR service provision by working with the BHASO to identify what enhancements would be needed to support the goals of the implementation plan. These enhancements will support and provide supplemental assistance to traditional MCR services. Traditional MCR services are expanding greatly in Washington with the activation of the 988-crisis line in July 2022, and additional funding to expand traditional MCR services.

The three Phase 1 regions designed their enhanced services to provide a timelier response to community crisis calls and to ensure acceptance of referrals from law enforcement as well as from co-responder teams.

Trueblood funded MCR enhancements have included:

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

Additionally, each region developed and implemented specific enhancements:

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

- Frontier reports that they receive police reports for follow up, including 911 and crime check calls that are more appropriate for mental health response over law enforcement. They 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.

- 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.

Pierce region
MCR services are contracted through Beacon. These services are provided by MultiCare Behavioral Health's mobile outreach crisis team.

- Pierce County MOCT reports that they filled their supervisor position in June 2021. All positions except for one DCR have been filled.

- MOCT reports that they are providing 31.5 percent of follow-up services to people who were seen by the MOCT team.

- Their face-to-face response time was approximately 79 minutes.

- The MOCT team has implemented a new follow-up board for tracking and confirming that follow-up contacts are made.

- Coordinated communication with tribal and law enforcement partners. MOCT continues to meet regularly with law enforcement, community hospitals, evaluation and treatment centers, and local community behavioral health providers. The team attends the Pierce County monthly Crisis Collaborative and provides updates on the progress of the enhanced mobile crisis team. The meetings consist of general information about the

mobile crisis team, referral processes, ways to increase coordination of people into the crisis system rather than legal system when appropriate, any new changes and outreach efforts.

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

- Sea Mar AMCI reports that they have been able to maintain all staffing positions, in part, due to the funding from the Trueblood enhancements. This increased staff coverage from six mental health providers and one second for safety/non-mental health provider staff, to 10 mental health providers and two seconds for safety/non-mental health provider staff. This has allowed the team to meet its goal of expanding hours to midnight effective June 1, 2021. Since then, AMCI has maintained hours of 8 a.m. to 12 a.m. every day. AMCI has continued to collaborate with new community partners including maintaining their motel voucher program with the Council for the Homeless and connecting people with Sea Mar's Delaware Street Clinic to add urgent medical and/or behavioral health needs. These programs have seen increased use since their implementation on July 1 and Aug. 1, 2021, respectively. AMCI has continued to collaborate with Sea Mar's Homeless Outreach team, and Outsider's Inn outreach team to provide more long-term options for people experiencing temporary or chronic homelessness.

- Comprehensive HealthCare reports that they are continuing to do community outreach to educate stakeholders and partners about their mobile crisis team and the services offered. Comprehensive continues to seek opportunities to promote mobile crisis and develop partnerships with new entities. Comprehensive HealthCare reports that their staff continue to conduct ongoing outreach and education to community hospitals on how to access the program. Comprehensive HealthCare reports that they recently hired a second crisis case manager. Other community outreach includes meeting with adult and juvenile probation and court-appointed special advocates to discuss the mobile crisis program, developing professional working relationships, and to gather feedback on ways the program can be of greater assistance. Remedies for addressing transportation concerns for Comprehensive have included their ability to see people experiencing emotional distress at local hospitals. This option allows law enforcement officers and other first responders take people experiencing a behavioral health crisis to the hospital while waiting to be seen by a mental health professional. Comprehensive HealthCare identifies that COVID-19 has had an overwhelming impact on their mobile crisis team since its inception; however, they have managed to increase their in-person responses. With a dedicated mobile crisis team, it is not only able to provide timely crisis follow up but is also assisting people in their attempts to access outpatient services by educating them about the behavioral health system and aiding in the completion of necessary

paperwork and in some cases, completing the initial assessment. Though crisis interactions continue to remain high, Comprehensive HealthCare reports that its mobile crisis team has afforded it "the opportunity to serve individuals and community partners more efficiently during this time of increased demand."

- Skamania County Community Health reports that its primary referral partners are law enforcement and emergency management services. Skamania reports that law enforcement has made 100 percent of the referrals, so increased outreach to additional referral resources is a must. Skamania reports that its referral form has been redesigned and that it has developed an information sheet that referring partners can utilize to cut down on handoff time normally required for an update on the status of the person and their contact information. Skamania County Community Health reports regular participation in local and regional collaboration meetings, and coordination with law enforcement, EMS, probation, and the prosecutor's office on programing and identifying community needs.

Areas of Concern

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

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

MCR data was submitted to HCA's Behavioral Health Data System by Jan. 31, 2022. However, there were substantial data quality issues with the submissions and the data was not suitable for accurate reporting on MCR services. Significant progress was made in instituting corrections, clarifying variables and data entry instructions, and adding error checks to notify providers immediately when there is an issue with key data fields. Additional updates will be published in the user guide in March 2022. As of this report, the State continues to be unable to report data for this program.

HCA is allocating additional resources to further improve data and coordinate with an expanded workgroup to discuss changes needed to report on statewide MCR expansion efforts required under E2SHB 1477, passed in the 2021 legislative session. Expansion will require changes to the data system used by providers across the state, and coordination with state agencies and providers to ensure changes don't impact the ability to report on Trueblood measures.

When the Trueblood region data are of sufficient quality and quantity, the number of interventions, individual characteristics of those served, and average response time will be reported (see Table 2). Data reporting will expand as the data improve and mature. WASPC is responsible for collecting/reporting co-responder's data.

TABLE 2. **PRELIMINARY EXAMPLE**

Mobile Crisis Response Interventions and Client Characteristics

QUARTER

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

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

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

Crisis Triage and Diversion-FPATH

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

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

Current Status and Areas of Positive Impact

FPATH teams improved their efforts to outreach and engage eligible people in jail and hospital settings. Changes in Covid-19 protocols across systems have increased access for some of the teams in regard to meeting individuals in jails and acute care hospital settings. Teams have noted that this has been helpful, especially with people who are exiting incarceration or hospitalization and getting them connected to resources for housing and behavioral health services.

Teams continue to utilize the FHARPS program for people who are interested in seeking assistance with housing. HCA has updated the data reporting tool used by FPATH providers to ensure that it collects information about referrals to the FHARPS program. A similar update was made to the Homeless Management Information System platform that is also used to report data on people served by FPATH providers.

In October and November, members of each FPATH team met weekly with the HCA FPATH program administrator to discuss best practices and to talk through questions that have developed over the last two years. This workgroup looked at things like conducting outreach to people on a by-name referral list, assertive outreach and engagement tactics, and sharing safety protocols. Several of the workgroup members stated that they would like to continue to have regular time to network and connect with other providers across the state. HCA is facilitating

more opportunities for FPATH team members, starting with an annual meeting HCA hosted in March 2022.

HCA has contracted with two community behavioral health agencies in the King County region for Phase 2. The two agencies under contract are the Community House Mental Health Agency and Telecare Corporation. These two agencies are ensuring that FPATH services are available throughout the King region, and HCA has met with the agencies regularly as they prepared for to begin their services in March 2022.

Areas of Concern

In the fall it was identified that there were discrepancies with the information being reported. Once this problem was identified, HCA started working with the providers to correct the errors and significant progress was made. FPATH teams continue to improve their data quality. In September, teams started submitting their data reporting tools to HCA through an automated data validation system. This process has improved the quality of the data submitted and the timeliness of data being submitted.

Another area of concern is workforce shortages and turnover. Several teams have reported losing team members over the last several months. Teams have reported that this has impacted their ability to outreach new people and work as closely with enrolled participants. Some teams have been able to fill their vacancies within a few weeks to a month, whereas others have vacant positions for a month or more.

Recommendations to Address Concerns

To address the concern around discrepancies with two data reporting processes, HCA IT has set up weekly office hours to provide real-time technical support to the contracted teams. HCA has been helping FPATH teams connect with the Department of Commerce when there are questions specific to the HMIS data system. RDA will also create a monthly error report for teams, so FPATH teams can stay current with error corrections. As mentioned, HCA, RDA, and the Department of Commerce are working on lasting resolutions to this problem.

HCA will work with FPATH providers to support them with workforce shortages as best as possible. One team has adopted a job-sharing model, bringing in a part-time team member to fill in hours for other team members as they complete internships in other parts of their agencies. HCA will continue to look for creative ideas for staff, especially as services are being rolled out in the Phase 2 region.

In December 2021, the HCA program administrator started site visits and was able to meet with the two Pierce Region providers, Comprehensive Life Resources and Great Lakes Mental Health Care. The site visits provided an opportunity to meet the teams and troubleshoot questions in person. As COVID restrictions change, HCA will resume in-person site visits to provide technical assistance.

Data-Crisis Triage and Diversion-FPATH

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

The FPATH program began March 1, 2020. Between March 1, 2020 and Dec. 31, 2021, 1,391 people within the Phase 1 regions were referred to the program (Appendix F, Table 1). HCA has asked providers to focus outreach efforts on a subset of these 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 734.

Of all people on the referral list, FPATH providers attempted to contact 702 (50 percent), and successfully contacted 411 (30 percent). Current data indicate that a total of 216 people (16 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Of these, the majority were male (80 percent) and between 30 and 49 years old (57 percent). More than half of enrollees (61 percent) were homeless, while 24 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population. The Southwest region enrolled the largest proportion of those on their referral list (31 percent), while the Pierce Region enrolled 10 percent and Spokane enrolled 19 percent. Among those discharged as of Dec. 31, 2021, the average length of stay in the FPATH program was 207 days. People in the Southwest Region had the longest length of stay at 286 days, while the Pierce Region had the shortest at 145 days.

Services

There have been 4,193 service encounters between FPATH providers and program participants over the duration of the program, with an average of 2.4 services per participant, per month (Appendix F, Table 2). People enrolled in the Pierce and Spokane regions had an average of 2.9 service encounters per month, while those in the Southwest Region had an average of 1.3 per month. The most common service encounter for people in the FPATH program was case management (1.3 per month, on average), followed by outreach services (0.5 per month).

Referrals

Of the 216 FPATH enrollees, 133 (62 percent) had received at least one referral through Dec. 31, 2021 (Appendix F, Table 2). The Spokane region provided the most referrals, with 82 percent of participants having at least one. Fifty-nine percent of program participants in the Pierce Region had at least one referral, as well as 45 percent of the Southwest Region. The most common referral throughout all Phase 1 regions was community mental health: 22 percent of participants received at least one referral for community mental health services. Approximately 20 percent of enrollees received a referral for FHARPS housing services.

Education and Training – Crisis Intervention Training

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

Current Status and Areas of Positive Impact

For Phase 1 regions through Dec. 31, 2021, the Criminal Justice Training Commission has completed twelve 40-hour courses for law enforcement and certified peace officers. Within these classes CJTC has trained law enforcement officers, mental health professionals, dispatchers, emergency responders, security officers, and corrections officers. As of Dec. 31, 2021, 892 officers have received the training, and there are 105 officers left to train to reach the 25 percent goal in the Phase 1 regions. Since August 2021, CJTC completed two classes and has one more scheduled in the Spokane Region. There are only a few officers left to train in this region to meet compliance. CJTC completed one course and has a second course scheduled for the Southwest Region to pick up the remaining nine officers left in this region. The Pierce Region still has 90 officers to train to meet the 25 percent minimum. However, five courses are scheduled in this region to be completed by June 30.

CJTC developed and deployed a webinar-style course to meet the needs of correctional agencies during the pandemic. CJTC conducted four of these classes in the second half of 2021. In addition to the earlier traditional courses and the addition of Clark County's 40-hour program, 675 corrections officers have received at least the minimum eight-hour CIT for Corrections training. The Lincoln and Skamania county sheriff's departments cross-train all of their corrections officers as 911 dispatchers. Those officers took the eight-hour 911 CIT training. There are an estimated 25 correctional officers left to train in the Phase 1 areas.

Phase 1 regions are now eligible to receive all 40 hours of cost coverage backfill dollars as a result of the Trueblood funding provided by the legislature. As an added incentive, lodging and per diem costs can be covered for agencies more than 50 miles from the training site. Not all agencies have availed themselves of this benefit. The CJTC team is continuing to provide significant outreach and education and has seen improvement using 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 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, 434 dispatchers have

received the full eight-hour training. A total of 99 percent of dispatchers in the Phase 1 regions have completed the training. Only four dispatchers in two agencies remain and three of those have completed the first four-hour block.

In Phase 2, King County has been running a robust 40-hour CIT program for several years. Because of this, of the 3,162 certified peace officers in King County, 1,484 have already completed the training (46%). However, not every agency has 25 percent of their officers trained. Fifty-eight officers remain to be trained to bring every King County agency up to the minimum requirement. King County has 12 of the 40-hour CIT courses scheduled for 2022.

King County has six correctional agencies encompassing 797 correctional officers. To date 120 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 454 Telecom/911 dispatchers. Of these, 270 (60%) 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

COVID-19 and its recent variants continue to have a significant impact on our ability to conduct in person training. King County Public Health, and in turn all its agencies, placed a moratorium on all in-person trainings. This caused four classes to be canceled in fall 2021. Going forward, there are 12 courses scheduled for the remainder of the calendar year and no more classes will be canceled, only postponed until later in the year.

Staffing levels of all agencies have in each discipline, gotten significantly worse this reporting period. The vaccine mandate in many agencies has increased shortages and required overtime for most, if not all, agencies. In addition, as vacant positions are filled, they are filled with new employees who will not have had the training, bringing compliance levels down.

Recommendations to Address Concerns

To mitigate some of the staffing issues CJTC has stepped up communication. In addition to the full 40-hour backfill/overtime coverage, we have offered lodging and per diem reimbursement to small agencies that are farther than 50 miles from the training site. We have also added an additional class to each of the three regions in Phase 1. CJTC will continue to offer the 8-hour corrections course in a virtual format for at least as long as King County is restricting in-person trainings. Once those restrictions end, we will offer both formats to accommodate all learners and provide a choice.

Data-Education and Training-CIT

Phase 1

CJTC monitors law enforcement training completion rates through the Learning Management System. Per the Agreement, 25 percent of patrol officers in each law enforcement agency are required to complete 40 hours of enhanced CIT throughout the three Phase 1 regions. Figure 5 displays training completion rates for each individual law enforcement agency in Phase 1. As of Dec. 31, 2021, 32 of the 56 (57 percent) law enforcement agencies met or exceeded the 25-percent benchmark (Figure 5). Large agencies had higher training completion rates than small agencies in all three regions.

As shown in Table 1, 19 percent of officers were trained in the Pierce region, compared to 56 percent in the Southwest region, and 53 percent in the Spokane region. Previously, these rates were 14 percent, 52 percent, and 42 percent, respectively (see September 2021 Semi-Annual Report). Washington State Patrol units in the Phase 1 regions have demonstrated a training rate of 19 percent. Due to the impact of COVID-19, in-person trainings continue to be impacted throughout the state.

The Settlement Agreement also requires all 911 dispatchers and correctional officers to complete an eight-hour CIT course by June 30, 2021. As of Dec. 31, 2021, nearly all Phase 1 911 dispatchers had completed CIT training, with completion rates of 100 percent in the Pierce and Southwest regions, and 98 percent in the Spokane region (Table 2). In addition, 96 percent of correctional officers in Phase 1 regions completed CIT training, ranging from 95 percent in the Spokane region to 97 percent in the Pierce and Southwest regions (Table 3).

Phase 2

Figure 6 displays the training completion rates for the law enforcement agencies in Phase 2, which began July 1, 2021. As of Dec. 31, 2021, 17 of the 28 (61 percent) law enforcement agencies were meeting or exceeding the 25 percent benchmark, with an overall training completion rate of 45 percent (Table 4). Washington State Patrol units in Phase 2 had a training completion rate of 19 percent. Similar to Phase 1, large law enforcement agencies had higher training completion rates than small and medium sized agencies.

Approximately 60 percent of 911 dispatchers and 15 percent of correctional officers in King County had competed the eight-hour CIT course by the end of 2021 (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 Dec. 31, 2021, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (Southwest 64 percent and Spokane 63 percent) than the Pierce Region (21 percent, Table 7). In the Phase 2 region, large agencies with higher population

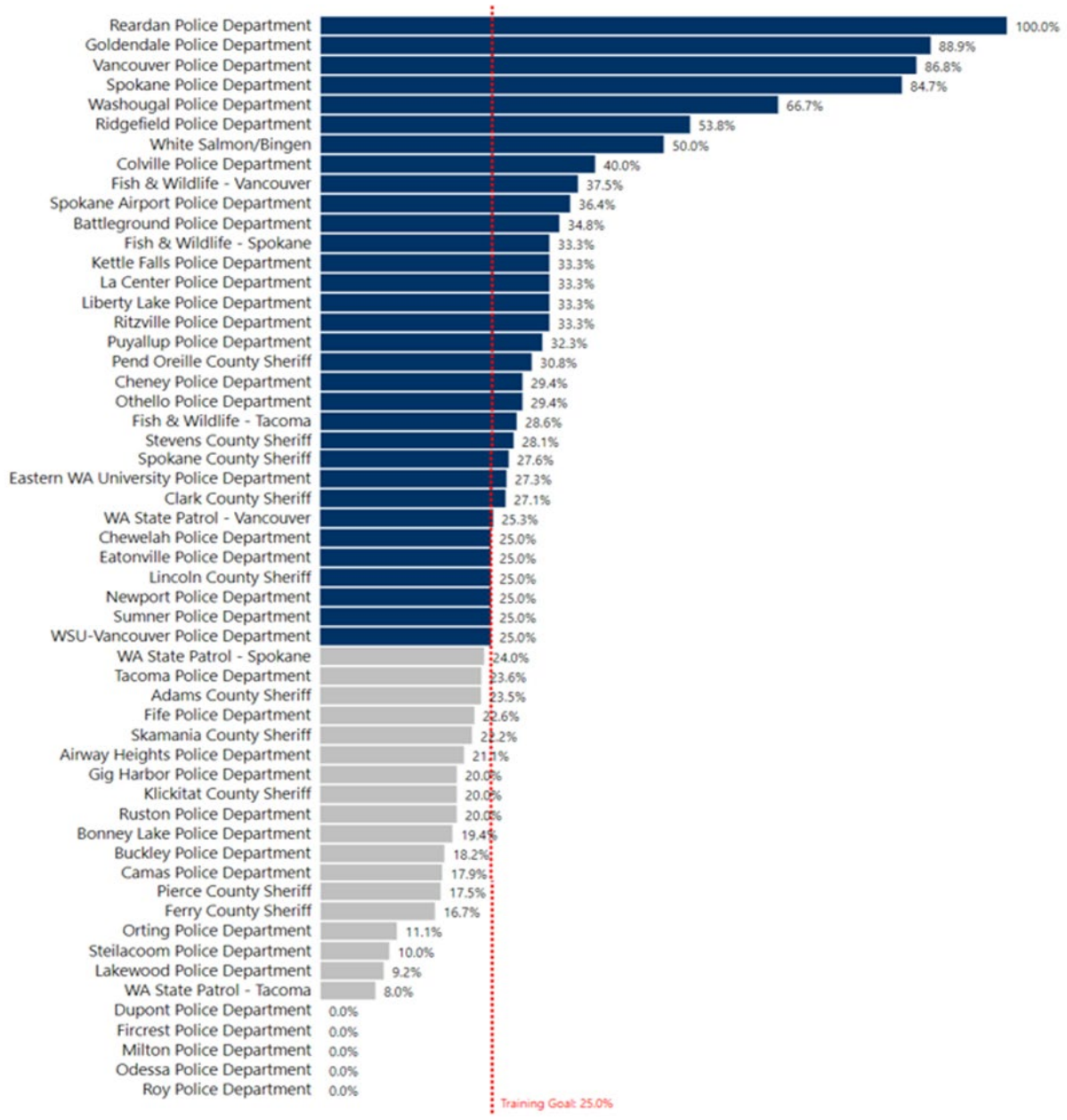
densities had higher training completion rates (47 percent) than medium and small agencies (37 percent and 29 percent, respectively, Table 8).

Figures 5 and 6 on the following pages display training completion rates for each law enforcement agency in the Phase 1 and 2 regions. Thirty-one (56 percent) law enforcement agencies in the Phase 1 regions are meeting or exceeding the 25 percent benchmark, as compared to 17 (61 percent) in Phase 2.

Figure 5.

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

DECEMBER 31, 2021



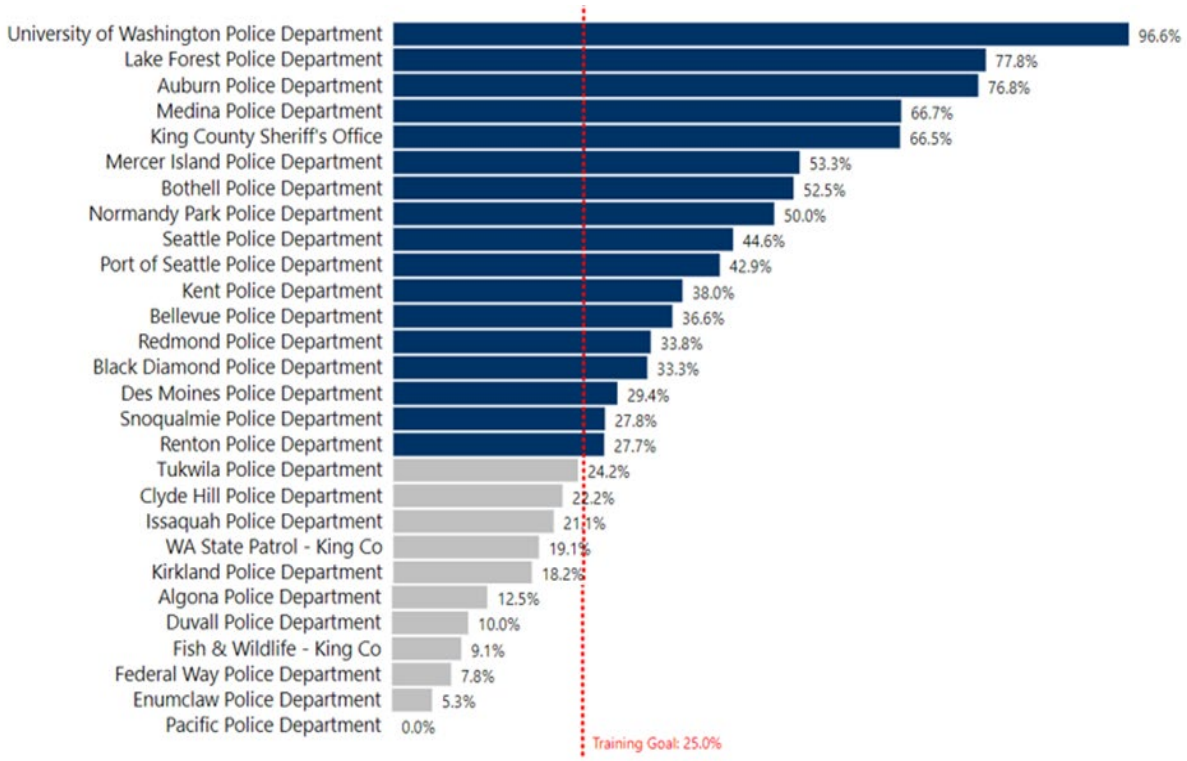
*Percent of officers who have received 40 hours of Crisis Intervention Training.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 6.

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

DECEMBER 31, 2021



*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

DECEMBER 31, 2021

Region	# of Officers	# of Officers Trained	% Trained
Fish & Wildlife - Phase 1	27	9	33.3%
Pierce Region	935	181	19.4%
Southwest Region	474	267	56.3%
Spokane Region	733	391	53.3%
WA State Patrol - Phase 1	229	44	19.2%
Total	**2398**	**892**	**37.2%**

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 2.

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

DECEMBER 31, 2021

Region	# of Dispatchers	# of Dispatchers Trained	% Trained
Pierce Region	135	135	100.0%
Southwest Region	81	81	100.0%
Spokane Region	175	172	98.3%
WA State Patrol - Phase 1	47	46	97.9%
Total	**438**	**434**	**99.1%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

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

DECEMBER 31, 2021

Region	# of Officers	# of Officers Trained	% Trained
Pierce Region	285	277	97.2%
Southwest Region	153	149	97.4%
Spokane Region	262	249	95.0%
Total	**700**	**675**	**96.4%**

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

DECEMBER 31, 2021

Region	# of Officers	# of Officers Trained	% Trained
Fish & Wildlife - Phase 2	11	1	9.1%
King Region	3150	1457	46.3%
WA State Patrol - Phase 2	136	26	19.1%
Total	**3297**	**1484**	**45.0%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 5.

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

DECEMBER 31, 2021

Region	# of Dispatchers	# of Dispatchers Trained	% Trained
King Region	437	265	60.6%
WA State Patrol - Phase 2	17	5	29.4%
Total	**454**	**270**	**59.5%**

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 6.

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

DECEMBER 31, 2021

Region	# of Officers	# of Officers Trained	% Trained
King Region	797	120	15.1%
Total	**797**	**120**	**15.1%**

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

DECEMBER 31, 2021

Region	Pierce Region			Southwest Region			Spokane Region			WA State Patrol - Phase 1			TOTAL - ALL REGIONS		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained
Small	117	15	12.8%	68	27	39.7%	171	49	28.7%				383	100	26.1%
Medium	214	42	19.6%	72	27	37.5%	32	9	28.1%	229	44	19.2%	547	122	22.3%
Large	604	124	20.5%	334	213	63.8%	530	333	62.8%				1468	670	45.6%

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

DECEMBER 31, 2021

Region	Fish & Wildlife - Phase 2			King Region			WA State Patrol - Phase 2			TOTAL - ALL REGIONS		
Agency Size	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained	# of Officers	# of Officers Trained	% Trained
Small	11	1	9.1%	137	42	30.7%				148	43	29.1%
Medium				391	144	36.8%				391	144	36.8%
Large				2622	1271	48.5%	136	26	19.1%	2758	1297	47.0%

DATA SOURCE: Washington State Criminal Justice Training Commission.

Education and Training – Technical Assistance for Jails

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

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

Current Status and Areas of Positive Impact

All training topics designated by the Settlement Agreement and the implementation plan have been delivered. Webinar-based trainings continue on a monthly basis, and the schedule for these trainings has been established through March 2022. Several of the topics scheduled for were identified by input from the field, including those attending prior trainings and providing feedback on additional trainings that would be useful. Other topics are extensions of prior trainings to provide greater depth of coverage than was possible in the initial training session.

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

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

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. DSHS continues to provide support for jail-based competency evaluations to be completed via video teleconferencing. A total of 24 jails (including county, city and tribal jails) are now using video conferencing to complete more than 180 competency evaluations per month via video teleconferencing.

Areas of Concern

A continuing area of concern is regional awareness of the JTA program. Although the foundation of the program has been established and a 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 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 February 2022, the number of participants in our monthly JTA training events has increased, but only very modestly. We are continuing to work to expand the number of persons 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 2022 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. Beginning in July 2021, JTA staff began including a survey during each monthly JTA webinar, in hopes of learning more about how to effectively deliver training to jail staff. 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 had arranged to staff a booth at the spring 2020 WASPC conference and planned to deliver an awareness campaign as well as to solicit additional information regarding JTA needs.

Unfortunately, this important outreach opportunity was canceled due to the COVID-19 pandemic. However, JTA staff was able to attend and give a presentation at the November 2021 WASPC conference to expand awareness of our training and technical assistance resources.

Data-Jail Technical Assistance

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

Enhanced Peer Support

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

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

Current Status and Areas of Positive Impact

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

All in-person continuing education trainings have been postponed due to COVID-19 and the continued need for physical distancing. HCA and OFMHS created pre-recorded overviews of the IBHL training modules to meet the May 1, 2020, deadline. These pre-recorded overviews have now been replaced by a full virtual training titled *The Intersection of Behavioral Health and the Law* available through a learning management system. Transitioning the written curriculum to a virtual format entailed several steps and required in-depth review by numerous parties. The virtual format has been designed to maximize learner engagement, to provide an interactive learning experience, and is Section 508 compliant and therefore accessible to all learners within the learning management system. Section 508 of the Rehabilitation Act of 1973 ensures that people that 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 virtual version of the training has been completed and is available to learners, thus meeting the Trueblood Settlement Agreement deadline of Jan. 31, 2022.

The development of additional training modules to IBHL regarding diversity, equity, and inclusion was identified. HCA contracted with a national diversity, equity, and inclusion subject matter expert to create this continuing education offering titled *Enhancing Your Cultural Intelligence*. The same contractor also facilitated a train-the trainer event for this diversity, equity, and inclusion training in February 2022.

On Nov. 15, 2021, certified peer counselors on Trueblood program teams and court-funded diversion programs were invited to come together for the inaugural quarterly Trueblood CPC

Learning Community meeting. Twenty-one CPCs representing teams across the state were in attendance, including CPCs working in the King Region. CPCs in attendance were informed of the status of the transition of the *Intersection of Behavioral Health and the Law* and *Enhancing Your Cultural Intelligence* trainings to a virtual format. Additionally, the learning community provided technical assistance, resourcing, and networking for CPCs on Trueblood program teams and court-funded diversion programs throughout Washington state.

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

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

The Washington State Behavioral Health Workforce Advisory Committee completed an 18-month, two-phase project focused on the behavioral health workforce. Phase 1 of this project culminated in November 2016 with a report of initial findings regarding barriers and short-term solutions to ensure a comprehensive and effective behavioral health workforce. In the Phase 1 report, it stated that the challenges to ensuring adequate access to behavioral healthcare are complex. Ensuring Washington's behavioral health workforce can meet the state's needs will require more than just "turning on the spigot" at education programs across the state. Because

the health care system is rapidly changing, workforce planning requires that attention be paid to the underlying systemic, structural, and perception challenges that affect the ability to recruit, educate, train, credential, and retain a sufficiently large and adequately skilled workforce to provide needed behavioral health services. The Phase 2 report identifies various specific issues that affect the availability and effective functioning of behavioral health occupations. These included issues related to education, regulation, and practice. Phase 2 focused on assembling more detailed information to describe the Washington behavioral health workforce and refining and updating Phase 1 recommendations as healthcare providers gained knowledge and experience regarding behavioral and physical health care integration.

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

Areas of Concern

The unique value of peer support is derived from lived experience. Certified peer counselors draw upon that experience to build connection and rapport with the people they serve. The certified peer counselors 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 jail.

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails. There have been recent reports from certified peer counselors working with class members, in which they have had success in entering the jails by working directly with the sergeant on duty. The Enhanced Peer Services Program administrator is working with certified peer counselors who have

successfully entered the jails to seek a way to operationalize certified peer counselors entering the jails. HCA is currently undergoing a pilot, Peer Pathfinders Transition from Incarceration, in which CPCs will be added to Jail Transition Services teams. This pilot has identified contracted Peer Pathfinder agencies that have an established agreement with local jails. The Enhanced Peer Services Program administrator is included on the team that is working on this pilot and will use knowledge gained from this project to inform the operationalizing of CPCs entering jails.

Data-Enhanced Peer Support

Between September 2021 and February 2022, 34 certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 regions completed the overview modules. One additional program staff also completed the overview. It is of note, that beginning February 2022, data collection around completion of trainings offered by the Enhanced Peer Support program will be captured by a learning management system that will register individual users and track each user's completion of trainings.

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.

Current Status and Areas of Positive Impact

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

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

WFD team members are delivering training in support of the recently implemented 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 Trueblood lawsuit. In August 2020, the Workforce Development team began to deliver trainings as part of NEO which included Philosophy of Care, Suicide Awareness, and Characteristics of Clients Served. As NEO training developed, the team also began to provide training on the Breaking Barriers curriculum for competency restoration, the Social Learning Program, and OFMHS Quality Assurance. These trainings are delivered monthly.

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

One of the recommendations that Groundswell Consulting Services provided regarding workforce development was to "increase basic forensic literacy." As a follow up to this, during summer 2021, Workforce Development staff, and JTA staff engaged with psychology and nursing leadership within the King County Jail to identify training topics of particular interest for jail staff. A key training need identified by King County Jail leadership was greater understanding of the forensic mental health system. Over the fall and winter, Workforce Development staff have followed up by designing a training series that will be piloted with King County Jail staff. Training modules will include an Overview of Trueblood, Diversion, Competency to Stand Trial, Competency Restoration, and Transition Planning/Continuity of Care. Based on feedback from the King County Jail staff, the training series will be further honed and then made available to jail staff statewide. A central focus of this training will be to increase jail staff's understanding of competency to stand trial, and how competency evaluations, competency restoration treatment and associated court activities interface with their daily work.

Following that, Workforce Development staff will expand this online training series and make it available at no cost to any/all partners in the Settlement Agreement work, to include prosecutors, defenders, judges, behavioral health providers, law enforcement, and especially to our partners in the field of education. Workforce Development staff hope partners within institutions of higher learning will consider using the training modules as part of their own curricula. Further, staff hopes this might lead to students developing an interest in possible careers working at the intersection of behavioral health and the law.

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

Efforts to establish relationships and opportunities for collaboration within post-secondary education have resulted in dialogues with Shoreline Community College and the University of Washington. These discussions were deepened during 2021 as Workforce development staff conducted structured interviews with educational partners as part of our work to prepare the report mentioned above. These conversations revealed a number of existing strengths and

potential collaborations. For instance, Shoreline Community College has a series of courses in forensic topics, and consultation has begun to explore ways in which this may serve the needs of expanding the workforce required to serve Trueblood class members. The University of Washington recently established The UW Center for Mental Health, Policy and the Law. This group has expressed interest in building partnerships. An introductory meeting was held on Sept. 3, 2020. A follow up meeting took place March 5, 2021. Eastern Washington University's master's in social work program expressed interest in expanding its options to expose students to the field of forensic mental health. WFD will continue to build on these budding partnerships and opportunities for collaboration. As mentioned above, a goal for the OFMHS Workforce Development team is interest partners at institutions of higher learning to incorporate some of the trainings we are developing this year into their future curricula.

Areas of Concern

The WFD team is on track to complete all required element tasks on time or ahead of schedule. One area of concern continues to be the short- and medium-term impacts of COVID-19. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. However, we and our partners have found ways to interact online via videoconferencing and other available means as we work to provide education and training to prepare people to enter and successfully work in this field. 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 more effectively reach our audiences. Toward that end, WFD purchased three licenses for the presentation software called Articulate. This format enables the creation of online trainings that are more interactive and multidimensional than PowerPoint. The WFD team already used Articulate to deliver trainings on abuse and neglect, and on social learning programs for DSHS staff. We are developing other trainings within Articulate as we have indeed found this format to be a more engaging way of presenting trainings. One example of this is the five-module training series currently being developed to provide jail staff with an overview of our state's adult forensic mental health system.

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

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

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

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. We then used population data to make estimates of how many staff, of which types, would be required to implement the Settlement Agreement statewide. This methodology 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, Trueblood project leads are hard at work implementing Phase 2 programming in the King region. 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 is tempered, however, by the challenges we face with the COVID-19 pandemic. Throughout spring and summer 2021, COVID-19 impacts intensified as much of the United States, Washington State included, suffered the fifth — and to date most severe — Delta variant wave of the pandemic. Just when it seemed the fifth wave might break, the Omicron variant emerged as the most rapidly infectious variant to date, but also as an overall less deadly form of COVID-19. 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 are contending with 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.

When the next semi-annual report is published in late September 2022, HCA and the department will be one year into implementing Phase 2 programming in the King region. Plans and ongoing activities to implement services in King County are underway.

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

Appendix A-Related Resources

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

State Agency Resources:

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

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

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

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

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

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

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

Trueblood *Contempt Settlement Agreement:* *www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/*Trueblood*/2018*Trueblood*/623_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 *February 2022 Progress Report for the Court Monitor and Appendices A-K:*

February | Appendix A-G | Appendix H | Appendix I | Appendix J | Appendix K

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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

Appendix B-OCRP Dashboard

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: July 1, 2020 to to December 31, 2021

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

TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	46	100.0%						
Among Enrolled Individuals…								
RESTORATION ORDER TYPE (unduplicated)								
Felony	38	82.6%						
Misdemeanor	8	17.4%						
GENDER								
Female	7	15.2%						
Male	39	84.8%						
AGE GROUP								
18-29 yrs	18	39.1%						
30-49 yrs	20	43.5%						
50+ yrs	8	17.4%						
RACE/ETHNICITY								
Non-Hispanic White	30	65.2%						
Black, Indigenous, and People of Color	16	34.8%						
HOUSING STATUS AT PROGRAM ENROLLMENT								
Stably Housed	10	21.7%						
Unstably Housed	27	58.7%						
Homeless	8	17.4%						
Unknown	1	2.2%						

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

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

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)								
Enrolled	46	100.0%						
Active	10	21.7%						
Discharged	36	78.3%						
Among Discharged Individuals…								
DISCHARGE REASON								
Charges Dismissed	6	16.7%						
Opined Competent	14	38.9%						
Opined Not Competent	3	8.3%						
Opined Not Restorable	0	0.0%						
Returned to Jail	1	2.8%						
Inpatient Medical Care	0	0.0%						
Inpatient Civil Psychiatric Care	1	2.8%						
Revoked Conditional Release	10	27.8%						
Death	0	0.0%						
Unknown	1	2.8%						
DISCHARGE LOCATION								
Community	24	66.7%						
Residential Treatment Facility	1	2.8%						
State Hospital	5	13.9%						
Jail	3	8.3%						
Unknown	3	8.3%						

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

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

OCRP Definitions

Variable name	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase One Regions: Pierce, Southwest, Spokane.
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
PARTICIPANT CHARACTERISTICS TABLE	
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.
DISCHARGES TABLE	
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.
Unknown	Provider did not select a reason for discharge.
Discharge Location	Location of participant at time of program end.
Community	Participant was not in a facility at the time of discharge. Some participants may be pending inpatient treatment.
Residential Treatment Facility	Maple Lane, Yakima, and Fort Steilacoom competency restoration facilities.
State Hospital	Western and Eastern State Hospitals.
Jail	County, city, or tribal jail facility.
Unknown	Discharge location unknown.

Appendix C-Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health Administration Forensic Navigator Program

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: July 1 ,2020 to December 31, 2021

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

TABLE 1.

Forensic Navigator Enrollment and Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Referred	1,562	100%	751	100%	311	100%	500	100%
Forensic Navigator Assigned	1,541	99%	739	98%	304	98%	498	100%
Among Individuals Assigned a Forensic Navigator…								
PARTICIPANT STATUS (on last day of reporting period)								
Active	154	10%	72	10%	37	12%	45	9%
Pre-Competency Hearing	138	9%	68	9%	28	9%	42	8%
OCRP Enrolled	11	1%	--	--	--	--	--	--
Post-OCRP (Coordinated Transition)	5	0%	--	--	--	--	--	--
Discharged	1387	90%	667	90%	267	88%	453	91%
GENDER								
Female	329	21%	159	22%	60	20%	110	22%
Male	1145	74%	540	73%	232	76%	373	75%
Unknown	67	4%	40	5%	12	4%	15	3%
AGE GROUP								
18-29	395	26%	189	26%	83	27%	123	25%
30-49	836	54%	404	55%	162	53%	270	54%
50+	310	20%	146	20%	59	19%	105	21%
RACE/ETHNICITY*								
American Indian or Alaskan Native	28	2%	23	3%	--	--	--	--
Asian	30	2%	20	3%	--	--	--	--
Black or African American	275	18%	204	28%	36	12%	35	7%
Hispanic or Latino	28	2%	11	1%	--	--	--	--
Native Hawaiian or Pacific Islander	27	2%	24	3%	--	--	--	--
White Only, Non-Hispanic	923	60%	365	49%	203	67%	355	71%
Other Race	7	0%	--	--	--	--	--	--
Unknown	231	15%	91	12%	46	15%	94	19%
MOST SERIOUS CURRENT CRIMINAL CHARGE								
Felony	934	61%	436	59%	174	57%	324	65%
Misdemeanor	607	39%	303	41%	130	43%	174	35%
HOUSING STATUS AT PROGRAM INTAKE								
Stably Housed	306	20%	123	17%	75	25%	108	22%
Unstably Housed	186	12%	105	14%	39	13%	42	8%
Homeless	402	26%	145	20%	124	41%	133	27%
Unknown	647	42%	366	50%	66	22%	215	43%

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

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

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

--Cells suppressed due to small n's.

TABLE 2.

Forensic Navigator Services

CUMULATIVE: July 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
POPULATION								
Active (at any point during the reporting period)	1,541	100.0%	739	100.0%	304	100.0%	498	100.0%
Avg Daily Navigator Caseload (most recent qtr of reporting period)	16	N/A	14.0	N/A	20.0	N/A	15.5	N/A
Among Active Participants (at any point during the reporting period)…								
FORENSIC NAVIGATOR SERVICES								
Assisting Clients with Attending Classes and Appointments	24	1.6%	11	1.5%	--	--	--	--
Attending Competency Hearing	581	37.7%	179	24.2%	221	72.7%	181	36.3%
Client Meeting, Interview, and/or Observation	957	62.1%	425	57.5%	219	72.0%	313	62.9%
Client Support-Network Interactions	125	8.1%	51	6.9%	13	4.3%	61	12.2%
Completed Recommended Services Plan	1,067	69.2%	479	64.8%	228	75.0%	360	72.3%
OCRP Compliance Monitoring	46	3.0%	16	2.2%	20	6.6%	--	--
Contact with Client's Attorney or Prosecutor	1,273	82.6%	618	83.6%	226	74.3%	429	86.1%
Coordination of Care	592	38.4%	140	18.9%	178	58.6%	274	55.0%
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	274	17.8%	47	6.4%	116	38.2%	111	22.3%
Information Gathering	1,534	99.5%	734	99.3%	303	99.7%	497	99.8%
Medication Monitoring	61	4.0%	11	1.5%	36	11.8%	14	2.8%
Outreach Services - Attempted Contact	411	26.7%	130	17.6%	73	24.0%	208	41.8%
Outreach Services - Client Contact	253	16.4%	34	4.6%	73	24.0%	146	29.3%
Post-OCRP Client Check-in (up to 60 days)	12	0.8%	--	--	--	--	--	--
Post-OCRP Coordinated Transitions	9	0.6%	--	--	--	--	--	--
Referral to Services	433	28.1%	154	20.8%	86	28.3%	193	38.8%
REFERRALS								
Adult Protective Services (APS)	0	0.0%	--	--	--	--	--	--
Community Outpatient Mental Health Services	111	7.2%	16	2.2%	18	5.9%	77	15.5%
Designated Crisis Responder (DCR) Referral	3	0.2%	--	--	--	--	--	--
EBT/ABD (Food/Cash Benefits)	31	2.0%	--	--	--	--	28	5.6%
Educational Services	7	0.5%	--	--	--	--	--	--
Employment Assistance	23	1.5%	--	--	--	--	22	4.4%
Forensic HARPS Services	213	13.8%	107	14.5%	43	14.1%	63	12.7%
Forensic PATH Services	289	18.8%	122	16.5%	59	19.4%	108	21.7%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Home and Community Services	41	2.7%	--	--	--	--	39	7.8%
Housing Services (Non-HARPS)	50	3.2%	--	--	--	--	46	9.2%
Job Training	3	0.2%	--	--	--	--	--	--
Medical Insurance Services	19	1.2%	--	--	--	--	18	3.6%
Other Community Based Resource	59	3.8%	--	--	--	--	41	8.2%
Primary Health Care/Dental Care	9	0.6%	--	--	--	--	--	--
SSI/SSDI	16	1.0%	--	--	--	--	16	3.2%
Substance Use Disorder Treatment	63	4.1%	--	--	--	--	56	11.2%
Supported Employment	4	0.3%	--	--	--	--	--	--
VA Benefits	2	0.1%	--	--	--	--	--	--

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

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

--Cells suppressed due to small n's.

TABLE 3.

Forensic Navigator Program Measures

CUMULATIVE: July 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
INDIVIDUALS DISCHARGED								
Discharged during the reporting period	1,387	100.0%	667	100.0%	267	100.0%	453	100.0%
Discharged w/ warm hand-off to provider or jail staff	489	35.3%	170	25.5%	80	30.0%	239	52.8%
Among Individuals Discharged…								
DISCHARGE REASON								
Charges Dismissed	118	8.5%	63	9.4%	26	9.7%	29	6.4%
Client Death	3	0.2%	--	--	--	--	--	--
Client Determined Competent	466	33.6%	241	36.1%	95	35.6%	130	28.7%
Dismiss & Refer (to DCR)	88	6.3%	54	8.1%	23	8.6%	11	2.4%
Diversion Program(s)	1	0.1%	--	--	--	--	--	--
Felony (72-Hour) Civil Conversion	14	1.0%	--	--	--	--	--	--
Civil Conversion - Removal from OCRP	4	0.3%	--	--	--	--	--	--
Inpatient Restoration	388	28.0%	223	33.4%	90	33.7%	75	16.6%
Not Restorable - Developmental Disability	4	0.3%	--	--	--	--	--	--
Not Restorable - Pre-Hearing/OCRP	1	0.1%	--	--	--	--	--	--
Order Canceled or Withdrawn	25	1.8%	--	--	--	--	--	--
Re-arrest	1	0.1%	--	--	--	--	--	--
Refused Forensic Navigator Services	52	3.7%	--	--	--	--	--	--
Released from Jail on Personal Recognizance (PR)	204	14.7%	43	6.4%	14	5.2%	147	32.5%
Successful OCRP Completion - Coordinated transition completed	10	0.7%	--	--	--	--	--	--
Successful OCRP Completion - Summary of treatment completed	0	0.0%	--	--	--	--	--	--
Violation of OCRP Conditions of Participation/Court Ordered CR	8	0.6%	--	--	--	--	--	--
LENGTH OF STAY								
Average Length of Stay in Forensic Navigator Program (days)	36	N/A	31.0	N/A	40.1	N/A	39.8	N/A

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

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

--Cells suppressed due to small n's.

Forensic Navigator Program Definitions

Variable Name	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase One Regions: Pierce, Southwest, Spokane.
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
ENROLLMENT TABLES	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred or enrolled more than once in Forensic Navigator services during the reporting period, the most recent information is included.
Referred	All individuals with an outpatient competency evaluation order are referred to the Forensic Navigator Program.
Forensic Navigator Assigned	Individuals assigned to a Forensic Navigator during the reporting period.
Participant Status (on last day of reporting period)	Program enrollment status on the last day of the reporting period, among those assigned to a Navigator.
Active	Individuals assigned a navigator, who have not yet been discharged from the program as of the last day of the reporting period.
Pre-Competency Hearing Clients	Individuals in the pre-competency hearing phase of Forensic Navigator services. These individuals have not yet had a competency hearing.
OCRP Enrolled	Individuals in the Outpatient Competency Restoration Program (OCRP) phase of Forensic Navigator services. These individuals have been found not competency to stand trial and ordered by the court to participate in outpatient (community-based) competency restoration treatment.
Post-OCRP (Coordinated Transition)	Individuals who have successfully completed the Outpatient Competency Restoration Program and are in the coordinated transition phase of Forensic Navigator services, meaning the Navigator is attempting to ensure the client is connected to community behavioral health services.
Discharged	Clients who were discharged from Forensic Navigator services during the reporting period.
Gender	Client's gender based on either self report or administrative records.
Age Group	Age at enrollment, based on date of birth and date the navigator was assigned.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. 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	
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 (NCM).
OCRP Compliance Monitoring	Forensic Navigator engaged in communication (phone, email, in-person) with OCRP providers, probation officer, legal counsel, and/or client to ensure client's compliance with conditions of release.
Contact with Client's Attorney or Prosecutor	Forensic Navigator called, emailed, met with, or in any other way either communicated with OR sent communication to client's defense attorney, the prosecuting attorney, or the defense/prosecution attorney of record for the case.
Coordination of Care	Forensic Navigator synchronized the delivery of a client's care between multiple providers and/or specialists to ensure care from disparate providers is not delivered in silos.
Court Reporting (Ad-hoc, Periodic, Testimony/Deposition)	Forensic Navigator provided written or oral report on client's progress to the court per the court's request, on a periodic basis, or at the time of hearing. Written reports may be provided by email, and oral reporting by phone.
Medication Monitoring	Forensic Navigator engaged in any form of communication (phone, email, in person) with OCRP providers, the client, or others to assure the client's adherence to prescribed medication(s). This also include assisting clients with obtaining medication.
Outreach Services - Attempted Contact	Forensic Navigator attempted to locate and engage client in the community, but was unable to make contact with the client.
Outreach Services - Client Contact	Forensic Navigator attempted to locate and engage client in the community, and successfully contacted the client.
Post-OCRP Client Check-in (up to 60 days)	After a client successfully completes OCRP, Forensic Navigator attempted to follows-up with the client and/or community provider (via phone, email, or in person) to determine whether the client is receiving community mental health services.
Post-OCRP Coordinated Transitions	Forensic Navigator engaged in any form of communication (phone, email, in-person) with community providers to establish on-going behavioral health care for a client after OCRP discharge.
Information Gathering	Forensic Navigator gathered one or more documents, or other reported information relevant to the client, prior to the competency evaluation hearing. Includes, but not limited to, behavioral health, educational, and/or law enforcement agency records.
Referral to Services	Forensic Navigator referred a client to a specific outpatient service (substance use, mental health treatment, employment, etc.). Active Forensic Navigator support on behalf of or in conjunction with a client to connect them to another provider, agency or organization for services.
Referrals	Referrals made by the Forensic Navigator on behalf of a client. Among active clients (at any point during the reporting period).
Adult Protective Services (APS)	Forensic Navigator referred client to Adult Protective Services.

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

Successful OCRP Completion - Coordinated transition completed	Individual ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator completed a coordinated transition for the client from OCRP to community behavioral health services.
Successful OCRP Completion - Summary of treatment completed	Individual was ordered to OCRP, was evaluated for competency, and was restored. The Forensic Navigator did not complete a coordinated transition for the client from OCRP to community behavioral health services, but did complete a summary of treatment.
Violation of OCRP Conditions of Participation/Court Ordered CR	Individual violated OCRP conditions of participation and/or conditions of release, and was removed from OCRP.
Length of Stay	
Average Length of Stay in Program (days)	The average number of days from the date the Forensic Navigator was assigned to the date the individual was discharged from the program.

Appendix D-Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Voucher Disbursals by Crisis Triage and Stabilization Facilities

CUMULATIVE UPDATE

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

REPORTING PERIOD

Cumulative: December 1, 2019 to December 31, 2021

Prepared by Washington State Department of Social and Health Services
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Contents

TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Vouchers Disbursed	280	100.0%	32	11.4%	102	36.4%	146	52.1%
Recipients (unduplicated)	211	100.0%	32	15.2%	90	42.7%	89	42.2%
Total Amount Disbursed	$268,712	N/A	$33,213	N/A	$110,872	N/A	$124,627	N/A
Average Amount Per Recipient	$1,274	N/A	$1,038	N/A	$1,232	N/A	$1,400	N/A
FACILITY REFERRAL SOURCE								
Crisis Call Center	2	0.9%						
Family/Friend	3	1.4%						
Hospital	88	41.7%						
Mobile Crisis Response	11	5.2%						
Designated Crisis Responder	16	7.6%						
Tribe or Indian Healthcare Provider	0	0.0%						
Emergency Responder	1	0.5%						
Other Healthcare Provider	15	7.1%						
Law Enforcement (Police, Co-Responders)	13	6.2%						
Court/Criminal Justice Referred	0	0.0%						
Self	60	28.4%						
Other	2	0.9%						
GENDER								
Female	66	31.3%						
Male	139	65.9%						
Other/Unknown	6	2.8%						
AGE GROUP								
18-29	33	15.6%	--	--	--	--	--	--
30-49	124	58.8%	16	50.0%	53	58.9%	55	61.8%
50+	54	25.6%	--	--	--	--	--	--
RACE/ETHNICITY								
Non-Hispanic White	145	68.7%	17	53.1%	71	78.9%	57	64.0%
Black, Indigenous, and People of Color	58	27.5%	15	46.9%	19	21.1%	24	27.0%
Unknown	8	3.8%	--	--	--	--	--	--

	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	97	46%	22	69%	23	26%	52	58%
Contacted by FHARPS staff	91	43%	22	69%	18	20%	51	57%
Enrolled in FHARPS	91	43%	22	69%	18	20%	51	57%
Housed or sheltered by FHARPS	81	38%	19	59%	17	19%	45	51%
Among Individuals Housed or Sheltered by FHARPS…								
FIRST FHARPS HOUSING TYPE*								
Permanent	3	4%	--	--	--	--	--	--
Transitional	7	9%	--	--	--	--	--	--
Shelter/emergency	70	86%	17	89%	14	82%	39	87%
Other	1	1%	--	--	--	--	--	--

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

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

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

Crisis Housing Voucher Definitions

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

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

Appendix E-FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

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

REPORTING PERIOD
Cumulative: March 1, 2020 to December 31, 2021

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

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Contents

TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Referred	920	100.0%	422	100.0%	187	100.0%	311	100.0%
Contacted	538	58.5%	246	58.3%	158	84.5%	134	43.1%
Enrolled	493	53.6%	231	54.7%	133	71.1%	129	41.5%
Among Referred Individuals…								
REFERRAL SOURCE								
Trueblood partner programs	471	51.0%	186	44.0%	85	45.0%	200	64.0%
Forensic Navigator	*154*	*16.7%*	*60*	*14.2%*	*35*	*18.7%*	*59*	*19.0%*
Forensic PATH	*145*	*15.8%*	*73*	*17.3%*	*14*	*7.5%*	*58*	*18.6%*
OCRP	*2*	*0.2%*	--	--	--	--	--	--
Crisis Stabilization Center	*149*	*16.2%*	*44*	*10.4%*	*34*	*18.2%*	*71*	*22.8%*
Mobile Crisis Response	*1*	*0.1%*	--	--	--	--	--	--
Co-Response Team	*20*	*2.2%*	--	--	--	--	*11*	*3.5%*
Behavioral Health Facility - Outpatient	174	18.9%	57	13.5%	80	42.8%	37	11.9%
Inpatient Facility	40	4.3%	20	4.7%	--	--	--	--
Family/Self	45	4.9%	29	6.9%	--	--	--	--
Other	190	20.7%	130	30.8%	15	8.0%	45	14.5%
Among Contacted Individuals…								
LOCATION OF INITIAL CONTACT								
Phone	359	66.7%	179	72.8%	147	93.0%	33	24.6%
Court	2	0.4%	--	--	--	--	--	--
Hotel/Motel	10	1.9%	--	--	--	--	--	--
Jail	37	6.9%	--	--	--	--	15	11.2%
Crisis Stabilization Center	63	11.7%	12	4.9%	0	0.0%	51	38.1%
Behavioral Health Facility - Outpatient	16	3.0%	--	--	--	--	13	9.7%
Inpatient Facilty	10	1.9%	--	--	--	--	--	--
Shelter	4	0.7%	--	--	--	--	--	--
Street/encampment	3	0.6%	--	--	--	--	--	--
Temporary Residence	4	0.7%	--	--	--	--	--	--
Other	30	5.6%	20	8.1%	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Among Enrolled Individuals…								
PARTICIPANT STATUS (on last day of reporting period)								
Active	164	33.3%	88	38.1%	38	28.6%	38	29.5%
Discharged	329	66.7%	143	61.9%	95	71.4%	91	70.5%
GENDER								
Female	151	30.6%	72	31.2%	42	31.6%	37	28.7%
Male	333	67.5%	153	66.2%	91	68.4%	89	69.0%
Other/Unknown	9	1.8%	--	--	--	--	--	--
AGE GROUP								
18-29	112	22.7%	55	23.8%	36	27.1%	21	16.3%
30-49	276	56.0%	108	46.8%	83	62.4%	85	65.9%
50+	105	21.3%	68	29.4%	14	10.5%	23	17.8%
RACE/ETHNICITY*								
American Indian or Alaska Native	45	9.1%	21	9.1%	--	--	--	--
Asian	10	2.0%	--	--	--	--	--	--
Black or African American	117	23.7%	83	35.9%	18	13.5%	16	12.4%
Hispanic or Latino	52	10.5%	24	10.4%	16	12.0%	12	9.3%
Native Hawaiian or Pacific Islander	5	1.0%	--	--	--	--	--	--
White Only, Non-Hispanic	265	53.8%	94	40.7%	79	59.4%	92	71.3%
Other Race	32	6.5%	--	--	20	15.0%	--	--
Unknown	18	3.7%	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT								
Unstably Housed	126	25.6%	49	21.2%	50	37.6%	27	20.9%
Homeless	367	74.4%	182	78.8%	83	62.4%	102	79.1%

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

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

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

-- Cells suppressed due to small n's.

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)								
Enrolled	493	100.0%	231	100.0%	133	100.0%	129	100.0%
Housed or Sheltered	407	82.6%	197	85.3%	103	77.4%	107	82.9%
Among Enrolled Individuals…								
SERVICES INDIVIDUAL AGREED TO								
Subsidies only	7	1.4%	--	--	--	--	--	--
Support Services and Subsidies	486	98.6%	230	99.6%	133	100.0%	123	95.3%
Among Housed/Sheltered Individuals…								
FIRST HOUSING TYPE								
Permanent	27	6.6%	--	--	--	--	--	--
Transitional	93	22.9%	48	24.4%	30	29.1%	15	14.0%
Shelter/emergency	276	67.8%	127	64.5%	66	64.1%	83	77.6%
Other	11	2.7%	--	--	--	--	--	--

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

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

-- Cells suppressed due to small n's.

TABLE 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS (on last day of reporting period)								
Enrolled	493	100.0%	231	100.0%	133	100.0%	129	100.0%
Active on last day of reporting period	164	33.3%	88	38.1%	38	28.6%	38	29.5%
Discharged during reporting period	329	66.7%	143	162.5%	95	250.0%	91	239.5%
Among Individuals Discharged…								
SUBSIDY								
Average total subsidy since enrollment	$5,343	N/A	$6,199	N/A	$5,456	N/A	$4,162	N/A
DISCHARGE REASON								
Transitioned to other housing support	44	13.4%	34	24.0%	--	--	--	--
Received maximum subsidy	*16*	*4.9%*	--	--	--	--	--	--
Did not receive maximum subsidy	*28*	*8.5%*	*27*	*18.9%*	--	--	--	--
Transitioned to self-support	41	12.5%	19	13.3%	--	--	--	--
Admitted to a facility	20	6.1%	--	--	--	--	--	--
Received maximum assistance (no transition)	43	13.1%	20	14.0%	--	--	--	--
Withdrew	35	10.6%	--	--	--	--	16	17.6%
Loss of contact	112	34.0%	36	25.2%	44	46.3%	32	35.2%
Served by another FHARPS team	1	0.3%	--	--	--	--	--	--
Other	33	10.0%	15	10.5%	--	--	--	--
LENGTH OF SUPPORT								
Average Length of Stay in Program (days)	177	N/A	156	N/A	210	N/A	174	N/A
HOUSING STATUS AT DISCHARGE								
Stably Housed	98	29.8%	59	41.3%	24	25.3%	15	16.5%
Unstably Housed	18	5.5%	--	--	--	--	--	--
Homeless	51	15.5%	28	19.6%	--	--	--	--
In a facility	42	12.8%	--	--	--	--	25	27.5%
Unknown	120	36.5%	36	25.2%	49	51.6%	35	38.5%

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

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

-- Cells suppressed due to small n's.

FHARPS Definitions

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

Jail	County, city, or tribal correctional facility.
Crisis Stabilization Center	A short-term residential stabilization service for individuals with mental health and/or substance use disorders.
Behavioral Health Facility - Outpatient	A community behavioral health agency that provides outpatient mental health or substance use services; excludes Crisis Stabilization Center.
Inpatient Facilty	Any inpatient facility providing treatment for mental health, substance use, or medical needs; excludes crisis stabilization centers and outpatient services.
Shelter	Service agency that provides temporary residence for homeless individuals and families.
Street/encampment	On the street or in a homeless camp/encampment site (an area with multiple homeless individuals).
Temporary Residence	Shelter or other temporary shared quarters (couch surfing, doubled up); excludes hotel/motel.
Other	Other locations not listed as a location option.
Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on 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	
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 Individual 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	
Participant Status (on last day of reporting period)	Participant program enrollment status.

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

Appendix F-FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

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

March 1, 2020 to December 31, 2021

Prepared by Washington State Department of Social and Health Services
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Contents

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Number on Referral List	1,391	100.0%	832	100.0%	209	100.0%	350	100.0%
Attempted Contacts	702	50.5%	359	43.1%	124	59.3%	219	62.6%
Contacted	411	29.5%	142	17.1%	104	49.8%	165	47.1%
Enrolled	216	15.5%	87	10.5%	64	30.6%	65	18.6%
PRIORITIZED POPULATION								
Prioritized Referral List	734	52.8%	443	53.2%	85	40.7%	206	58.9%
Attempted Contacts	412	56.1%	239	54.0%	49	57.6%	124	60.2%
Contacted	223	30.4%	87	19.6%	46	54.1%	90	43.7%
Enrolled	125	17.0%	54	12.2%	30	35.3%	41	19.9%
Among All Enrolled Individuals…								
PARTICIPANT STATUS								
Active (on last day of reporting period)	124	57.4%	50	57.5%	34	53.1%	40	61.5%
Discharged	92	42.6%	37	42.5%	30	46.9%	25	38.5%
Average Length of Stay in Program (days)	207	N/A	145	N/A	286	N/A	203	N/A
GENDER								
Female	41	19.8%	13	15.3%	15	25.0%	13	21.0%
Male	166	80.2%	72	84.7%	45	75.0%	49	79.0%
Unknown	9	4%	--	--	--	--	--	--
AGE GROUP								
18-29	61	28.2%	27	31.0%	17	26.6%	17	26.2%
30-49	123	56.9%	41	47.1%	39	60.9%	43	66.2%
50+	32	14.8%	19	21.8%	--	--	--	--
RACE/ETHNICITY*								
American Indian or Alaskan Native	7	3.2%	--	--	--	--	--	--
Asian	5	2.3%	--	--	--	--	--	--
Black or African American	46	21.3%	30	34.5%	--	--	--	--
Hispanic or Latino	25	11.6%	12	13.8%	--	--	--	--
Native Hawaiian and Other Pacific Islander	4	1.9%	--	--	--	--	--	--
White Only, Non-Hispanic	105	48.6%	35	40.2%	39	60.9%	31	47.7%
Other Race	9	4.2%	--	--	--	--	--	--
Unknown	33	15.3%	--	--	--	--	26	40.0%

HOUSING STATUS AT PROGRAM ENROLLMENT								
Stably Housed	25	11.6%	--	--	--	--	--	--
Unstably Housed	52	24.1%	12	13.8%	20	31.3%	20	30.8%
Homeless	131	60.6%	64	73.6%	35	54.7%	32	49.2%
Unknown	8	3.7%	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM EXIT								
Stably Housed	21	22.8%	--	--	--	--	--	--
Unstably Housed	2	2.2%	--	--	--	--	--	--
Homeless	17	18.5%	15	40.5%	--	--	--	--
In a Facility	13	14.1%	--	--	--	--	--	--
Unknown	39	42.4%	--	--	18	60.0%	--	--

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

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

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

-- Cells suppressed due to small n's.

TABLE 2.

Forensic PATH Services

CUMULATIVE: March 1, 2020 - December 31, 2021

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS								
Total Forensic PATH Service Encounters	4,193	N/A	1,748	N/A	979	N/A	1,466	N/A
Average Service Encounters (per participant, per month)	2.4	N/A	2.9	N/A	1.3	N/A	2.9	N/A
Among Enrolled Individuals…								
FORENSIC PATH SERVICES - *Average number of services per participant, per month*								
Outreach services	0.5	N/A	0.5	N/A	0.3	N/A	0.8	N/A
Re-engagement	0.1	N/A	0.0	N/A	0.1	N/A	0.2	N/A
Screening	0.2	N/A	0.5	N/A	0.0	N/A	0.1	N/A
Clinical assessment	0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
Habilitation/rehabilitation	0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
Community mental health	0.1	N/A	0.0	N/A	0.2	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
Case management	1.3	N/A	1.6	N/A	0.5	N/A	1.7	N/A
Residential supportive services	0.1	N/A	0.1	N/A	0.1	N/A	0.0	N/A
Other	0.0	N/A	0.0	N/A	0.0	N/A	0.0	N/A
Among Enrolled Individuals…								
REFERRALS - *Number of participants with at least one referral*								
Any Referral	133	61.6%	51	58.6%	29	45.3%	53	81.5%
Referral Type								
Community mental health	48	22.2%	23	26.4%	--	--	--	--
Substance use treatment	27	12.5%	--	--	--	--	16	24.6%
Primary health/dental care	23	10.6%	--	--	--	--	17	26.2%
Job training	3	1.4%	--	--	--	--	--	--
Educational services	3	1.4%	--	--	--	--	--	--
FHARPS housing	43	19.9%	22	25.3%	--	--	--	--
Permanent housing (non-FHARPS)	13	6.0%	12	13.8%	--	--	--	--
Temporary housing (non-FHARPS)	21	9.7%	20	23.0%	--	--	--	--
Other Housing Services (non-FHARPS)	46	21.3%	--	--	26	40.6%	--	--
Housing services (pre-August 2021)	38	17.6%	--	--	--	--	28	43.1%
Income assistance	6	2.8%	--	--	--	--	--	--
Employment assistance	12	5.6%	--	--	--	--	--	--
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	16	7.4%	--	--	--	--	13	20.0%

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

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

-- Cells suppressed due to small n's.

FPATH Definitions

Variable Name	DEFINITION
Total - All Regions	**Includes all Phase One Regions: Pierce, Southwest, Spokane.**
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County
Southwest Region	Clark, Klickitat, and Skamania Counties
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties
ENROLLMENT TABLES , Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated, 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.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.
Race/Ethnicity	Race and Ethnicity information is based on an individual's self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
Unknown	Housing situation indeterminate at time of program enrollment.
Housing Status at Program Exit	Self-reported housing status at time of program end.

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