Trueblood Programs

Cassie Cordell Trueblood, et al., v. Washington State Department of Social and Health Services, et al.

Case No. C14-1178 MJP

Semi-Annual Report 12

Sept. 30, 2025

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List of Abbreviations in this Document

BHHA-Behavioral Health and Habilitation Administration, part of DSHS *(previously BHA, Behavioral Health Administration)*

BHASO-behavioral health administrative service organization

CIT-Crisis Intervention Training

CJTC-Criminal Justice Training Commission

CS/CT-crisis stabilization/crisis triage

DSHS-Department of Social and Health Services

ESH-Eastern State Hospital

FRA-forensic risk assessment

HCA-Health Care Authority

LTCC-long-term civil commitment

NGRI-Not Guilty by Reason of Insanity

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

RDA-Research and Data Analysis, part of DSHS

SAR-semi-annual report

SUD-substance use disorder

WASPC-Washington Association of Sheriffs and Police Chiefs

WSH-Western State Hospital

Preamble

Each March and September, a semi-annual report is published to review the implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress from January through June 2025. The report provides updates on each of the element areas and related programs being designed and implemented as part of the Settlement Agreement. Many new Trueblood programs initially launched during the Phase 1 implementation of the Settlement Agreement, and those operations are ongoing. With the exception of one task item[1], work to implement Phase 2 programming of the Settlement Agreement was completed by June 2023 or earlier and those operations remain ongoing. Phase 3 of the Settlement Agreement became effective on July 1, 2023. Implementation work in the five counties of the Phase 3 regions is complete as of June 30, 2025.

A major focus of this report is to provide relevant data that demonstrates program use and outcomes, where possible. As in past reports, most of the elements have aggregate or program-level data to display a high-level picture of initial program operations and engagement. As programs continue their operations and mature, this report will expand over time to include more data and reporting elements. For this SAR, several programs continue to have publicly available Power BI dashboards, which display their data. These include trend data where possible. RDA and HCA continue collaboration to refine data following the implementation of a new collection tool by HCA for several HCA programs. Once completed, work can continue on external dashboards to provide more dynamic trend data. With a few exceptions noted in the report, the data is current through June 30, 2025. Data from new regions will typically be included in the SAR following at least two calendar quarters of operations, assuming sufficient counts to preserve confidentiality.

As of the previous reporting period, the Settlement Agreement's Crisis Triage and Diversion Co-responder Element is no longer included in the Phase 3 Trueblood Contempt Settlement Agreement, so it has been removed from this report. For additional information on this Element, visit OFMHS' "resources and legislation" webpage and scroll down to "semi-annual reports." Each report from September 2023 back to March 2020 includes information about the Crisis Triage and Diversion Co-responder Element.

[1] For additional details, please visit page 46 and the "Areas of Concern" sub-section for the Element, Crisis Triage and Diversion-Additional Beds and Enhancements.

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

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

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

Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium. Phase 1 completed as of June 30, 2021. Phase 2 concluded on June 30, 2023. Phase 3 concluded on June 30, 2025. Phase 4 is the current active settlement phase. Implementation began July 1, 2025, and the next SAR in March 2026 will provide greater details about Phase 4 implementation.

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

Behavioral Health & Treatment Centers or BHTCs*:* Refers to an inpatient facility that treats either forensic or civil clients without indication of acute violent behavior to self or others, or otherwise complex treatment needs, which require a level of care provided in the state hospitals; as part of the department's ongoing efforts to establish additional civil BHTCs during the next several years, the existing facilities were re-named to better align for current and future needs systemwide. The Maple Lane Competency Restoration Program, or MLCRP as it has been known, is part of a growing campus of programs hosted at Maple Lane. The new campus name is DSHS Behavioral Health & Treatment Center – Maple Lane Campus and MLCRP was known as Cascade Unit. The Cascade Unit building now houses NGRI patients. Similarly, the forensic BHTC housed on WSH's campus has updated its name as well. It will now be known as DSHS Behavioral Health & Treatment Center – Steilacoom Unit or Steilacoom Unit for short.

Crisis housing vouchers: Allow unhoused or unstably housed people 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.

Crisis Stabilization Facilities*:* Refers to facilities that serve their communities by providing least restrictive alternatives to care for the purpose of diverting people from arrest, detention, and lengthy hospitalizations. Services within these facilities are short term and focus on stabilizing and returning the individual back to their community.

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

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

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

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

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

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

Global leasing: Previously known as master leasing, this is a strategy that many communities are using to address the affordable housing crisis. The approach involves local governments, agencies, or nonprofit organizations leasing units from an owner and then subleasing individual units or property to unhoused residents. By providing flexible, tailored housing options for individuals and families, global leasing presents a promising solution for addressing housing inequities.

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.

Program Data Acquisition Management and Storage or PDAMS: A centralized data collection system managed by HCA that includes FHARPS, FPATH, and crisis housing vouchers.

Impacts of civil conversion cases on the inpatient forensic bed supply

Court-ordered felony civil conversion cases have grown rapidly and substantially in the past few years, which led to increased demand for state hospital beds. Civil conversion cases increased 68.6 percent in 2022 as compared to 2021 coinciding with the system's emergence from pandemic-era criminal court shutdowns and contributing toward increased wait lists and class member wait times. In 2023, civil conversion cases dropped 34.3 percent as compared to 2022 and 2024 continued the trend, with a 25.8 percent decrease in the number of civil conversion patients throughout the system compared to 2023. So far the first two quarters of 2025 follow a similar pattern.[2]

New treatment beds for forensic and felony civil conversion patients in Q1 and Q2 2025

Since our last report, following Q4 2024, the biennial budget for 2025-2027 has been signed into law, which has resulted in significant updates to our bed opening projections:

HCA secured a decision package that currently increases the LTCC reimbursement rate from $940 to $1,250 per day. HCA contracted civil conversion beds are located in acute care hospitals, psychiatric hospitals, and Evaluation & Treatment facilities, and receive an additional $500 to care for these patients, for a total of $1,750 per day.

As a result, HCA has managed to increase community-based civil conversion bed capacity by amending existing LTCC contracts. There are currently 68 beds at community facilities that can be used for civil conversion. The University of Washington is also contracted to provide 75 beds; however, they are still ramping up and only a portion are currently operational. When the additional University of Washington beds are operational there will be 143 beds available for civil conversion patients.

BHHA expects to bring 32 new civil conversion beds online in the Baker Unit at the Maple Lane campus during the second half of 2025.

BHHA added a bed allocation manager to develop and implement a data-driven strategy around bed management and throughput in our facilities, which has allowed the department to better manage patient flow and hit record levels of on-time inpatient admissions. The state has also begun a period

[2] Sources: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated by Research and Data Analysis July 2025; and
Document 943. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, The Department's Response to Plaintiff's Motion for Material Breach of Contempt Settlement Agreement and Motion for Civil Contempt, January 2023, Filed Jan. 11, 2023, p. 9.

of significant growth in inpatient restoration capacity around the state, as additional, similar facilities and hundreds of new beds are brought online from 2024 until approximately 2028. As civil and NGRI patients shift to new facilities, bed space opens for Trueblood class members at WSH and ESH. Critically, this increased flexibility allows the department to better serve civil patients as well as forensic class members. This ultimately allows patients the potential to receive restoration treatment closer to their home communities, enabling access to family support and critical community resources that are vital for successful restoration and return to the community.

Breach motion

Plaintiffs to the Trueblood et al. v. Washington State DSHS lawsuit filed a motion with the Court on Dec. 22, 2022, requesting that the department be found in material breach of the Contempt Settlement Agreement and alleging lack of compliance with the Contempt Settlement Agreement's terms. A hearing was held in June 2023, and the Court issued its initial ruling on July 7, finding the State to have breached a portion of the Contempt Settlement Agreement. As part of the Court's July 7, 2023, order, the State and the Plaintiffs met and conferred on various aspects of the order and jointly proposed modified language. A hearing on the modification language was held on Aug. 7, 2023, and the court issued a second order, based on the joint proposals from the State and the Plaintiffs on Aug. 14, 2025. Recently, the parties filed a joint motion to modify and the court heard oral arguments on that motion on Sept. 16, 2025. The hearing resulted in the court taking the matter under advisement and it will issue a written order.

Workforce challenges – recruitment and retention

Competing for staff talent with the private sector in the context of the well-publicized post-pandemic workforce challenges has left many positions, especially at our treatment facilities, chronically unfilled. BHHA has identified and implemented creative solutions within our existing authority and partnered with executive leadership, state human resources, labor, and other partners to develop and implement innovative approaches to recruiting and retaining critical staff positions. In spring and summer 2022, DSHS completed several steps to alleviate staffing challenges. Steps taken included hiring more contractors and travel nurses, adding hiring recruitment resources to both WSH and ESH, especially to hire nurses, partnering with the Washington State Office of Financial Management to adjust pay ranges for certain positions, expanding our successful forensic evaluator training and recruitment post-doctoral program from three to five interns, and engaging a successful demand to bargain with labor partners to allow for contract evaluations to take place until vacancies can be filled. Additionally, implementing new policies and practices to attract and retain passionate, talented staff remains critical to success, and BHHA continues to focus on this critical topic. Even with these successful actions, BHHA continues to face high vacancy rates in several critical patient-centered job classes. As of early July 2025, vacancies in these classes now range between 16-43 percent. RN and LPN vacancies have been decreasing, but psychologist and psychiatrist vacancies remained at similar levels throughout the reporting period.

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

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

The 2024 legislative session passed several new pieces of legislation designed to increase staff recruitment and retention, including:

- Extending eligibility of the Public Safety Employees Retirement System to staff of the Special Commitment Center and staff of the civil and NGRI residential treatment facilities effective June 1, 2025.

- Adopting a social work licensure compact to make it easier to hire social workers from as many as 25 other states.

- Adopting a physician assistant compact, making it easier to hire PAs from as many as 16 other states.

- Outlining opportunities for out-of-state providers to provide telehealth services; allowing providers to establish a patient relationship via telehealth.

To continue to increase staff recruitment and retention, the 2025 legislative session passed the following wage increases:

- Most employees received a three-percent cost of living adjustment effective July 1, 2025. Effective July 1, 2026, most employees are scheduled to receive an additional two-percent cost of living adjustment.

- Forensic Evaluators saw their range increase two salary bands by July 1, 2025.

Evaluation and monitoring overview

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

Project monitoring

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

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

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

For programs using Excel data trackers, HCA replaced data trackers with a centralized data collection called the Program Data Acquisition Management and Storage, or PDAMS, system for FHARPS in August 2023, crisis housing vouchers in November 2023, and FPATH in June 2024. Merged data through June 2025 are provided in this report for these programs. HCA and RDA continue to collaborate on how to minimize provider data entry errors and merge sources to track people and events accurately across data platforms.

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

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

- Crisis Intervention Training
- Forensic Navigator Dashboard
- Misdemeanor Restoration Orders by Fiscal Year

A Power BI dashboard is under development for the FHARPS program as efforts to streamline and verify case data between Excel data trackers and PDAMS continue. Upon completion of the FHARPS dashboard, additional Power BI dashboards for crisis housing vouchers, OCRP and FPATH will follow.

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

Longer-term impact analyses

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

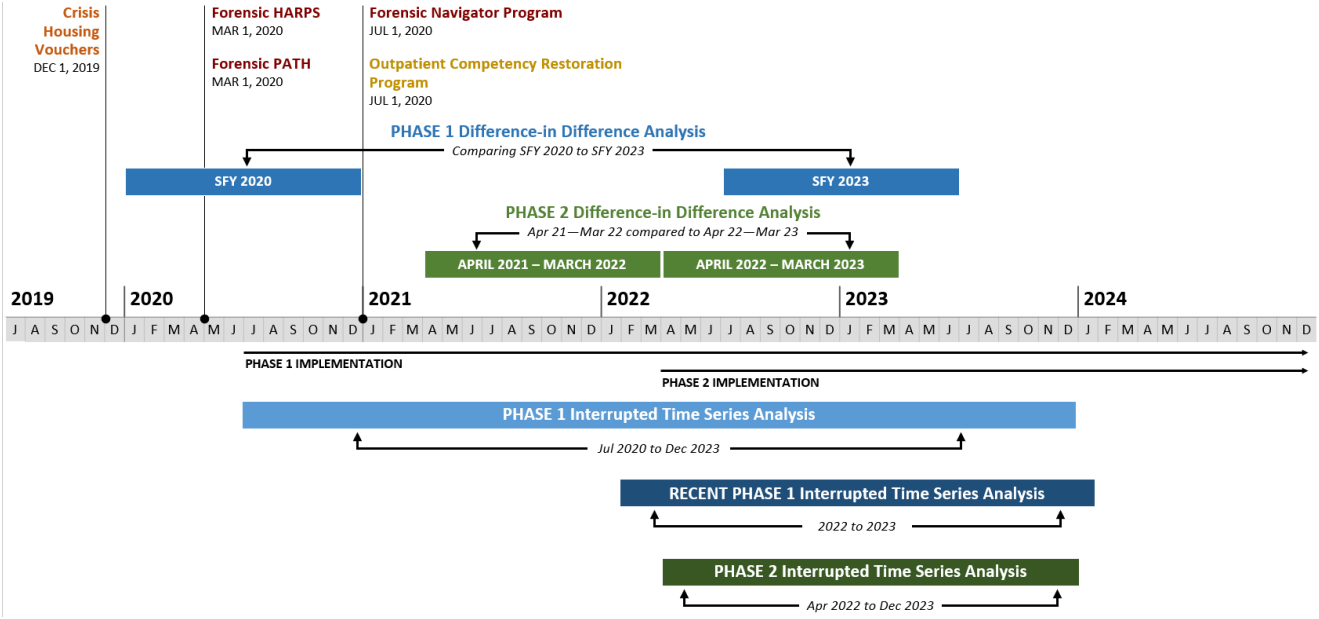
- Use of mental health and SUD treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

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

FIGURE 1.

Trueblood Evaluation Reference Periods

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



DATA SOURCE: Research and Data Analysis division of DSHS

Interrupted Time Series Analysis

RDA used an interrupted time series analysis to compare order rates in Trueblood Phase 1 and Phase 2 regions to the balance of the state (regions where new programs had not yet been implemented). ITA is a quasi-experimental design to evaluate the effects of an intervention (in this case the full set of regional Trueblood programs) by comparing competency referral rates before and after the intervention.

Four iterations of the interrupted time series analysis have been completed, the most recent of which was completed in spring 2024 and presented to stakeholders in fall 2024. Findings from each analysis are summarized below.

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

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

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

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

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

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

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

Analysis 3: The model was updated to allow for separate Phase 1 and Phase 2 analyses, included in the September 2023 report:

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

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

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

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

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

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

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

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

Analysis 4: Phase 1 analyses conducted over two time periods across three and a half years; Phase 2 analyses conducted over one year and nine months:

- Phase 1 Overall: July 2020 to December 2023

- Competency Evaluation – There was a decrease in the rate of competency evaluation orders in Phase 1 counties of 2.7 per 100,000 residents relative to the expected rate, significant at $p<.001$. There was a similar decrease in the rate relative to expected for Trueblood class members.

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

- Phase 1 Recent: 2022 to 2023

- Competency Evaluation – A decrease in the rate of competency evaluation orders in Phase 1 counties of 1.4 per 100,000 residents relative to expected, approached significance, $p=.09$.

- Competency Restoration – There was a decrease in the rate of competency restoration orders in Phase 1 of 1.4 per 100,000 residents relative to the expected rate, significant at $p<.001$. There was a similar decrease in the rate for Trueblood class members.

- Phase 2 Overall: April 2022 to December 2023

- Competency Evaluation – An increase in the rate of competency evaluation orders in Phase 2 (King) of 1.1 per 100,000 residents relative to expected was approaching significance, $p=.06$. The rate relative to expected for Trueblood class members similarly increased, significant at $p<.05$.

- Competency Restoration – There was a decrease in the rate of competency restoration orders in Phase 2 (King) of 1.0 per 100,000 residents relative to expected, significant at $p<.01$. The similar decrease for Trueblood class members was significant at $p<.05$.

- Recent impacts in Phase 1 regions showed that the rate of competency evaluation orders in Phase 1 regions trended down, but there was no statistically significant difference between the rate of evaluation orders in 2022 and the rate of orders in 2023. The rate of competency restoration orders in Phase 1 regions did significantly decrease between 2022 and 2023. These results differed from previous analyses.

- While early findings for Phase 2 King region suggested there was no impact on competency orders, this analysis found an increasing trend in the rate of competency evaluation orders. There was a higher rate of competency evaluation orders in Phase 2 regions in December 2023 as compared to April 2022. The rate of competency restoration orders in Phase 2 regions did significantly decrease between December 2023 and April 2022.

Difference-in-Difference Analysis

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

- Mental Health Treatment: There was a significant increase in the rate of mental health treatment among people with at least one competency evaluation order in Phase 1 regions compared to the balance of the state at p<.0001.[5]

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

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

Overall, a larger proportion of people needing treatment in Trueblood Phase 1 regions are receiving treatment than those in other areas. This aligns with the intent to better address individual treatment needs through programs such as forensic navigators, Outpatient Competency Restoration, and FPATH. There were no effects detected on other outcomes. Impacting outcomes like homelessness and incarceration is more difficult to achieve given the complexities (e.g., individual, community, and governmental) that contribute to these issues, many of which are outside the influence of Trueblood initiatives. Updated analyses for Phase 1 and Phase 2 outcomes are complete. Findings will be presented to key stakeholders and then included in the next iteration of the SAR.

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

Individual Outcome Evaluation(s)

FHARPS

The FHARPS aim to provide tailored housing supports and connect with housing maintenance resources for homeless or unstably housed individuals who have current or previous (or who are at risk for) involvement in the forensic mental health system. The outcome study evaluated FHARPS programs in three regions of Washington State: 1) Pierce (Pierce County), 2) Southwest (Clark, Klickitat, and Skamania Counties), and 3) Spokane (Spokane, Ferry, Pend Orielle, Lincoln, Stevens, and Adams Counties) regions.

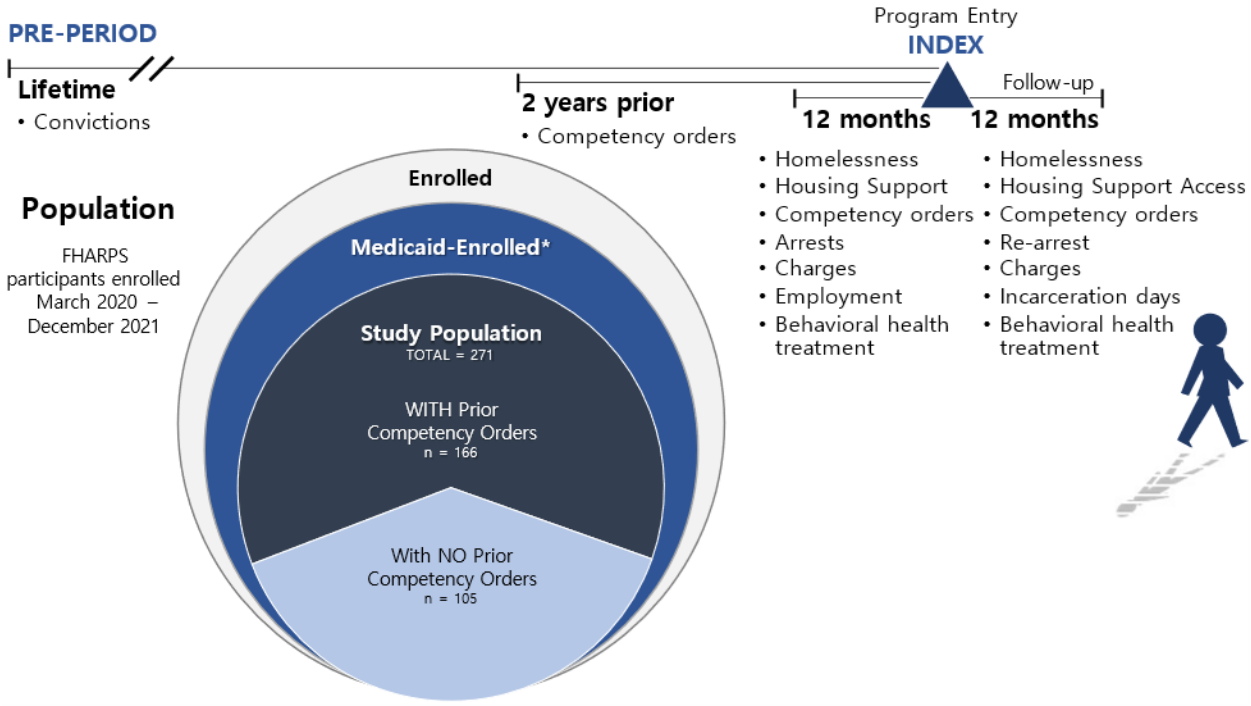
To assess the impact of FHARPS on homelessness and other key measures, RDA compared outcomes for two groups of Medicaid-enrolled FHARPS program participants enrolled between March 2020 and December 2021, one group with and one group without a competency order history in the two years prior to FHARPS enrollment (see Figure 2 below), to statistically matched comparison groups of similar individuals not enrolled in FHARPS.

The following 12-month outcomes were measured: homelessness, housing support access, new competency service orders, re-arrests, new charges, days of incarceration, and both inpatient and outpatient mental health and SUD treatment. For FHARPS program study participants, the outcome period began on the program enrollment date (known as an index date). An equivalent index date for the comparison groups was calculated using the month an individual had indicators for both homelessness and a mental health treatment need.

FIGURE 2.

FHARPS Study Timeline and Population

FHARPS Outcome Evaluation Timeline and Study Population



DATA SOURCE: Research and Data Analysis division of DSHS

Overall, FHARPS study participants were significantly more likely to use Foundational Community Supports (e.g., 30 percent of the competency order history group relative to 15 percent of the matched comparison group) and crisis services (e.g., 61 percent of the competency order history group relative to 49 percent of the comparison group). FHARPS participants with a competency order history had one month less indicated homeless in the 12-month outcome period (6.3 months versus 7.4 months for the comparison group, significant at $p < .05$) and a lower annualized re-arrest rate (2.0 arrests versus 2.9 arrests for the comparison group, approaching significance at $p = .053$). Participants with no competency order history were significantly more likely to access outpatient mental health treatment (93 percent relative to 82 percent of the comparison group).

There was no statistically significant difference between FHARPS participants and their respective comparison groups on competency orders, felony and misdemeanor charges, inpatient mental health treatment, state hospital admission, incarceration days, or SUD treatment in the 12-month outcome period.

There were challenges in evaluating FHARPS program impacts which fell into six general areas:

1. Overlapping enrollment in programs with similar services and objectives (i.e., many participants exposed to several Trueblood programs making isolating the benefits of the FHARPS program challenging).

2. Potential selection bias (i.e., bias in unmeasured factors such as program readiness or motivation to engage).

3. Limited participant pool and outcome period (i.e., smaller participant groups due to participant differences and a 12 instead of 24-month outcome period due to data lag).

4. Varying program practices (e.g., enrolling individuals that did not meet measurable enrollment criteria (n=126), varying housing options, staffing, funds, etc.).

5. Administrative data limitations (i.e., once a homelessness indicator is on in a data system, it may stay on until it is time to renew or re-verify benefit eligibility even if the individual is no longer unhoused).

6. The COVID-19 pandemic impacted program services and resources such as type of contact, housing shortages, and support services during the index period.

The FHARPS program is the first outcome evaluation for an individual program within the suite of programs and services implemented under the Settlement Agreement. FHARPS in Phase 1 regions met the threshold for a sufficient study cohort in December 2021. Data for twelve-month outcomes was available by fall 2023. Additional work was required to analyze the baseline population and create appropriate treatment and comparison groups. High-level findings were presented to stakeholders in early July 2024, and a detailed report was released in December 2024. Access the report at The Impact of Forensic Housing and Recovery Through Peer Services (FHARPS) on Homelessness and Housing Support Access – An Outcome Evaluation | DSHS.

A second FHARPS evaluation is underway to examine outcomes for Medicaid-enrolled FHARPS program participants enrolled in Phase 1 regions between January 2022 and December 2023. The results of the second Phase 1 outcome evaluation will be presented to partners and included in the March 2026 SAR.

FPATH

The FPATH programs provide outreach and intensive case management services to people with current or prior involvement in Washington state's forensic mental health system and who face significant barriers to accessing behavioral health services and mainstream community supports.

The outcome study evaluated FPATH programs serving three regions of Washington State:

- Pierce (Pierce County).
- Southwest (Clark, Klickitat, and Skamania Counties).
- Spokane (Spokane, Ferry, Pend Orielle, Lincoln, Stevens, and Adams Counties).

FPATH programs target people who have had two or more competency evaluation referrals in the past 24 months, as identified by a monthly eligibility list produced by RDA.

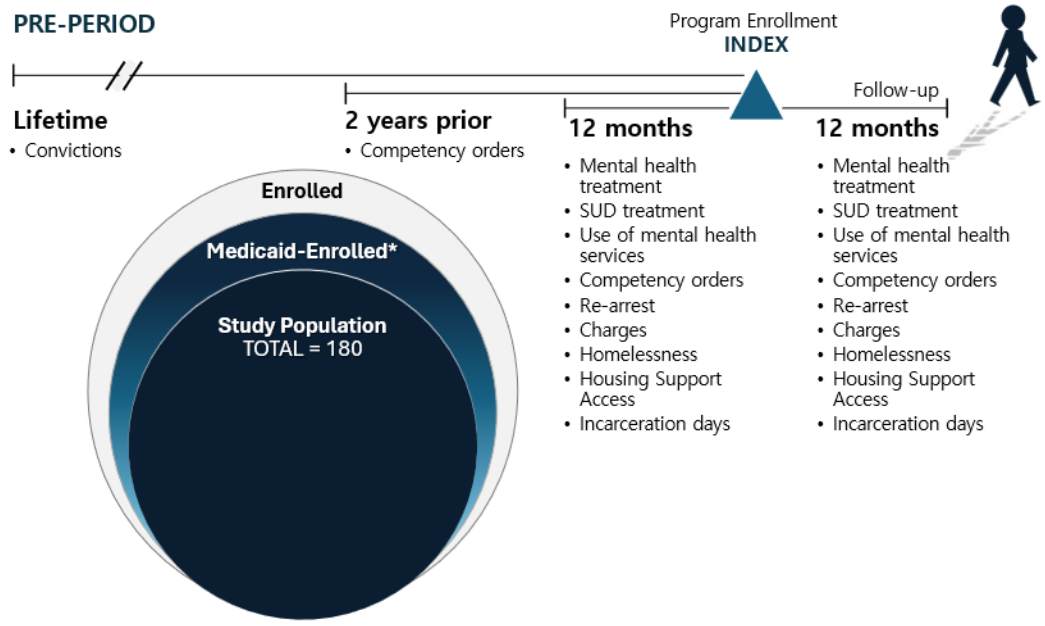
The study population included 180 people enrolled in FPATH between March 2020 and March 2022 who were Medicaid-enrolled for at least one month in the 12 months both pre- and post-FPATH program enrollment, as well as a statistically matched comparison group of people who did not participate in the program (Figure 3).

The evaluation sought to assess the impact of the FPATH program on the following outcomes: new competency service orders, inpatient and outpatient mental health treatment, SUD treatment, new arrests, new charges, days of incarceration, homelessness, and housing supports. All outcomes were measured over a 12-month period starting at the "index month" for both the treatment group (i.e., FPATH participants) and the matched comparison group. For FPATH participants, the index month was the month they enrolled in the FPATH program. For the comparison group, an equivalent index month was assigned by randomly selecting a competency evaluation referral from each comparator's history and adding 60 days to the referral date to assign the index month. The period of 60 days was selected based on the average time between FPATH participants' most recent competency evaluation referral date and their enrollment date.

FIGURE 3.

FPATH Study Timeline and Population

FPATH Outcome Evaluation Timeline and Study Population



DATA SOURCE: Research and Data Analysis division of DSHS

Overall, FPATH participants were significantly more likely to use crisis services than their comparison group peers, with 57 percent of participants using these services compared to 44 percent of comparators. Higher rates of outpatient emergency room services were also observed among the FPATH participant group. Additionally, FPATH participants had higher involvement in inpatient SUD treatment than the comparison group (28 versus 13 percent, respectively). Finally, FPATH participants were significantly more likely to use Foundational Community Supports services (18 percent versus 7 percent of the comparison group) and for a longer period (1.25 months versus 0.37 months for the comparison group). These findings align with the program's objectives of improving access to behavioral health, housing, and supportive services.

FPATH participants did not demonstrate a reduction in competency orders or criminal legal system involvement (e.g., arrests, new legal charges) during the study period — two primary objectives of the program. It is possible that changes in competency orders, arrests, and legal charges may require more time to manifest, and future research with a longer follow-up period (e.g., 24 months) could help determine whether such effects take longer to appear.

Evaluating the impacts of the FPATH program presented several challenges, which can be grouped into seven broad areas:

1. Overlapping enrollment in programs with similar goals and services
2. Potential selection bias
3. Limited sample size
4. Short follow-up period
5. Variation in policies and practices across FPATH programs statewide
6. Challenges in defining and measuring homelessness using administrative data
7. The influence of the COVID-19 pandemic on various aspects of the criminal legal system and the implementation of Trueblood program components

The FPATH program is the second outcome evaluation for an individual program within the suite of programs and services implemented under the settlement agreement. High-level findings were presented to stakeholders in early 2025 and a detailed report will be released in Fall 2025. A follow-up evaluation of the FPATH program is also underway, focusing on outcomes for Medicaid-enrolled participants in Phase 1 regions who enrolled between January 2022 and December 2023. As with the updated FHARPS evaluation, findings from this second Phase 1 analysis will be shared with stakeholders and included in the March 2026 SAR.

OCRP

The OCRP outcome evaluation work is ongoing. Given data challenges and difficulty in identifying an appropriate comparison group, the study was revised to address questions such as:

- How often is outpatient competency restoration and inpatient competency restoration utilized?
- What is the competency restoration rate following outpatient competency restoration and following inpatient restoration?
- How long does it take to restore individuals to competency in an outpatient/community setting and in an inpatient setting?
- Are individuals exiting OCRP connected to community supports?

RDA plans to present high-level findings from the OCRP study in early 2026 and release a detailed report in spring 2026. These findings will be included in the fall 2026 SAR.

Implementation plan elements

The sections that follow detail the current status of the 13 elements included in the Phases 1, 2, and 3 Settlement Agreement Final Implementation Plans, or FIPs. Phase 4 Implementation began July 1, 2025, and the next SAR in March 2026 will provide greater details about Phase 4 implementation.

Each element's report considers the following five items as they relate to the element specifically and to the Settlement Agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) available data pertaining to the element. Data tables included in this report reflect data through June 30, 2025, with exceptions noted.

Competency evaluation – additional evaluators

The Settlement Agreement required hiring 18 additional forensic evaluators over two years for Phase 1. Phases 2 and 3 did not have any requirements to hire additional staff; rather, the focus is on the referral data and whether enough evaluators are hired to support this demand. OFMHS has continued to request positions and as of FY26, there are 96 full-time evaluator positions. Additionally, OFMHS has eight 12-month non-permanent positions completing evaluations, in addition to up to six contractors. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines for in-jail competency evaluations, evaluators are also assigned to address the need of completing non-Trueblood forensic assessments (such as specialized FRAs for the NGRI population in forensic beds, NGRI evaluations, out-of-custody competency evaluations, and diminished capacity assessments). Furthermore, monitoring all these referrals and hiring correspondingly 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 FRAs, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity as the NGRI patient is transitioned to the community.

Current status and areas of positive impact

For the 2023-2025 biennium, OFMHS received funding for an additional 19 positions (11 for fiscal year 2024 and eight for 2025). With staff movement naturally occurring, as of June 30, 2025, 89 of the 96 positions were filled. Recruitment continues to work to fill the remaining vacancies with an emphasis on filling positions located in the northern part of the state. Three positions are filled with future start dates several months into FY25. OFMHS implemented the following measures to improve recruitment:

1. Continue to offer hybrid work schedules emphasizing ability to work from home.
2. Nationwide recruitment.
3. Create seven out-of-state remote telehealth positions.
4. Attend conferences/workshops to recruit.
5. Add more administrative support staff to assist evaluators.
6. Leverage technology to assist with data tracking and scheduling.

WSH continues to staff clinical psychologists that complete civil commitment treatment reports for the court, further freeing evaluators to focus on the completion of competency evaluations (versus having to complete civil petition evaluations). Furthermore, to assist forensic evaluators, the

department has also worked with the evaluator's labor union to allow for contracting. During this period, OFMHS used up to six contractors.

During the January - June 2025 reporting period, 71 FRAs were completed at WSH and Maple Lane. ESH is now up to date on all FRAs. Both state hospitals are now on the same FRA system. During the January - June 2025 reporting period, 33 FRAs were completed at ESH. However, due to staffing challenges, the department is currently recruiting contractors to help have the new system in place as currently each patient has an FRA. The next phase, where annual updates will be completed, is now underway. This is in addition to continuing to recruit to fill vacant positions and the addition of two post-doctoral positions in the eastern region. While completion of risk assessments for the NGRI population at the state hospitals assists in vacating forensic beds that can be occupied by those in need of inpatient competency restoration services, completion of competency evaluations for class members remains prioritized over other types of evaluations, including FRAs.

Areas of concern

Demand for competency services (both in and out of custody) remains near record highs and remains concerning. Non-competency forensic evaluations seem to be increasing as well (e.g., mental state evaluations). In fiscal year 2024, the number of referrals for all jail-based competency evaluations was 6,348, which compares to fiscal year 2023's, then record number of referrals for all competency evaluations (6,781[6]). Compared to FY23, FY24 referral levels decreased moderately by 432 orders and 6.4 percent. Although FY23 saw record referral levels, growth slowed significantly year-over-year from FY22. Subsequently, in FY24, there was an actual decline in orders compared to FY23. This proved to be a temporary plateau, as FY25 set a new record high of 7,061 orders, which is 11 percent higher than FY24 and 4 percent higher than the previous record in FY23. Overall demand remains historically high and comes despite the original 12 fine-funded[7] diversion programs, six of which remain under contract with HCA for a third year of funding in FY25, three state-funded prosecutorial diversion programs that have continued operating under contract with BHHA, and the statistically significant impact of Trueblood interventions demonstrated in the Phase 1 regions. Without these programs, demand for evaluations would have increased even more. Despite the new record level of referrals, compliance numbers continue to be at a high level.

Recommendations to address concerns

OFMHS continues developing and implementing telehealth resources for jails throughout the state. Establishing this technology in multiple locations (especially in rural areas of the state) allows OFMHS to conduct more evaluations, thereby helping to meet court-ordered requirements, making it easier

[6] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2025.
[7] The fine-funded diversion programs transitioned to longer-term funding sources or discontinued operations in a few instances. The programs continuing to operate do so under HCA oversight now for a third fiscal year (including FY23, 24, & 25) while receiving appropriations from the state legislature.

for attorneys to be present for their clients' interviews, and minimizing lost productivity due to time spent on the road. As part of this initiative, OFMHS worked with IT to reorganize the telehealth committee, so that IT became a committee co-chair, taking a more active role in the process and immediately responding to issues in the field. The OFMHS' staff development and operations administrator has also worked to expand representation in the telehealth committee and has become part of BHHA's telehealth governance committee. This has increased organization, information flow, strengthened communication, and has allowed for more discussion pertaining to allocation of resources toward improved telehealth.

To date, OFMHS has reached out to all county jails in the state as well as tribal and municipal jails to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). Currently, county jails with telehealth capacity include Benton, Chelan, Clallam, Clark, Cowlitz, Ferry, Franklin, Grant, Grays Harbor, Island, Jefferson, King, King-Maleng Regional Justice Center, Kittitas, Okanogan, Pacific, Pend Oreille, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Whitman, and Yakima. Local jails with telehealth capacity include Aberdeen, Enumclaw, Forks, Hoquiam, Issaquah, Kent, Kirkland, Marysville, Nisqually, Puyallup, South Correctional Entity (SCORE), Sunnyside, and Yakima City jails, Airway Heights and Geiger Corrections facilities in Spokane. Tribal jails with telehealth capacity include Chehalis Tribal Jail, Colville Tribal Correctional Facility, Nisqually Tribe Corrections Center, and Yakama Nation Correction & Rehabilitation Facility.

Data – competency evaluation-additional evaluators

DSHS continues to use data from FDS to determine whether the evaluator capacity (current and funded increase) maintains substantial compliance with the injunction with respect to in-jail competency evaluations. Timeliness metrics are shown in Figure 4. Overall, compliance rates for jail-based evaluations remain high. As of Aug. 6, 2025, data reflects that in June 2025, a total of 94 percent of evaluation orders were completed within court-ordered time limits, with 92 percent of orders in the WSH catchment area and 100 percent of orders in the ESH catchment area completed within court-ordered time limits. Note, these numbers may continue to evolve as the good cause extensions are recomputed based upon the court's order entered on Sept. 7, 2023, and subsequent orders issued in 2024 that affect GCE protocols and processes. DSHS expects additional information will become available for inclusion in the spring 2026 SAR.

In advance of the upcoming budget cycle, the department examined the number of orders filed by the courts between March 2020 and March 2025 and projected the number of evaluation orders through March 2030 using an exponential smoothing forecast model.[8] Data over the 12-month period corresponding to the start of the COVID-19 pandemic (March 2020-March 2021) was interpolated to

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

account for pandemic-related effects. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood Agreement and Engrossed Substitute Senate Bill 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

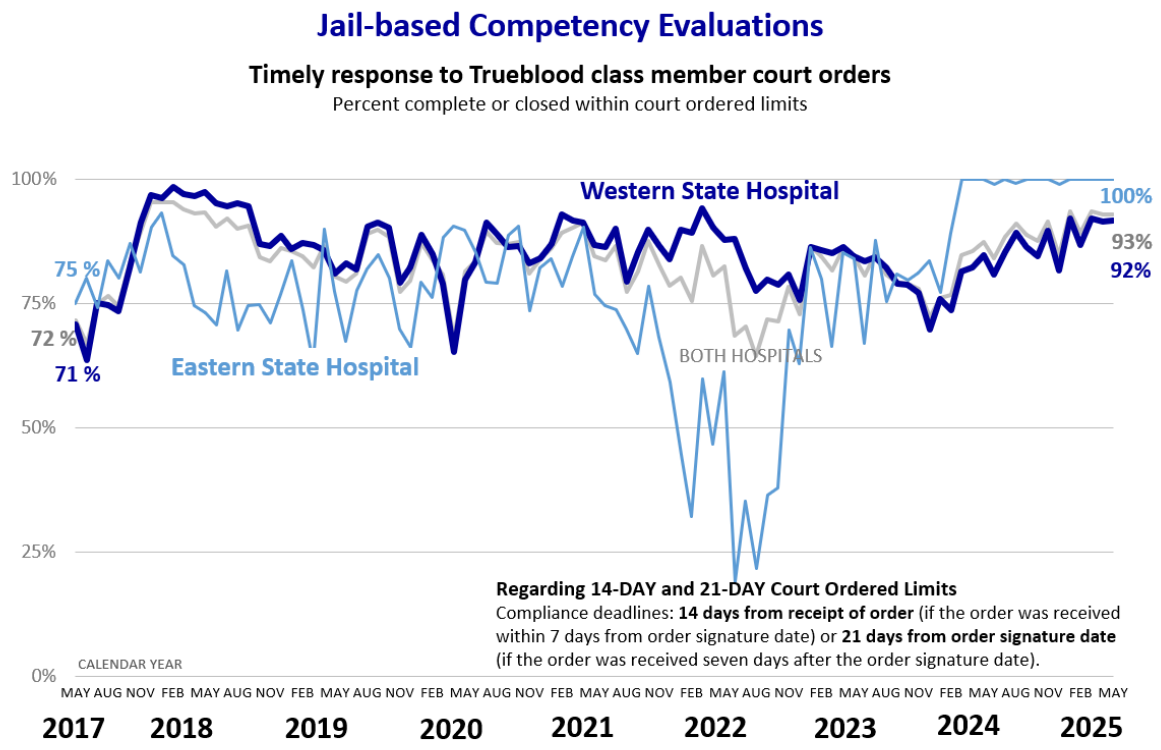
Projections indicate that the number of Trueblood competency evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 96 FTEs in the FY2027 budget and 96 FTEs in the FY2028 budget), and all evaluators work at the expected rate of productivity. Note that 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 and staff prioritize jail-based cases. These calculations do not account for evaluations for FRAs (both initial evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks.

FIGURE 4.

Jail-based competency evaluations: timely response to Trueblood class member court orders

Percent complete or closed within court-ordered limits

JUNE 2025



DATA SOURCES: FES modules in Cache database (WSH) and MILO database (ESH) and the Forensic Data System as of Aug. 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 10.77.645, and RCW 10.77.650. These changes went into effect July 28, 2019. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.650 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 10.77.650).

RDA maintains a dynamic Power BI report to show the average number of misdemeanor restoration orders made by courts each month, organized by fiscal year. Figure 4 displays the data from July 2017 through June 2025. In the two fiscal year period prior to the law change (FY2018-FY2019), courts issued an average of 23 misdemeanor restoration orders per month. In the two fiscal year period after the law change (FY2020-FY2021), the average number of misdemeanor restoration orders decreased to 14 orders per month. However, the average number of misdemeanor restoration orders then began to increase with an average of 21 misdemeanor restoration orders between FY2022 and FY2023 and an average of 27 orders between FY2024 and FY2025. The department had the highest number of misdemeanor restoration orders in April 2025 (46). Most recently, in June 2025 there were 36 misdemeanor restoration orders. This chart and data are updated online in Power BI monthly and can be found on the OFMHS' Trueblood website. Due to these monthly updates, data in the Power BI dashboard will likely be updated beyond what is described above.

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

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

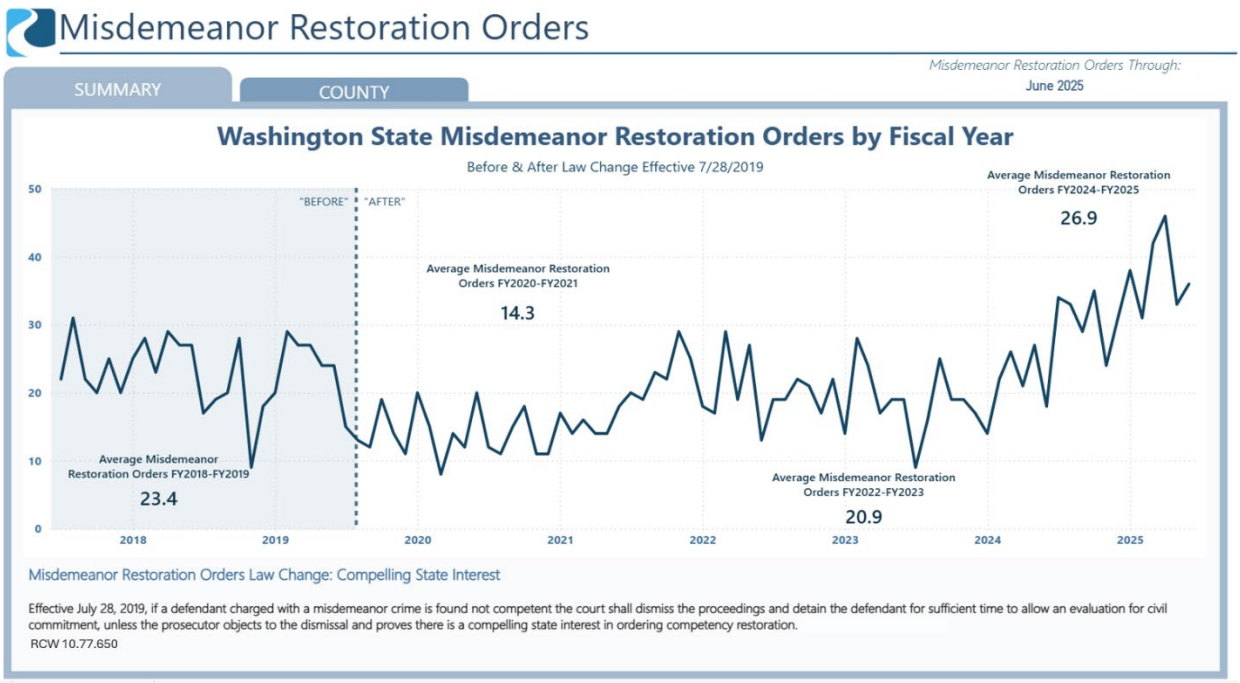
Note that in 2023, RCW 10.77.650 was amended by E2SSB 5440 (signed into law May 15, 2023, and effective July 23, 2023) to require the court to consider "all available and appropriate alternatives to inpatient competency restoration." This included developing a diversion program for defendants charged with nonfelony crimes. While the program is ongoing, the department will be reporting on its status outside of this report. In 2025, HB 1359 created a task force to review RCW 10.77 and laws related to criminal insanity and competency to stand trial. The task force will submit recommended changes to the governor and the legislature by Dec. 1, 2026. Task force membership will include representation from DSHS/BHHA, HCA, Disability Rights Washington, and plaintiff's counsel.

FIGURE 5.

Misdemeanor restoration orders before and after the 2019 session law that required "Compelling state Interest" (RCW 10.77.650)

Number and average misdemeanor restoration orders by fiscal year

JUNE 2025



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

DATA SOURCE: Forensic Data System.

Competency restoration – Community outpatient services

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

Current status and areas of positive impact

OCRP providers in the Phase 1, 2, and 3 regions are continuing to accept outpatient restoration orders from courts in their regions and working with DSHS forensic navigators to communicate and certify when adequate space is available in each of the separate programs. HCA worked with providers to fill vacancies, improve staff retention, and increase staffing and programmatic capacity. HCA, DSHS, and the plaintiffs finalized the Phase 4 FIP which will create program enhancements for OCRP.

Due to improved staffing retention, the OCR programs in King, Southwest, Thurston-Mason, and Spokane regions successfully maintained adequate space for every person recommended for OCRP throughout the reporting period. The OCRP providers in Pierce and Kitsap Counties maintained adequate space for most of this reporting period. HCA continues working with providers to increase adequate space through increasing staffing, working with providers around hiring practices, and creating more capacity for individualized support.

In the Phase 3 region, HCA contracted with a second provider, Peninsula Behavioral Health, to provide additional OCRP services to participants in the northwest area of the Salish region. The contract was executed in March, and they are actively working on start-up activities to be able to begin taking referrals by late summer, with an estimated start date of Aug. 1. 2025.

In April, DSHS and the HCA held a two-day virtual retreat with competency restoration providers from across the state and various settings to discuss the Breaking Barriers curriculum. The group discussed what is working well with the curriculum, shared supplemental materials, and discussed areas of growth. OCRP providers brought forward the strengths of their approaches, discussed challenges they have encountered, and shared suggestions based on their experiences. After all of these conversations, HCA and DSHS agreed to convene a smaller workgroup to make changes to the Breaking Barriers workbooks based on the feedback.

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

- Increasing the amount of curriculum time with OCRP participants and providing individual sessions for participants who need more intensive educational support
- Discussing recent participant removals from the program to assess and learn from trends in order to improve OCRP services
- At a minimum, monthly case staffing events between Settlement Agreement elements to ensure communication and program coordination for people enrolled in multiple Trueblood programs
- OCRP staff participate in regular meetings with forensic navigators and other Settlement Agreement elements, as applicable to review all people enrolled in OCRP services.
- The OCR program manager, in conjunction with DSHS, uses feedback from the program to update the Breaking Barriers Competency Restoration Program curriculum to better address the needs of outpatient participants.

DSHS and HCA continue to work on a process that allows inpatient competency teams to refer people to the Forensic Navigator Program to be re-assessed for suitability for OCRP services as an alternative to completing their entire restoration treatment in an inpatient facility-based program. During the first half of 2025, the use of this step-down process has increased significantly, and staff continue to develop internal processes to make this sustainable.

In an effort to reduce housing-related barriers to OCRP in 2023 and 2024, HCA supported the King County OCRP provider, Community House Mental Health Agency, with opening two transitional houses that can serve up to thirteen people enrolled in OCRP and provide in-home competency restoration programming and care coordination. HCA will continue to work with OCRP providers to expand viable housing options for people enrolled in OCRP and address other identified barriers to OCRP enrollment.

During the first half of 2025, HCA had a series of meetings with the FHARPS and OCRP providers in Pierce County to discuss the benefits of creating OCRP-specific housing. Participants were able to create coordination plans and resolve all questions from the providers, and in June 2025, our FHARPS provider in Pierce County dedicated one of their global leased houses to housing OCRP clients. Our agencies look forward to seeing how this will benefit Pierce County OCRP participants.

Areas of concern

During this reporting period, OCRP use has increased overall. However, this has not included the Spokane region, which has continued to receive a low number of referrals.

Recommendations to address concerns

HCA, in coordination with DSHS, has worked to learn more about the potential reasons behind the low referral rate in the Spokane region, including reviewing pertinent data.

HCA plans to continue to increase education and outreach to regional court partners to address questions, to remove barriers to ordering suitable people into OCRP, and provide data-informed updates. Additionally, the Phase 4 enhancements will include adding an engagement specialist with the focus on increasing referrals to OCRP and reducing removals from OCRP.

Data – competency restoration-community outpatient services

OCRP services began July 1, 2020, in Phase 1 regions and Oct. 31, 2022, in the Phase 2 region. The program expanded to the Phase 3 regions on April 30, 2024. The OCRP data tables in Appendix B present information from Phase 1, 2, and 3 regions. However, to protect confidentiality, data for Phase 3 regions are combined in the OCRP data tables. The data in Phase 3 regions will be reported separately (by region) when there are sufficient cases.

Between July 1, 2020, and June 30, 2025, 356 clients were enrolled in OCRP Phase 1, 2, and 3 regions: 93 in Pierce, 93 in Southwest, 57 in Spokane, 92 in King, and 21 in Salish and Thurston-Mason combined (Appendix B, Table 1). This is an increase of 71 people (25 percent) since December 2024. Across regions, most enrollments were for felony restoration orders (84 percent) and participants were mostly male (72 percent), 30-49 years old (54 percent), non-Hispanic white (58 percent), and unstably housed or homeless (a combined 61 percent).

Of the 295 participants discharged (Appendix B, Table 2), 38 percent were opined competent, 26 percent had their conditional release revoked, and 12 percent had their charges dismissed. About 63 percent were discharged to the community, 17 percent were admitted to inpatient services at either a state hospital or a behavioral health and treatment center, and 12 percent were returned to jail. Among those discharged, the average length of stay in OCRP was 82 days, ranging from 75 days in the King region to 92 days in the Spokane region. The average length of stay includes misdemeanor and felony orders and all discharge types (e.g., those who completed the program and were opined competent, and those who were returned to jail or whose conditional release was revoked).

Forensic navigators

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

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

If the court finds that a person is suitable for outpatient competency restoration and agrees to order the client to outpatient restoration, forensic navigators continue to work with these participants. 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 to retain as many services as possible for their clients.

Current status and areas of positive impact

Forensic navigators remain in close contact with attorneys and OCRPs. Forensic navigators fill a wide array of gaps in services facilitating client connections to programs such as housing and recovery programs, forensic peer services, and case management supports. These connections are attempted even when class members are not ordered into outpatient restoration, and after the forensic navigator is no longer actively assigned to the client. As mentioned above, forensic navigators have also connected with both OCRP and BHTCs to pilot a program that re-assesses clients on a second 90-day inpatient restoration order, who may be suitable for community restoration. This pilot has slowly integrated into WSH and ESH. The team meets with WSH monthly, and staff have made significant strides in partnership with the social work staff regarding potential suitable clients. Additionally, the forensic navigator team has implemented a step-down process with both ESH and WSH. This allows the navigator team to visit with inpatient staff regarding the status of Trueblood Class Members and

to explore diversion and outpatient competency restoration options to present to the court and legal parties.

DSHS and its service partners continue to work well together to maintain programmatic alignments. Communication between HCA and DSHS is consistent and efficient. DSHS holds ongoing discussions to explore opportunities for enhancing communication between the two groups. With the expansion of more diversion services and the implementation of the new phase, regular communication with HCA is expected to continue.

The Phase 2 forensic navigators continue making every effort to advocate for Trueblood class members in King County. The Phase 2 supervisor has done an excellent job leading the staff, which has allowed the team to increase communication with courts and attorneys.

The region is fully staffed and appears to be thriving with communication with courts. Despite only meeting/interviewing and observing about one fourth of clients due to an absence of attorney approval, they have been able to consistently get individuals into outpatient competency restoration. Phase 2 supervisors and team continue to adapt advocacy efforts as the OCRP provider increases capacity.

Phase 3 staff began forensic navigator engagement on April 15, 2024. The forensic navigator team continues to maintain positive correspondence based on early outreach in the area. The Salish region had one position that had not been filled as of the reporting period's end and was subsequently filled in Q3 2025. They have continued to create positive engagement with both Salish prosecution and defense.

Additionally, the program continues expansion in its current regions with diversion navigators who will support clients who have had engagement with the court. As RCW 10.77.610 notes, the diversion navigator's role will be to divert people who have received two competency evaluations in the last 24 months where cases have been dismissed. Since these people are in custody for a new charge, the program seeks to engage with these clients before they receive another referral into the forensic competency system. The diversion navigator's goal is to connect with each client to complete the recommended diversion plan and provide the completed plan to all court parties. Southwest region staff have been the first to engage and access jail/court systems to initiate practices to support Trueblood class members and begin the diversion process. Pierce County staff continue to work extensively with defense and prosecution to advocate for better communication. This has resulted in better outcomes for clients as well as better understanding of the navigator assessment process. Spokane region has met with courts to understand any potential hinderances to program participation and any enhancements that can be created.

Areas of concern

While some jurisdictions have accepted the role of the forensic navigator as one that primarily serves Trueblood class members, regions continue to express dissatisfaction that the forensic navigator role does not necessarily extend to a larger group of people for whom competency to stand trial has been raised, particularly those for whom a competency evaluation is ordered at or after their release from jail. Additional stakeholder frustration appears to be focused on the availability of other non-navigator resources and diversion options.

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

Diversion navigator staff continue to face barriers with engagement due to court timeliness and court systems hindering staff from engaging Trueblood class members. The diversion team continues conducting outreach and training to courts and stakeholders regarding options for clients who meet diversion criteria. The diversion team is strategizing different options to create more opportunities to engage with clients that meet eligibility criteria.

Recommendations to address concerns

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

Data – forensic navigators

The department publishes a dynamic Power BI report to track program data and illustrate trends. This report provides both quarterly and cumulative data that can be broken down by region to enhance reporting capabilities. The data presented below and in Appendix C represents selected figures and tables from the new Power BI report. The full report can be accessed online. Please note that this is dynamic data and is continuously evolving.

There were 560 people active in the Forensic Navigator Program at the end of Q2 2025 (Appendix C, Figure 1). Fifty-six of them were enrolled in OCRP and 45 were being reassessed for OCRP as of the last day of the reporting period (Appendix C, Table 2). These are the highest OCRP enrollment and reassessment counts to date. As can be seen in the full Power BI report, the King region had the highest number of people enrolled in OCRP (32) and being reassessed for OCRP (14) as of the end of Q2 2025. OCRP enrollment data for all other regions is suppressed in the full report due to numbers less than 11. Note that suppressing region-level numbers less than 11 occurs throughout the full Power BI report to protect client confidentiality.

Cumulatively, 9,760 people were assigned to a forensic navigator between July 1, 2020, (program start) and June 30, 2025 (Appendix C, Figure 1). As can be seen in the online Power BI report, this includes 4,441 people in King County, where forensic navigator services began in January 2022. Phase 3 services began in April 2024 for the Thurston-Mason and Salish regions, where 358 people in the Thurston-Mason region and 277 people in the Salish region were assigned a forensic navigator. Statewide, 44 percent were charged with a felony, and 56 percent were charged with a misdemeanor (Appendix C, Figure 1). However, in the King region about 7 in 10 people (72 percent) served by forensic navigators had a misdemeanor offense.

Two-thirds of the people assigned a forensic navigator since the program's start were male (67 percent), and more than half were between the ages of 30 to 49 (56 percent). About half (51 percent) were non-Hispanic white (Appendix C, Table 1). These patterns are consistent across regions. Note that for gender reporting, due to a small number of people identifying as a gender other than male or female, that category is combined with "unknown" to protect client confidentiality. As the program grows, the department continues to monitor if it is possible to break out these categories. The program additionally continues to make improvements to data collection and data quality.

Across all regions, forensic navigators had an average of 16 clients in their caseload (Appendix C, Figure 1). This is an increase from Q4 2024 but still slightly lower than previous average caseloads, likely due to the smaller average caseload in the newer Phase 3 regions. While average caseloads differed by region, all region caseloads have been at or below the program standard of 25 since Q1 2024. (Appendix C, Figure 3). In Q2 2025, the Southwest region had the highest average daily caseload (20), and the Thurston-Mason region had the lowest average caseload (7). Forensic navigators worked to gather information for the courts for nearly all people assigned a navigator during the reporting

period (99 percent, Appendix C, Figure 4). This is the most common service provided for people since the program's start. Client meetings, interviews, or observations were conducted with 45 percent of people assigned a navigator. Forensic navigators provided coordination of care for 44 percent of clients overall, with the highest rate being in the Southwest region (65 percent) and the lowest being in the King region (27 percent) as can be seen in the online report. Across all regions, a recommended service plan was completed for 85 percent of people. Note that at this time, this calculation may include cases where a recommended service plan was not needed (e.g., when an order was cancelled or withdrawn). The department and program continue to develop the data to ensure it is as accurate as possible. As currently calculated, the percentage of clients receiving a completed recommended service plan has remained around 85 percent since Q4 2024 (Appendix C, Figure 4). More than one in three (38 percent) received a referral to services. Note that forensic navigator services in Phase 2 and Phase 3 regions started prior to other Trueblood programs in the region. Forensic navigator services and referrals are expected to increase as OCRP services expand and the program matures.

The most common types of referrals were for other Trueblood partner programs: 21 percent received a referral to the FPATH program and 20 percent received a referral to FHARPS (Appendix C, Figure 5).

A total of 9,200 people were discharged during the reporting period, with an average length of stay in the program of 38.5 days, ranging from 28.2 days in the Salish region to 57.7 days in Southwest region as can be seen in the online report. About one-third (30 percent) of those were discharged with a warm handoff to providers or jail staff. Twenty-eight percent of cases were closed because the person was determined competent. Twenty-two percent of cases were closed when people were released from jail on personal recognizance and twenty-two percent because the person was ordered by the court to receive inpatient restoration (Appendix C, Table 2). Sixteen percent were discharged due to charges being dismissed (Appendix C, Table 2). This did vary by region, for example, the full online report shows the Southwest region had a smaller number of discharges due to release from jail on PR (12 percent) and the Spokane region had a higher number due to PR (33 percent).

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

Crisis triage and diversion – additional beds and enhancements

Trueblood funds were provided to increase crisis bed capacity in Phase 1, 2 and 3 regions. Crisis stabilization/crisis triage facilities are residential treatment facilities that are licensed through the Department of Health to provide short-term clinical interventions in a safe, structured environment, and to offer support and behavioral health crisis stabilization services to people who are experiencing a behavioral health crisis. The services provided in these facilities are short-term, usually 23 hours or less, but on an as-needed basis; care can be extended for up to two weeks.

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

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

In Phase 3, enhancements were allocated through the regional BHASO contracts to provide support to the two Salish region crisis stabilization facilities operated by Peninsula Behavioral Health and Kitsap Mental Health and Recovery, and the crisis response teams in Thurston-Mason.

Current status and areas of positive impact

Additional crisis beds – Spokane Phase 1

The Spokane Regional Stabilization Center, or SRSC, is operated by Pioneer Human Services and continues providing intensive discharge planning and connecting people to housing resources, outpatient behavioral health services, medical care, and medication management. SRSC collaborates regularly with local law enforcement agencies and first responders to provide support and diversion for people brought to the SRSC by police hold or drop-off. During this reporting period, the SRSC increased outreach to regional first responders and created relationships with new community providers to improve access to treatment.

During this reporting period, the SRSC served 338 people who also had law enforcement contact in the prior 24-month period; 85 people who were referred to the SRSC by police drop-off; and 211 people with co-occurring disorders.

Additional crisis beds – King Phase 2

ConnectionsWA Kirkland campus continued their work on staff recruitment, outreaching with community partners, and collaborating with local law enforcement and first responders. ConnectionsWA also met with the regional Tribes to increase access to Tribal community members. The King County FHARPS, FPATH, and OCRP teams continue to refer to ConnectionsWA and utilize the regional crisis services.

Additional crisis beds – Thurston-Mason Phase 3

In June, ConnectionsWA was awarded a Commerce grant for an additional 16 crisis stabilization beds in Thurston-Mason as a part of the Phase 3 Implementation Plan. ConnectionsWA is planning to begin construction in 2026, and HCA will continue to support the implementation of these new crisis stabilization beds.

Areas of concern

The Phase 2 implementation plan required that two crisis stabilization facilities be under contract with the Department of Commerce by June 30, 2022, and that contractors begin their construction in King County by December 2022. Recovery Innovations, or RI, was under contract with the Department of Commerce since the June 30, 2022 deadline, but never began construction. Commerce terminated the contract with RI in late 2024, and HCA and Commerce have been working to identify a solution for this outstanding Phase 2 requirement.

Recommendations to address concerns

HCA continues to meet regularly with Commerce and King County to complete the Phase 2 FIP requirement of establishing a second crisis stabilization facility in South King County. Commerce received funding in the SFY 26-27 biennium budget for the South King County facility and will award funding to the applicant chosen for King County's Crisis Care Center, or CCC, initiative. King County is processing through the CCC applications and is hoping to determine an awardee by the end of July.

Current status and areas of positive impact

Crisis enhancements – Phase 1

The crisis enhancement funding for the Phase 1, 2, and 3 regions continues to support staff recruitment, retention, and training in the regional crisis stabilization facilities or crisis response teams.

The Lifeline Connection crisis stabilization facility in the Southwest region served over 321 people, averaged a 54 percent occupancy rate, and reported an increase of referrals during this reporting period. Of the people served, 77 percent of people discharged with connections to community

behavioral health support. The case management team continues to build strong relationships with community partners to connect people to services upon discharge. They also use internal resources to provide onsite coordinated entry assessments and identify housing resources.

Carelon BHASO recently awarded funding for a new crisis stabilization facility in Pierce County to replace the closed RI facilities. HCA will add funding to the Carelon BHASO contract to reallocate crisis enhancement funds for the new facility once it opens in late summer. During this reporting period, the crisis enhancement funds were used to support hiring bonuses and needed training for the regional crisis response teams.

The Spokane BHASO continues to support Pioneer Human Services with maintaining the 24/7 firehouse model of crisis stabilization services. During this quarter, PHS provided and engaged in the following training and staff development: Crisis Prevention Institute training, Mental Health First Aid, CPR training, Medical Necessity Documentation training, Program Criteria training, and ongoing external training for American Society of Addiction Medicine 4th edition.

Crisis enhancements – Phase 2

The Downtown Emergency Services Center (DESC) Crisis Solutions Center (CSC) in King County served over 1,340 people this reporting period, including 411 people who were referred by police or first responders. DESC forged strong relationships with local law enforcement and first responder teams to divert people in crisis. DESC's medical team met with regional emergency rooms to improve the continuum of care and increase referrals to the CSC. DESC also received referrals from new referring partners including Health One and Health 990, Seattle CARES team, Mobile Response Team, and Sound Health-MCCRT.

Crisis enhancements – Phase 3

During this reporting period, crisis enhancements in the Thurston-Mason region funded training to enhance crisis response on the regional crisis teams. Funds were used to purchase a training program through Reflex AI, a platform to help crisis centers enhance responder skills, improve call outcomes, and streamline quality assurance, all while prioritizing the wellbeing of the crisis teams. All crisis clinicians and peers received training to help enhance their skills to effectively engage with people in crisis both in-person and via phone calls.

The Salish BHASO contracts with Peninsula Behavioral Health (PBH) and Kitsap Mental Health Services (KMHS) for enhanced stabilization/crisis triage. KMHS used the funding to offer substantial hiring bonuses for their mental health professional positions, which have historically been difficult to fill. With the use of the hiring bonuses, KMHS was able to fill most of their mental health professional vacancies. Additionally, both PBH and KMHS used the funds to continue marketing their crisis stabilization facilities to regional police departments, regional hospitals, and community behavioral

health agencies. During this reporting period, KMHS partnered with the local emergency department, fire/EMS, and law enforcement leadership to co-host a community education event about accessing crisis services in Kitsap County.

Areas of concern

Despite large improvements in workforce hiring and retention, Spokane, King, and Southwest crisis providers all reported workforce turnover as their biggest challenge. Particular vacant positions including registered nurses, mental health professionals, behavioral health clinicians, and overnight staff are taking a longer time to fill.

Recommendations to address concerns

HCA staff will continue to provide technical assistance and resources including linking these providers with the DSHS workforce development team and related initiatives that will further support strong crisis service systems. HCA will also continue to support the providers with workforce challenges by encouraging the crisis enhancement funds to be used for staff hiring and retention bonuses.

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 people in mental health crisis) may divert some people from arrest and incarceration. HCA will provide information on the date, location, and number of beds added. Data on crisis housing vouchers distributed by crisis triage and stabilization facilities is included in the Crisis Triage and Diversion-Residential Supports section and (Appendix D).

Crisis triage and diversion – residential supports

Residential supports connect people with shelter-based, transitional, and temporary housing subsidies through peer support. These housing subsidies can be used for things such as but not limited to application fees, security deposits, several months of rent or rental arrears, as well as other approved necessities. This model fosters engagement with staff who have lived experience with recovery and who are certified to provide peer support services in Washington state.

Current status and areas of positive impact

The goal of FHARPS is to provide immediate, low-barrier, and person-centered housing placements, subsidies, and supportive services. The FHARPS teams also strive to create a long-term or permanent housing plan for participants after their enrollment in the program.

To date, Phase 2 FHARPS programs have a higher proportion of participants who were referred by the forensic navigators rather than other referral sources. HCA has observed many benefits to this practice and continues to ensure that FHARPS teams work closely with forensic navigators in their regions. FHARPS data for Phase 2 will reflect this, showing most referrals to the program have come from forensic navigators.

HCA worked with RDA to distribute the FPATH eligibility list to FHARPS providers to improve a continuum of services and ensure that the FHARPS teams are serving as many FPATH-eligible people as possible.

The Phase 1 and 2 FHARPS providers are continuing to use and expand global leasing as a viable housing option for class members. The Phase 3 FHARPS providers are expanding housing placement types as their programs continue to grow.

FHARPS teams have developed strong relationships with local housing providers and property management agencies. Teams regularly meet with housing providers to increase housing connections for FHARPS participants.

FHARPS providers have also developed substantial connections and relationships with the state hospitals, community centers, enhanced shelters, emergency rooms, PACT teams, coordinated entry teams, SUD treatment programs, rental subsidy administrators, landlords, social services offices and regional mobile crisis teams to better the outcomes for FHARPS participants as they work to re-integrate back into the community. These relationships have been built through countless hours of coordination and collaboration.

The FHARPS program is dedicated to aligning each participant's housing plan with their self-determined goals and priorities, and providers use participant voice to reflect participant housing

goals. FHARPS offers personalized options, resources and support while collaborating closely with individuals to address their unique needs. This ensures that FHARPS participants can access a diversity of housing options within their regions.

An ongoing practice of FHARPS teams is to connect participants to long-term or permanent housing resources. For example, all FHARPS providers can refer to their local housing authorities, as part of their process for creating individualized housing plans. Many of the programs have been able to secure long-term housing for participants. Specifically, during this reporting period, Telecare secured four long-term, permanent supportive housing placements. Additionally, Peninsula Behavioral Health is in the process of adding two additional homes for participants which will be ready by the end of September. These homes would allow several FHARPS participants to transition from motels to more stable, supportive housing. Both homes are centrally located near services and transit. A wide variety of housing options are given to each participant based on their individual needs, wants and unique circumstances. These housing options can range from permanent supportive housing, global lease options, and even hotel placements depending on the participants' individual barriers. These various housing options are indicative of the program's ability to navigate systemic challenges and secure critical resources for participants.

To respond to the high demand for FHARPS programs in Phase 2, HCA conducted outreach to potential providers and successfully obtained a new provider. Community House Mental Health Agency is now providing FHARPS services in King County and they went live with their program services in January 2025. Community House has secured one global lease and has two other potential global lease opportunities.

HCA continues meeting monthly with Phase 3 providers to offer technical assistance and ensure successful program implementation. The Phase 3 teams have completed the required tailored trainings on trauma-informed care, outreach best practices, overcoming implicit bias, housing first principles, and person-centered case management. All Phase 3 providers have fully staffed teams, aside from the newly added Phase 4 enhancement positions, and are actively serving participants throughout this reporting period.

Crisis housing vouchers

Emergency housing subsidies

HCA continues to facilitate meetings between emergency housing providers and regional FHARPS providers to facilitate referrals and increase connection to FHARPS. Data shows that through support and technical assistance, use of the emergency housing subsidies in the phased regions has continued to increase.

In Phase 3, emergency housing subsidies were added to the Thurston-Mason BHASO contract because there is no licensed crisis stabilization facility currently located in that region. HCA executed direct contracts with the two agencies in the Salish Region that operate the region's crisis stabilization facilities, Kitsap Mental Health Services and Peninsula Behavioral Health Services.

In Phase 2, providers continue to use a high amount of the crisis housing vouchers, or CHVs, and are on track to spend almost the entirety of their funds for SFY25.

In Phase 1, Carelon BHASO changed one of the CHV subcontractors in the Pierce Region to better align with the intent of the crisis housing vouchers. As the new agency becomes an active distributor of the CHVs, HCA will host meetings with the regional FHARPS team to increase utilization and referrals.

HCA continues to reach out to providers to continue education on how these subsidies can be used and offers technical assistance including creative placements in the rural regions where access to hotels/motels is limited.

Areas of concern

FHARPS teams are required to offer a diversity of housing types to be responsive to participant needs and preference. This can be a challenge in certain regions depending on the availability and diversity of housing resources. FHARPS providers unanimously agree that two of the largest challenges are available housing and lack of available bed space.

FHARPS teams lack accessible and community-based prescribing services and clinical support for enrolled participants. Access to timely and effective medication interventions are often a huge barrier when it comes to participant stability, especially for those transitioning from jail.

Most FHARPS teams manage high caseloads (more than 15 active participants) and striving to keep up with the high volume of referrals. The high caseloads are in part due to the high volume of referrals, but also the outreach efforts of the FHARPS teams, attempting to locate FHARPS-eligible participants now that they have access to the FPATH list. FHARPS teams spend a considerable amount of time doing outreach to connect with those in the community who are challenging to reach.

Lastly, a portion of the FHARPS participants discharged from the program due to loss of contact. HCA was particularly concerned with the high proportion of participants in the King region who were discharging due to loss of contact (approximately 70 percent) and has been continuing to work with the providers to reduce this discharge reason.

Recommendations to address concerns

HCA is providing intensive and regular technical assistance to the FHARPS providers, particularly in King, to reduce the number of people who are discharged due to loss of contact. One of the drivers for this issue in King is the high volume of referrals and the challenge of balancing existing caseloads while providing timely response to new referrals. However, most of the FHARPS teams are discharging participants for this reason at a comparable proportion to other time-limited housing programs. Also, King County's FHARPS providers showed a huge improvement for this discharge reason during this reporting period (reduced from about 70 percent to approximately 50 percent)

HCA regularly reviews data with each of the FHARPS providers regarding housing placement types to learn how each provider is offering housing resources to participants. HCA is working closely with the FHARPS teams to identify creative and diverse housing options.

Although caseload sizes remain higher due to the high demand for FHARPS services, the newly added Phase 4 positions that are now in contract are designed to address these challenges. Adding a referral and outreach coordinator to each of the FHARPS teams will allow teams to better triage referrals and reduce caseload size. The added case managers and certified peer specialists on each team will lower caseloads to approximately 12 to 15 participants.

Data – crisis triage and diversion-residential supports

Residential supports are provided through two mechanisms: (1) CHVs, provided by crisis triage and stabilization facilities; and (2) the FHARPS program. Data from HCA's PDAMS is merged with Excel tracker data in this report. HCA provides ongoing training to providers to refine data entry practices, which may result in shifting data for future reports.

Vouchers data

CHVs became available in December 2019 in the Phase 1 regions and July 2022 in the Phase 2 region. The program expanded to the Phase 3 regions in January 2024. The CHV data tables in Appendix D present information from Phase 1, 2, and 3 regions. To protect confidentiality, data for Phase 3 regions are combined in the CHV data tables. Once there are sufficient cases, data for each Phase 3 region will be reported separately.

Between Dec. 1, 2019, and June 30, 2025, the crisis stabilization and triage facilities and provider teams contracted by HCA distributed 1,223 housing vouchers to 905 people in Phase 1, Phase 2, and

Phase 3 regions (Appendix D, Table 1).[9] The number of vouchers issued increased 24 percent from December 2024 to June 2025.

Southwest and King regions each issued 30 percent or more of the vouchers and accounted for nearly two-thirds of voucher recipients combined (31 and 34 percent, respectively). The total amount disbursed across Phase 1, 2, and 3 regions was $1,043,368 and the average amount per recipient was $1,153. Due to vouchers being distributed both by CS/CT facilities and within the community, 'referral source' can mean either how the individual was referred to the CS/CT facility or to the community entity distributing housing vouchers. Self-referrals, law enforcement (including police and co-responder programs), and hospitals accounted for nearly two-thirds of referrals among those receiving vouchers (30 percent, 17 percent, and 17 percent, respectively). Approximately 4 in 10 King region recipients were referred by law enforcement (42 percent).

Most voucher recipients were male (64 percent), between 30 and 49 years old (55 percent), and non-Hispanic white (59 percent).

Based on matching CHV recipients to those within the FHARPS program data, 17 percent of voucher recipients were referred to FHARPS, 14 percent were enrolled, and 12 percent were housed or sheltered by FHARPS. Slightly over half of initial housing placements through FHARPS were shelter/emergency placements (51 percent), which included motels.[10]

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

FHARPS Data

The FHARPS program began on March 1, 2020, in the Phase 1 regions and April 12, 2022, in the Phase 2 region. The program expanded to the Phase 3 regions on April 30, 2024. The FHARPS data tables in Appendix E present information from Phase 1, 2, and 3 regions.

[9] Crisis housing vouchers transitioned to HCA's PDAMS in November 2023. Pierce region data are incomplete due to one provider, RI International, not submitting the final Excel tracker following the data collection transition to PDAMS, which may include up to four weeks of data in October.

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

A total of 3,143 people were referred for FHARPS services across Phase 1, 2, and Phase 3 regions from March 1, 2020, to June 30, 2025 (Appendix E, Table 1).[11] Of these referrals, 1,700 (54 percent) were contacted[12] and 1,422 (45 percent) were enrolled. It is important to note that there are ongoing data clean-up efforts and the data will continue to be updated accordingly.

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

Overall, Trueblood partner programs (e.g., forensic navigators, FPATH, crisis stabilization center) were responsible for 71 percent of recorded referrals. Forensic navigators made the most referrals, 51 percent overall, and comprised 88 percent of referrals in the King region. FPATH referred 12 percent, and crisis stabilization and triage facilities referred five percent.

Most initial contacts were made in jail (36 percent), largely due to the King region conducting 74 percent of their contacts in jail, which is down from 95 percent at year end 2024. Twenty-five percent of initial contacts were made by phone, down from 74 percent at year-end 2020 when outreach methods were limited due to COVID-19 protocols.

Nearly seven in ten people (67 percent) enrolled in FHARPS were male, 60 percent were between 30 and 49 years old, and 43 percent were non-Hispanic white. Twenty percent of participants identified as Black or African American and 9 percent as Hispanic or Latino. People can identify as more than one race or ethnicity. Over half of the people enrolled were reported as homeless at the time of enrollment (58 percent).

Of those enrolled, 68 percent were housed or sheltered at least once (Appendix E, Table 2). Forty-six percent of first housing types were emergency/shelter placements, which included motels. This is down from 68 percent at year-end 2021. There was a shift in transitional housing from 23 percent at year-end 2021 to 45 percent as of June 2025, mainly due to an increase in the use of global leasing (previously known as master leasing) options and the King region mostly using transitional housing placements (91 percent). In Phase 3 regions combined, 29 percent of those housed or sheltered were first housed in shelter/emergency placements and another 29 percent were first housed in other types of placements not classified as permanent, transitional, or shelter/emergency (not shown in

[11] FHARPS data collection transitioned to PDAMS in August 2023. Data are subject to change due to challenges tracking people across Excel trackers and PDAMS data. RDA and HCA will collaborate on improvements.
[12] 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.

table). As enrollment continues to grow in Phase 3 regions, detailed first housing type information will become available for permanent and transitional housing placements.

Seventy-one percent of FHARPS participants had been discharged from the program as of June 30, 2025, with an average length of support of 217 days, ranging from 97 days in the Thurston-Mason region to 268 days in the Spokane region (Appendix E, Table 3). The average total subsidy support received by those discharged as of June 30, 2025, was $4,564.

HCA continues working with providers, particularly in the King region, on entering discharge information and appropriate housing status at discharge. Half of the discharges from King region providers occurred due to loss of contact (50 percent), down from 70 percent in December 2024 due to data clean-up efforts. King reported 48 percent were homeless at time of discharge, down from 81 percent in June 2024, also due to data clean-up efforts, and 32 percent had an unknown housing status at discharge, likely because of loss of contact.

Among people discharged, 32 percent of cases were closed due to loss of contact, 14 percent withdrew, 13 percent transitioned to other housing support, and 11 percent transitioned to self-support. Seven percent received the maximum assistance and were discharged without transition to other services. At the time of discharge, 28 percent were stably housed, 16 percent were homeless, and 14 percent were in a facility. Housing status at program discharge was unknown for 35 percent of people (similar to the loss of contact rate).

Crisis triage and diversion – FPATH

FPATH teams provide assertive outreach, in-reach, and engagement, receive referrals from other Trueblood Settlement Agreement elements, and provide intensive case management services to those they enroll. On a monthly cadence, RDA identifies people with two or more competency evaluation orders on separate cases in a 24-month period to provide class members who have a higher risk of future intersection with the criminal court system with FPATH services. The FPATH Program administrator also sends the FPATH teams a prioritized list so that outreach and engagement efforts are focused on people who have the highest barriers, such as people who live in rural counties, have four or more competency evaluation referrals, or experience homelessness.

Current status and areas of positive Impact

Since the last reporting period, Phase 1, 2 and 3 FPATH providers have made an additional 339 attempted contacts. Providers continue to report an increase in referrals to FPATH from the forensic navigators and other Trueblood elements during this reporting period. FPATH programs are working to engage and enroll eligible class members into the program as much as capacity allows. It takes several contact attempts to engage and enroll FPATH-eligible class members into the program. Providers meet participants where they are at, whether they are in the jail or community. FPATH providers have worked to enhance coordination with the forensic navigators, OCRP, FHARPS, Trueblood Diversion and local jails to strive for warm handoffs into the program when possible.

Providers reported many participants are connected to housing programs, such as FHARPS, upon discharge from FPATH. Since the last reporting period, 168 participants were referred to FHARPS from FPATH. A main driver of this is improved coordination between FHARPS and FPATH teams, many of which meet on a weekly basis to discuss dually enrolled participants, and FHARPS gaining access to the FPATH eligibility list. This has improved collaboration with the FHARPS teams, especially teams within different agencies. FHARPS and FPATH teams are now outreaching in tandem, increasing coordination and communication in the region. FPATH has reported higher levels of attempted contacts, successful contacts and enrollments.

FPATH providers work with dually enrolled OCRP participants and successful coordination has improved teams' ability to ensure all participants needs are met. Agencies that provide both FPATH and Trueblood Diversion programs are also outreaching together in hopes to engage with as many people as possible in the community.

Providers have reported strong collaboration with mental health case managers at the jail, the public defender's office and DSHS Forensic Navigators. These partners provide support and crucial information about FPATH participants. FPATH providers have spent significant energy working to build relationships with case managers and have seen huge benefits come from connecting with as many

resources in their regions as possible. These resources include homeless shelters, adult outpatient services, engagement teams, PACT, and crisis triage centers.

FPATH has been able to meet with participants in WSH more frequently and seamlessly. This has enabled some FPATH providers the ability to meet with people while still in the hospital to complete intakes and be part of their transition into the community.

The FPATH teams have consistently reported that many FPATH-eligible people are being found competent for their current charges and then incarcerated for long periods of time. Teams have found other avenues of services for people who do not meet FPATH eligibility upon release. Teams are now connected with the Reentry Community Safety Program which provides long-term support on release from DOC custody, pre-engagement services, intensive case management, specialized treatment services, and housing assistance.

Providers continue to work to engage people who have disengaged. In this current reporting period, the discharge reason for loss of contact has decreased by four percent. King County has decreased loss of contact by over 50 percent. This is significant as there was also a 19 percent increase of FPATH-eligible individuals from the last reporting period.

FPATH is dedicated to ensuring participants leave the program with a strong foundation for continued success. Staff work closely with participants to secure essential documents like government IDs and birth certificates, activate benefits such as health insurance and food assistance, and connect them to outpatient mental health and substance use services. Discharge planning often involves coordinating access to stable housing, reliable transportation, and employment support. Providers report helping participants maintain their jobs by assisting with practical needs like phones and car repairs, and build comprehensive discharge plans that link participants to long-term services such as Foundational Community Supports and case management.

FPATH teams now have access to the Judicial Access Browser System, or JABS, to support participants with any current legal involvement. This can include quashing warrants, following court orders, and supporting members with scheduled court dates.

HCA and RDA worked together to improve the FPATH eligibility list for the providers. Teams were challenged with identifying a person's eligibility which caused some gaps in services and delays in enrolling eligible people. Additionally, FPATH referral forms and processes were updated to allow the FPATH teams to quickly meet with eligible people before they are released from jail.

During this reporting period, HCA worked with the FPATH providers to prepare for the Phase 4 program enhancements to the FPATH program. Phase 4 enhancements will add one Substance Use Disorder Professional (SUDP), one engagement and outreach specialist, and one data specialist per

team. Additional peers and case managers will be added on certain teams and the program's length of time will be extended up to 24 months.

As a part of the Phase 4 program enhancements, HCA is drafting logic models, program guidelines, and best practices to help improve FPATH services. FPATH teams will be given clearer expectations, particularly on time spent performing outreach and case management services outcomes.

Areas of concern

FPATH providers face several challenges that impact the quality and continuity of services provided. One of the most pressing issues is the lack of housing for unhoused participants. FPATH teams work closely with FHARPS providers to connect participants to housing, but housing resources are limited and remain a pressing challenge.

Traditional outpatient mental health services continue to be a challenging system for many FPATH participants. Providers report that when participants lack stability, it is difficult for them to consistently participate in meaningful care.

Furthermore, participants often face the loss of essential belongings – such as phones and clothing – due to theft, damage, or lack of secure storage, adding further instability. These obstacles make it clear that achieving long-term, meaningful progress requires addressing both systemic barriers and the complex realities faced by participants.

Teams report continued barriers when working within the judicial system. Delays in communication and lack of timely notification about participant releases hinder their ability to engage people during critical transition periods. While the goal is to connect with referred people in jail within 24 hours, unpredictable release timelines and limited access to key tracking systems often result in missed opportunities for early intervention. Additionally, some judicial decisions, such as denying release when a hotel is the only available housing, create further challenges to stabilization and reentry planning. FPATH teams in rural regions have reported that court systems are more apt to release people and dismiss charges quickly because of frequent arrest and less serious charges. While this is a positive trend, it creates a short timeframe for FPATH teams to connect with people before they are released.

Teams reported that to better serve the complex population, there is a clear need for more hands-on training opportunities, particularly in areas like crisis de-escalation and working with people facing multiple challenges such as co-occurring disorders. Providing staff with these essential skills will ensure that they are better equipped to handle the diverse needs of participants and respond effectively in high-pressure situations.

Despite teams seeing improvements in workforce retention and staffing, retaining staff is a continual challenge for the FPATH providers.

Recommendations to address concerns

The additional Phase 4 staff positions will address many of the existing challenges. The newly added SUDPs will work with FPATH teams so participants are able to receive accessible substance use services in the community. The position will coordinate with teams and work closely with partners in the community and act as a liaison with other SUD treatment providers. The SUDP will connect people with needed care at a quicker rate, provide individual and/or group sessions, and provide guidance and expertise to all teams.

The FPATH teams continue to receive a high volume of referrals. Teams continue to work on balancing referrals while serving actively enrolled people. The outreach and engagement specialist will be able to focus on responding to new referrals, allowing the case managers to focus their time on active participants. The engagement and outreach specialists will also prioritize locating and outreaching enrolled participants who are not engaged. These positions will serve as a liaison to Forensic Navigators to communicate referral status and engagement in the program.

The data entry specialists will improve data quality and help reduce data-entry challenges. The data entry specialist will meet regularly with the Trueblood Data Program Manager to focus on data quality assurance.

The Office of Public Defense will offer legal system liaison, coordination support, and trainings for the FPATH teams. This legal coordination contract will provide education to the teams so they can support participants with reducing recidivism and legal involvement.

Lastly, teams will be provided with new and comprehensive training to better improve services for FPATH participants. These trainings will include drug overdose prevention, harm reduction, housing resources, legal navigation, and tribal resources. FPATH supervisors will also be taking curriculum centered around peer support and the complexities of the people served in FPATH.

Data – crisis triage and diversion – FPATH

FPATH data in the current report are from the Homeless Management Information System, monthly Excel trackers submitted by FPATH providers, and PDAMS, which FPATH providers transitioned to for data collection in May 2024.

The FPATH program began March 1, 2020, in the Phase 1 regions, April 1, 2022, in the Phase 2 region, and April 30, 2024 in the Phase 3 regions. The FPATH data tables in Appendix F present information from all three phases and their respective regions.

Program suitability is based on an eligibility list of people who had two or more competency evaluation court orders within the prior 24 months. Between March 1, 2020, and June 30, 2025, 4,917 people were eligible for FPATH services across the Phase 1, 2, and 3 regions (Appendix F, Table 1). HCA encourages providers to focus outreach efforts on a subset of these people based on housing status (prioritizing unstably housed and homeless people), number of competency evaluation orders (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 3,197, which was 65 percent of the total eligibility list.

Of all people on the eligibility lists for Phase 1, Phase 2, and Phase 3, FPATH providers attempted to contact 1,920 (39 percent) and successfully contacted 1,804 (37 percent). As of June 30, 2025, a total of 1,030 people (21 percent of people on the eligibility list) were enrolled in the FPATH program (Appendix F, Table 1). Of these, more than half were from the prioritized population (522 enrollees or 51 percent, not shown in table).

Of the Phase 1 regions, Southwest had the smallest eligibility list and continued to enroll the largest proportion (38 percent, Appendix F, Table 1). The Pierce region had the largest eligibility list and enrolled 21 percent, while the Spokane region enrolled 20 percent of their eligibility list. The King region has enrolled 330 people since the program started in April 2022, which was 17 percent of its eligibility list. Of these, nearly half were from the prioritized population (48 percent, not shown in table). The Phase 3 regions have enrolled 63 people since their programs started in April 2024, with the Salish region enrolling 52 percent of people on its eligibility list and the Thurston-Mason region enrolling 6 percent.

Among enrolled people, the majority were male (71 percent overall) and between 30 and 49 years old (62 percent). More than half of enrollees (54 percent) had a housing status of homeless at program enrollment, while 21 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among the 666 people discharged from the FPATH program through June 30, 2025, the average length of stay in the program was 308 days. People in the Spokane region continued to have the longest length of stay at 505 days, while the Thurston-Mason region had the shortest at 120 days. (Appendix F, Table 1). Loss of contact remained the most common reason for FPATH discharge statewide, accounting for 42 percent of program exits. The second most common reason for FPATH discharge statewide was successful exits (18 percent), meaning the participant was successfully transitioned into ongoing services such as outpatient mental health, employment, housing, or substance use treatment. This was followed by withdrew (12 percent) and incarceration (10 percent).

Services

As of June 30, 2025, 24,384 service encounters have occurred between FPATH providers and participants over the duration of the program, with an average of 2.8 services per participant, per

month (Appendix F, Table 2). Averages ranged from 2.3 services per month in the Spokane and Pierce regions to 7.3 in the Salish region. Statewide, the most common service encounter was case management (1.3 per person, per month, on average), followed by outreach services, peer services, and service coordination, all occurring 0.3 times per person, per month, on average (Appendix F, Table 2). In the Thurston-Mason region, the most common service provided was peer services, with enrollees having an average of 2.1 encounters per month.

Referrals

Of the 1,030 FPATH enrollees, 373 (36 percent) received at least one referral for services outside of the FPATH program through June 2025 (Appendix F, Table 2). Among regions where referral data are presented, FPATH enrollees in the Spokane region had the highest rate of referrals, with 59 percent of participants having at least one, followed by 46 percent in the Southwest region, and 33 percent in the Pierce region. In the Phase 2 King region, 24 percent of enrollees had received at least one referral for outside services.

The most common referral program-wide was to FHARPS housing, with 16 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Community mental health referrals were the second most common (12 percent), particularly in the Spokane region where 25 percent of enrollees had at least one referral. As enrollment continues to grow in the Phase 3 regions, detailed referral information will be available in future reporting.

Education and training – crisis intervention training

For all the phased regions through June 30, 2025, the Criminal Justice Training Commission has completed 58 of the 40-hour courses for certified peace officers. Within these classes, CJTC has trained law enforcement officers, mental health professionals, dispatchers, co-responders, military police, and corrections officers. As of June 30, 2025, 3,527 law enforcement officers have completed this training. As of June 30, 2025, 36 percent of Phase 3 officers have completed the 40-hour training. Phase 1 and 2 regions continue to conduct 40-hour CIT training on a regular basis. Eight trainings were completed in Phase 1 and 2 regions in the last six months.

CJTC has developed and deployed a webinar-style eight-hour course, specifically to meet the needs of correctional agencies. Through the combination of the earlier traditional courses and the addition of Clark County's 40-hour program, 1,444 corrections officers have received at least the minimum eight-hour CIT for corrections training.

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

CJTC collaborated with the State 911 office to provide the eight-hour CIT course for dispatchers, which includes the cross-trained corrections officers in Lincoln and Skamania counties. The telecom/911 training was reformatted to a hybrid course comprised of four hours of self-paced online training and a follow-up four-hour instructor-led webinar course. It was also found that several telecom training programs already included the eight-hour CIT materials. Several of these programs applied and were granted equivalency status. Telecom dispatchers are 100 percent compliant in Phase 1 region, 99 percent compliant in the Phase 2 region and already 99 percent compliant in the Phase 3 region.

For Phase 2, the King region continues running a robust 40-hour CIT program. Because of this, of the 3,782 certified peace officers in the King region, 2,147 have completed the training (50 percent). As of June 30, 2025, every police agency in King County (Phase 2) had met or exceeded the mandate of 25 percent of not just officers assigned to patrol but of certified officers assigned to their individual agencies. The King region completed six of the 40-hour CIT courses in the second half of 2024.

The King region has six correctional agencies, encompassing 642 correctional officers. To date, 603 officers (94 percent) have completed the required eight-hour CIT for corrections training. These courses have been offered exclusively in an interactive webinar format.

The three phased regions combined have 1,064 telecom/911 dispatchers. Of these, 1,055 (99 percent) have completed either the hybrid four-hour static/four-hour webinar or equivalent training. At least

two webinar courses are scheduled each month, and the static course can be taken at any time as the prerequisite.

Areas of concern

Present high agency vacancy rates and projected state budget deficits have contributed to challenges for agencies to send officers to a week-long training. Due to low enrollment, CTJC has needed to cancel three classes. CTJC scheduled nine additional 40-hour CIT courses between mid-March 2025 and June 30, 2025, across the Trueblood Phased regions. During the reporting period, CTJC completed the 25-percent-requirement for Phase 3 agencies.

Recommendations to address concerns

CJTC is actively exploring options to mitigate potential disruptions and ensure continuity of training programs. The present legislature has proposed bills to assist in funding for additional officers across the state to mitigate shortages in staffing. CJTC has received approval to continue recruitment for subject matter experts, mental health professionals, and PhD level trainers to assist with instruction for these courses. CJTC is actively communicating with agency administrations to educate them on available training and incentives that are built into these trainings, and will provide updates on our progress as more information becomes available.

Data – education and training – CIT

CJTC monitors training completion rates for law enforcement, correctional officers, and 911 dispatchers through its Learning Management System. Per the Settlement Agreement, at least 25 percent of patrol officers in each law enforcement agency within a Trueblood phased region must complete 40 hours of enhanced CIT training. The Settlement Agreement also requires all correctional officers and 911 dispatchers in these regions to complete an eight-hour CIT course.

Phase 1

Appendix G, Figure 1 displays training completion rates for each law enforcement agency in Phase 1. As of June 30, 2025, 35 of the 53 agencies (66 percent) met or exceeded the 25 percent benchmark. Overall, the training completion rate remained stable compared to Dec. 2024, with 38 percent of all Phase 1 officers meeting or exceeding the 25 percent requirement (Appendix G, Table 1). Rates varied by region: 24 percent in Pierce, 50 percent in Southwest, and 52 percent in Spokane. Washington State Patrol units in the Phase 1 regions had a 29 percent completion rate.

The Settlement Agreement directs that the 25 percent training target should prioritize law enforcement agencies that serve areas with higher population densities. As of June 30, 2025, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (57 percent and 61 percent, respectively) than smaller

agencies. This pattern was not observed in the Pierce region, however, where rates were similar across agency sizes (Appendix G, Table 1). The CIT program achieved 100 percent compliance with the Phase 1 law enforcement training requirement in June 2022. Training rates continue to shift, however, as the number of officers in each agency fluctuates over time.

As of June 30, 2025, 98 percent of 911 dispatchers in Phase 1 regions had completed CIT training, including 99 percent in the Southwest region and full compliance (100 percent) in the Spokane region. In addition, 95 percent of correctional officers in Phase 1 had completed the training, with rates ranging from 87 percent in the Southwest region to 98 percent in the Pierce region (Appendix G, Tables 2 and 3). The CIT program achieved 100 percent compliance with the 911 dispatcher training requirement for Phase 1 in June 2022.

Phase 2

Appendix G, Figure 2 displays the training completion rates for the law enforcement agencies in Phase 2, which began July 1, 2021. As of June 30, 2025, 26 of the 27 agencies (96 percent) had met or exceeded the 25 percent benchmark, with an overall completion rate of 49 percent (Appendix G, Table 1). Training data for the Washington State Patrol units in Phase 2 indicated a training completion rate of 44 percent (not shown in Figure 2, as updated records were received after the reporting deadline). In the King region, small law enforcement agencies had the highest training rate (57 percent) while medium-sized agencies had the lowest (35 percent). Large agencies in densely populated areas had a completion rate of 51 percent.

By June 30, 2025, 94 percent of correctional officers had completed the eight-hour CIT course, along with 99 percent of 911 dispatchers (Appendix G, Tables 2 and 3). Dispatchers and correctional officers in the Phase 2 region were required to reach 100 percent training compliance by June 30, 2023.

Phase 3

Appendix G, Figure 3 displays the training completion rates for the law enforcement agencies in Phase 3, which began on July 1, 2023. As of June 30, 2025, 12 of the 22 agencies (55 percent) had met or exceeded the 25 percent training requirement, with an overall rate of 35 percent. Large law enforcement agencies had a higher proportion of trained officers than small agencies (31 percent versus 23 percent, respectively), and Washington State Patrol units had a training completion rate of 29 percent (Appendix G, Table 1). Rates increased across all agency sizes and for Washington State Patrol compared to the previous reporting period.

CIT rates among correctional officers in Phase 3 increased substantially from 19 percent in Dec. 2024 to 88 percent by June 30, 2025 (Appendix G, Table 2). Training rates among 911 dispatchers in Phase 3 was 90 percent (Appendix G, Table 3). Both dispatchers and correctional officers in these regions had until June 30, 2025, to achieve 100 percent training compliance.

Education and training – jail technical assistance

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

Current status and areas of positive impact

In 2019, the Jail Technical Assistance team worked in collaboration with several entities to create a guidebook of best practices for behavioral health services in a jail setting. The guidebook workgroup included representation from Disability Rights Washington, WASPC, the Washington State Office of the Attorney General, HCA's enhanced peer services program administrator, and representatives from city and county jails both within and outside of Phased regions. The guidebook was completed in 2020 and is available on the DSHS website and has served as a support document for trainings on the topics it covers. In April 2024, staff initiated a revision and update of the guidebook, soliciting feedback from many different subject matter experts and stakeholders. The guidebook has been reviewed by BHHA staff and plaintiffs. Feedback has been received and incorporated, and a final review is in process.

All training topics designated by the Settlement Agreement and the implementation plans have been delivered and are available on the JTA website. These webinar-based learning events continue monthly with robust participation. Many of the training topics are the direct result of information gained through jail visits and through input from participants attending prior events and providing feedback on topics of interest to jails. Per the Phase 3 Implementation Plan, JTA provided 22 statewide training events toward the minimum of twenty required during this phase.

The learning events presented from July 1, 2024, through June 2025, were:

- July 2024: Motivational Interviewing
- August 2024: An Overview of the NGRI Program
- September 2024: University of Washington Psychiatry Consultation Line
- October 2024: Diversion Navigator Program Overview
- November 2024: Statewide Reentry Council Expands to Include County, City, and Tribal Jails
- December 2024: No Event
- January 2025: WSU Rural Jail Project

- February 2025: Olympic Health and Recovery Services
- March 2025: Role of Jail Transition Coordinators, Clark County Jail Reentry Program
- April 2025: Washington Association of Sheriffs and Police Chiefs
- May 2025: Transforming Live in Jails by Using Human Dignity Models
- June 2025: Recovery Navigator Program collaborates with Asotin County Jail

Through outreach and relationship-building efforts, staff have extended the reach of JTA training. Staff have worked toward improving audience engagement by inviting all interested stakeholders to participate in various presentation events and through increasing opportunities for discussion. Staff have also standardized communication avenues for all JTA learning events and initiated a regular resource-sharing email. Throughout the year, JTA staff disseminate relevant information to its 250-plus stakeholder network; this includes articles, free trainings, legislative updates, etc. Additionally, these efforts have helped bring in a broader and more diverse audience, such as representatives from jail leadership-chiefs, directors, commanders, superintendents, lieutenants, captains, and sergeants; correction deputies; mental health professionals; nurses, behavioral health navigators; certified peer counselors; county prosecutors; legal system partners; psychiatrists; diversion specialists; community mental health agency representatives; reentry specialists; case managers; transition specialists; social workers; jail mental health liaisons; designated crisis responders; therapists; community care coordinators; police officers; police chiefs; educational partners; and representatives from WASPC.

Outreach efforts and a regular presence at the WASPC conference also helped foster relationships which led to three significant workgroup invitations: the Washington Jail Commander meetings, the Legislative Joint Jail Standards and Accountability Taskforce meetings, and the Washington State University Rural Jail Project meetings. The Washington Jail Commander meetings occur twice a month and are facilitated by the Washington Association of Sheriffs and Police Chiefs. Representatives from jail leadership and other stakeholders discuss ongoing issues and topics with potential impacts to jails. JTA staff attend to provide updates, keep current on relevant issues, maintain relationships, and gather input on future learning event topics. The Jail Standards and Accountability Taskforce was established to determine if there should be statewide standards and oversight of Washington jails. This group has since completed its task. The WSU Rural Jail Project is funded by a grant from the Vera Institute of Corrections and involves graduate students and professors working with rural jails to identify challenges and assist with making positive changes. JTA staff meet with this group quarterly to discuss progress and share information.

Areas of concern

Previous areas of concern have been addressed. This included enhancing awareness of the JTA program, building stakeholder relationships through varied outreach efforts, developing a resource

library of trainings, and updating the JTA guidebook. Through in-person jail visits, a continued presence at the Washington Association of Sheriffs & Police Chiefs meetings and conference, hosting webinars, and participating in relevant workgroups, JTA has increased awareness of its program as well as significantly increased its network. With regards to developing a resource library of trainings, JTA staff began recording, editing, and posting the JTA Monthly Learning Events to the JTA website so that they can be accessed on-demand. The Best Practices for Behavioral Health Services in Jail Settings guidebook was identified as needing updates and the revision is in its final draft. An area of future focus for the JTA program is to further expand outreach efforts to tribal jails and counties in Trueblood phased areas. Tribal jail participation in the JTA webinar events is low and it would be beneficial to provide additional continued support for counties in the phased areas.

Currently, in-person engagement and collaboration with jails and relevant partners has been curtailed due to recent state budget shortfalls. A reduction in the ability to travel and meet with jail partners in person has a potential impact in maintaining and building strong relationships and collaboration.

Recommendations to address concerns

It is recommended that JTA staff finalize the Best Practices for Behavioral Health Services in Jail Settings guidebook revision and post it online with a communication sent out to all partners. It is also recommended that staff expand outreach efforts to tribal jails in the state and to counties within the phased areas of the Settlement Agreement. To address in-person engagement with jails and community partners, it is recommended that JTA staff:

- Maintain a continued presence at virtual events such as the WASPC weekly meetings.
- Increase participation in partner activities through conducting targeted outreach and requesting time on meeting agendas to provide agency updates, information, and training opportunities.
- Continue to research best practices and jail resources throughout the nation and share the information with the statewide distribution list.
- Work with jails and community partners to share information about their programs through JTA avenues such as monthly webinars and website content.
- Promote the JTA mailbox in which jails and community partners can reach out with questions and concerns.
- Leverage communication opportunities through video conferencing platforms, allowing for visual contact and opportunities to engage with each other in productive and interactive ways. A number of quarterly meetings have been scheduled where participants share and discuss ongoing issues and projects. Microsoft Teams is also being used to advertise and

register participants for JTA events. This has led to a more professional invite and has increased the number of participants.

Data – jail technical assistance

In July 2021, JTA staff began tracking the number of participants in each JTA Monthly Learning Event. During calendar year 2022 and 2023, the average number of participants per event was 16 people. The average number of attendees for calendar year 2024 was 23. From January 2025 to June 2025 the average attendance was 17 with a high of 48 people attending in the month of November. Overall, the number of attendees has increased and reflects JTA's outreach and engagement efforts.

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

In 2024, a review and update of the online training series, Washington's Adult Forensic Mental Health System, was initiated. These modules provide learners with a foundational understanding of our state's forensic mental health system, helping to address the strategic goal of enhancing basic forensic literacy. The modules are:

- Overview of the Trueblood Contempt Settlement Agreement.
- Competency to stand trial.
- Competency restoration.
- Diversion.
- Continuity of care.

This series has been posted on the OFMHS workforce development website, making it available to a variety of system partners, to include jail staff, prosecutors, defenders, judges, law enforcement, educational partners, behavioral health providers, and any/all partners in implementation of Settlement Agreement endeavors.

The foundational source for this training series was the guidebook, The Intersection of Behavioral Health and the Law which was created through a collaborative effort between DSHS and HCA. This workforce training resource addresses history, rules, laws, services, and practices pertaining to forensic mental health. The workforce development team has also initiated an update to the guidebook in parallel with the training series with the addition of a module on civil commitment, to be included in both the guidebook and the online training series. The anticipated completion date for these is in the first quarter of 2026.

Also, in 2024 the workforce development team assembled a workgroup with subject matter experts from both DSHS and HCA to address the Groundswell recommendations from their 2023 report, Views from the Courtroom: Attorney and Judiciary Perceptions of Washington's "Competence to Stand Trial Crisis." This report was based on focus groups and interviews with prosecutors, defense

counsel, and judges in Washington state regarding their perspectives on the continuing increase in demand for pretrial competency services. The four recommendations Groundswell offered suggested looking at opportunities for greater collaboration among a cross-section of public agencies, additional options for restoration, innovations from other states, and working with decision-makers to find solutions.

The workgroup then developed action items to further develop each of the Groundswell elements which included:

- Researching and compiling information on California's initiative to increase volume and access to community services.
- Exploring innovations in states like Colorado and Texas (Harris County).
- Engaging with forensic evaluators from other states.
- Analyzing prosecutorial diversion programs for earlier identification and the relational impacts of housing challenges.
- Studying the inmate exclusion policy under Medicaid.
- Researching long acting injectables.
- Exploring innovative options for staffing in OCRPs and community need-based competency restoration alternatives.

After the team concluded their research and information gathering, they identified 10 areas to focus future efforts on to address the continuing increase in demand for pretrial competency services. These are the goals the 10 areas are working towards:

- Non-court placement decisions.
- The dismissal of charges after competency restoration.
- Establishing outpatient competency restoration as the default restoration service.
- Updating the current language in RCW 10.77.615 requiring forensic navigators to meet clients.
- Making the Medicaid pre-release services under 1115 wavier permanent.
- Expanding housing options for class members.

- Expanding diversion options.
- Removing misdemeanor cases from the competency system.
- Investigating and removing barriers to using long acting injectables.
- Reducing competency referrals through working with prosecutors to prescreen for diversion.

In February 2025, the workforce development team presented this work to leadership and then to all OFMHS staff and continues to engage in opportunities to forward these efforts.

Workforce development staff also continue to be centrally involved in providing guidance and technical assistance statewide with the BHHA telehealth governance committee. This committee focuses on telehealth policy, expanding the use of telehealth for competency evaluations, and providing ongoing support for relevant facilities. The BHHA telehealth governance committee has been successful in creating a community of knowledgeable practitioners and subject matter experts to facilitate the use of technology and the inherent benefits for forensic evaluations. The committee also fosters discussions around prioritization, goals, and future planning. WFD staff are responsible for collecting and compiling data for the telehealth key performance indicators and the site status databases. This committee was established to better meet the needs of expanding telehealth and is tasked with developing and expanding DSHS telehealth capabilities as well as supporting existing infrastructure used by DSHS. The expansion and strengthening of telehealth for applications such as healthcare appointments and forensic assessments provide an alternative method to in-person interaction. This often brings efficiencies pertaining to patient wait times, staff travel, service provider availability and scheduling challenges. The use of this technology for evaluations has helped improve the efficiency with which competency evaluations can be completed.

In the first half of 2025, the telehealth program accomplished several new achievements. In January, the telehealth installation in the Olympic Heritage Behavioral Health facility was completed. In February, the DSHS telehealth installations in the Chelan County Jail and the Skagit County Jail were completed, and staff are currently working with Pierce, Klickitat, and Clark County Jails to install systems in their facilities.

Two of the BHHA telehealth committee key performance indicators that pertain to forensic evaluations are travel miles saved due to using telehealth and an increase in evaluations via telehealth. In the first half of 2025, 64,527 miles were saved, equating to time that evaluators could spend on evaluations instead of driving. Also, in the first half of 2025 2,774 evaluations were completed through telehealth, an increase over the same time period in 2024. The telehealth committee and state IT staff continue to work with county partners as staff troubleshoot various aspects of technology-related issues pertinent to telehealth implementation and sustainment.

WFD continues to build on partnerships and opportunities for collaboration. Some examples are WFD staff's active engagement with the Workforce Training and Education Coordinating Board workgroups, the King County Competency Continuum Workgroup, the BHHA Employee Engagement Workgroup, the Washington State Association of Sheriffs and Police Chiefs, HCA's Division of Behavioral Health and Recovery, DSHS' E-learning Community of Practice, the WSU Rural Jail Project Collaboration, the Southwest Reentry Provider group, the DSHS Digital Access Plan Committee, the BHHA Recruiting, Managing, and Retaining Talent Workgroup, and the King County Behavioral Health Workforce Learning Collaborative.

Workforce development team members continue to lead the delivery of training in support of the New Employee Orientation program for OFMHS staff and are continuing to offer NEO on the first and sixteenth of every month. This ensures minimal time between an employee's first day and OFMHS orientation. This effort is designed to aid in staff retention by welcoming and preparing staff for their new position and orienting new hires statewide to varied aspects of the forensic mental health system, including an overview of the Contempt Settlement Agreement. Early in this year, WFD staff also worked with the OFMHS administrative assistants to provide a new employee orientation specifically tailored to their work.

Workforce development also continues to deliver satisfaction surveys which are delivered to new employees on their 30-day, 90-day, six-month and eleven-month anniversaries. These surveys assist in determining if new staff are well supported in their first year of employment and identify any gaps or issues for OFMHS to address. WFD staff then meet with senior leadership to discuss responses and evaluate strategies for improvement.

In the first half of 2025, OFMHS workforce development staff continued to provide support to hiring managers through one-on-one assistance and by providing information on this topic at leadership meetings. Workforce development also continues to lead the hiring and onboarding committee to keep current with changes and facilitate awareness and adherence to procedural updates. The team also continues to lead the OFMHS mentorship committee and is working to recruit and orient new mentors.

OFMHS workforce development staff also continue to provide training to contracted behavioral health provider staff regarding an orientation to the Breaking Barriers curriculum used in OCRP and completed trainings in March and June 2025. Staff have developed an e-learning version of this training and plan to make it available to contracted OCRP staff for onboarding new staff. Workforce development staff have also completed trainings on attorney client privilege, and enabling accessibility in MS Word, PowerPoint, and Adobe files and have made them available to all staff via the state's Learning Center. The workforce development team also continues to manage the state's Learning Center for OFMHS as well as the OFMHS SharePoint sites.

Areas of concern

A broad challenge regarding workforce development continues to be the ongoing statewide workforce shortages within the field of mental health. Recruiting and retaining staff continues to be an area of focus. State travel restrictions have made these efforts more challenging.

Recommendations to address concerns

To address concerns around workforce shortages within the field of mental health, workforce development staff should continue to engage in the initiatives below that support recruitment and retention efforts.

Enhance external website (supporting recruitment and retention efforts)

Our previous efforts led to a plan to revamp our external-facing website to increase engagement with our intended audience. Staff initiated that plan and continue to add and refresh content on this site.

Promoting careers in behavioral health (supporting recruitment)

It is recommended that staff continue to participate in educational outreach and events, which support recruitment. Due to state travel restrictions, staff should focus on virtual events and ways to connect and engage through online and virtual forums.

Develop trainings for staff (supporting retention)

It is recommended that staff continue supporting the Breaking Barriers training for OCRP staff, continue the work on the Adult Forensic Mental Health System online training, and the navigator case management system training. Workforce development should also continue to work with staff on identifying necessary training and work products that can be developed or converted for uploading to a virtual format. This assists staff with their everyday work and ensures that employees feel supported and well-trained which further aids retention.

Develop current staff (supporting retention)

The OFMHS mentorship program (which workforce development oversees) supports staff and offers professional development and leadership opportunities. The program started accepting applications in early 2024 and continues to be met with positive feedback. It is recommended that staff continue to assess staff development programs such as the OFMHS mentorship program, the peer program, and New Employee Orientation.

Data – workforce development

OFMHS workforce development surveys which are delivered to new employees on their 30-day, 90-day, six-month and eleven-month anniversaries assist us in determining if new staff are well

supported in their first year of employment and identify any gaps or issues to address. Two of the questions that are common to all four surveys are:

- "Thus far the training and communication I have received to meet requirements of my position has been:" (response options are excellent, good, fair, or poor).
- "My overall satisfaction with my job is:" (response options are excellent, good, fair, or poor).

For June 2025's 30-day survey, 22 of 39 staff responding to the first survey question replied excellent, another 14 replied good, two reported fair and one replied poor. For the second question, 24 of 39 staff responding to the survey replied excellent, another 13 replied good, and one each replied fair and poor. For the 90-day survey, 17 of 35 staff responding to the first survey question replied excellent, 15 replied good, two reported fair and one poor. For the second question, 18 of 35 staff responding to the survey replied excellent, 14 replied good, two reported fair and one poor. After 30 days, over 92 percent of new staff responding to the survey felt that they had received good or excellent job-related training and communication, and over 94 percent had good or excellent satisfaction with their job. After 90 days, over 91 percent of new staff responding to the survey felt that they had received good or excellent job-related training and communication, and over 91 percent had good or excellent satisfaction with their job.

Conclusions

Behavioral health transformation is well underway in Washington state. The two-year designated implementation period for Phase 1 of the Settlement Agreement concluded on June 30, 2021. Successful Phase 1 implementation required completion of 137 tasks[13] from the Phase 1 FIP. Each task item was completed and has contributed to the enhanced level of services that remain available to Trueblood class members and other eligible clients in the 10 counties that comprise the three Phase 1 regions. In Phase 2, 92 of 93 task items are complete,[14] with the only exception being the 16-bed crisis facility. The Phase 2 implementation period ran from July 1, 2021, through June 30, 2023. Phase 3 completed June 30, 2025, and all 69 task items for that phase were completed.

State and local providers continue to contend with an enduring nationwide behavioral health workforce shortage. With many vacancies remaining unfilled, persistent high levels of demand for behavioral health services strain the system; however, it does appear likely that criminal courts have processed much of their significant case backlogs built up during the pandemic. In part, these backlogs had fueled ongoing record-high demand for jail-based evaluation services during FY23. Recent services demand data suggest a plateau for some of our competency services, and our performance has improved dramatically over the last two quarters for timely inpatient evaluation and restoration admissions. Additionally, COVID-19's overall impact has lessened as well, but it does remain endemic and present in our facilities among other seasonal illnesses like influenza and RSV that have potential to impact our operations. Progress is strong but also tentative and potentially fragile.

The state remains committed to both implementing the elements of the Settlement Agreement and improving those elements already established in Phases 1, 2, and 3. Phase 1 and 2 programs continue to gain experience serving Trueblood clients, and the more recently implemented Phase 3 programming continues rapidly gaining experience in the field and benefiting from the knowledge already gained from Phase 1 and 2 implementation and operations. Phase 4 implementation began July 1, 2025, and will focus on additional enhancements to the HCA programs while also creating additional opportunities for diversion and enrollment in OCRP by stepping down inpatient levels of care. The initial work in Phase 4 will be discussed in more detail in the next Semi-Annual report.

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

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

Appendix A – Related Resources

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

State Agency Resources:

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

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

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

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

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

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

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

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

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

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

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

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

Workforce Development Program: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/workforce-development-2

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

CUMULATIVE UPDATE

OCRP Dashboard

Outpatient Competency Restoration Program

The Outpatient Competency Restoration Program (OCRP), administered by the Health Care Authority (HCA) through provider contracts, is designed to provide timely and effective outpatient competency restoration services to individuals determined by the court as a) not competent to stand trial and b) appropriate for community-based services to restore competency. The intent of the OCRP is to reduce the number of individuals waiting to receive inpatient competency restoration, provide competency services in a safe and cost-effective environment, and provide the most appropriate level of care. The program was implemented in the following phased approach:

- Phase 1: services began July 2020 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: services began October 2022 in King Region.
- Phase 3: services began April 2024 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

As of June 30, 2025, OCRP enrolled 356 individuals across Phase 1, 2, and 3 regions. Due to small numbers, Phase 3 regions are combined until there are sufficient numbers to report them separately.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2025

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

CONTACTS

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Contents

TABLE 1.

OCRP Participant Characteristics - Phase 1 and 2

CUMULATIVE: July 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	356	100%	93	100%	93	100%	57	100%	92	100%
Among Enrolled Individuals…										
RESTORATION ORDER TYPE (unduplicated)										
Felony	299	84%	72	77%	71	76%	--	--	--	--
Misdemeanor	57	16%	21	23%	22	24%	--	--	--	--
GENDER										
Female	73	21%	--	--	--	--	13	23%	16	17%
Male	257	72%	66	71%	70	75%	44	77%	64	70%
Other/Unknown	26	7%	--	--	--	--	0	0%	12	13%
AGE GROUP										
18-29 yrs	92	26%	26	28%	33	35%	--	--	20	22%
30-49 yrs	193	54%	43	46%	43	46%	32	56%	60	65%
50+ yrs	71	20%	24	26%	17	18%	--	--	12	13%
RACE/ETHNICITY*										
Non-Hispanic White	207	58%	53	57%	64	69%	46	81%	30	33%
Black, Indigenous, and People of Color	127	36%	--	--	--	--	--	--	--	--
Unknown	22	6%	--	--	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	123	35%	46	49%	15	16%	19	33%	32	35%
Unstably Housed	171	48%	27	29%	66	71%	--	--	55	60%
Homeless	46	13%	--	--	11	12%	20	35%	--	--
In a Facility	15	4%	11	12%	--	--	--	--	--	--
Unknown	1	0%	--	--	--	--	--	--	--	--

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

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

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

TABLE 1.

OCRP Participant Characteristics - Phase 3

CUMULATIVE: July 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024* SALISH/THURSTON-MASON	
	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)				
Enrolled	356	100%	21	100%
Among Enrolled Individuals…				
Felony	299	84%	--	--
Misdemeanor	57	16%	--	--
GENDER				
Female			--	--
Male			13	62%
Other/Unknown			--	--
AGE GROUP				
18-29 yrs			--	--
30-49 yrs			15	71%
50+ yrs			--	--
Non-Hispanic White			14	67%
Black, Indigenous, and People of Color			--	--
Unknown			--	--
Stably Housed			11	52%
Unstably Housed			--	--
Homeless			--	--
In a Facility			--	--
Unknown			0	0%

DATA SOURCE: The Navigator Case Management system (NCM) and the Forensic Data System (FDS).
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Race/ethnicity categories will be expanded when there are sufficient numbers to report by region.

TABLE 2.

OCRP Discharges - Phase 1 and 2

CUMULATIVE: July 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
			NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Enrolled			93	100%	93	100%	57	100%	92	100%
Active			--	--	11	12%	--	--	28	30%
Discharged			--	--	82	88%	--	--	64	70%
Charges Dismissed			16		--	--	--	--	--	--
Opined Competent			--	--	36	44%	22	42%	31	48%
Opined Not Competent			--	--	--	--	--	--	--	--
Opined Not Restorable			--	--	0	0%	0	0%	--	--
Returned to Jail			--	--	--	--	0	0%	--	--
Inpatient Medical Care			--	--	0	0%	0	0%	--	--
Inpatient Civil Psychiatric Care			--	--	0	0%	--	--	--	--
Revoked Conditional Release			19	22%	27	33%	16	31%	--	--
Legal Authority Ended			--	--	--	--	0	0%	--	--
Death			--	--	0	0%	--	--	--	--
Other	5	2%	--	--	0	0%	0	0%	--	--
Community			59		49		--	--	41	
Behavioral Health & Treatment Center*			--	--	--	--	0	0%	--	--
State Hospital			--	--	12	15%	16	31%	13	20%
Jail			12	14%	--	--	--	--	--	--
Unknown	21	7%	--	--	12	15%	--	--	--	--
Average Length of Stay in Program (days)			80	N/A	82	N/A	92	N/A	75	N/A

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started July 1, 2020*						PHASE 2 REGION *Started October 31, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
HOUSING STATUS AT PROGRAM DISCHARGE										
Stably Housed			36		25	30%	28	54%	--	--
Unstably Housed			27	31%	18	22%	--	--	35	55%
Homeless			--	--	19	23%	--	--	--	--
In a Facility			--	--	--	--	12	23%	--	--
Unknown/Missing			12	14%	--	--	--	--	--	--

DATA SOURCE: The Navigator Case Management system (NCM).
NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Formerly referred to as resdiential treatment facility for inpatient restoration.

TABLE 2.

OCRP Discharges - Phase 3

CUMULATIVE: July 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024* SALISH/THURSTON-MASON	
	NUMBER	PERCENT	NUMBER	PERCENT
CLIENT STATUS (on last day of reporting period)				
Enrolled	356	100%	21	100%
Active	61	17%	--	--
Discharged	295	83%	--	--
Among Discharged Individuals…				
DISCHARGE REASON				
Charges Dismissed	34	12%	--	--
Opined Competent	112	38%	--	--
Opined Not Competent	16	5%	--	--
Opined Not Restorable	5	2%	0	0%
Returned to Jail	12	4%	--	--
Inpatient Medical Care	2	1%	0	0%
Inpatient Civil Psychiatric Care	15	5%	0	0%
Revoked Conditional Release	78	26%	--	--
Legal Authority Ended	11	4%	--	--
Death	5	2%	0	0%
Other	5	2%	0	0%
DISCHARGE LOCATION				
Community	187	63%	--	--
Behavioral Health & Treatment Center*	6	2%	--	--
State Hospital	45	15%	--	--
Jail	36	12%	--	--
Unknown	21	7%	0	0%
LENGTH OF STAY				
Average Length of Stay in Program (days)	82	N/A	82	N/A

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024* SALISH/THURSTON-MASON	
	NUMBER	PERCENT	NUMBER	PERCENT
HOUSING STATUS AT PROGRAM DISCHARGE				
Stably Housed			--	--
Unstably Housed			--	--
Homeless			--	--
In a Facility			0	0%
Unknown/Missing			--	--

DATA SOURCE: The Navigator Case Management system (NCM).
NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Formerly referred to as resdiential treatment facility for inpatient restoration.

OCRP Definitions

VARIABLE NAME	DEFINITION
ALL TABLES	
Total - All Regions	Includes all Phase 1 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
Phase 3 Regions	Phase 3 Regions, as determined by the Trueblood settlement agreement, listed below.
Salish Region	Kitsap, Jefferson, Clallam Counties.
Thurston-Mason Region	Mason, Thurston Counties.
ENROLLMENT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Individuals assessed and enrolled into OCRP during the reporting period.
Restoration Order Type	Restoration order type, based on most serious charge of first competency period orders (including concurrent orders). An individual with both a misdemeanor and felony competency restoration order is counted as a felony restoration order.
Misdemeanor	Restoration order with one or more misdemeanor charges as specified in RCW 9a.20.
Felony	Restoration order with one or more felony charges as specified in RCW 9a.20.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on participant self-report. Non-Hispanic White and Black, Indigenous, and People of Color categories are mutually exclusive.
Non-Hispanic White	Participants who identify as White and non-Hispanic.
Black, Indigenous, and People of Color	Participants who identify as American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, Other race, Hispanic or Latino.
Unknown	Participants for whom race/ethnicity information was not reported.
Housing Status at Program Enrollment	Self-reported housing status at time of program enrollment.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.

VARIABLE NAME	DEFINITION
In a Facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program enrollment.
DISCHARGE TABLE, Cumulative	
Participant Status (on last day of reporting period)	Participant program enrollment status.
Active	Participants enrolled during the reporting period and still active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Discharge Reason	Reason the program ended for participant. Providers are limited to one dropdown option. Table reflects this selection.
Charges Dismissed	Participant charges were dismissed by court order; program has no legal authority to retain participant in the program.
Opined Competent	Evaluator opined the participant competent to stand trial.
Opined Not Competent	Evaluator opined the participant not competent to stand trial but possibly restorable.
Opined Not Restorable	Evaluator opined the participant not competent to stand trial and not restorable.
Returned to Jail	Participant returned to jail and there is no expectation that they would return to the program. Used if 'returned to jail' was the only reason for program end.
Inpatient Medical Care	Participant admitted to a medical hospital due to a serious medical condition and there is no expectation the participant will return, or participant did not return from a Leave of Absence for inpatient medical care.
Inpatient Civil Psychiatry Care	Participant admitted voluntarily or involuntarily to an inpatient psychiatric facility (community or state hospital) due to grave disability and/or danger to self or others (e.g., participant is at risk of suicide or homicide) with no expection the participant will return, or participant did not return from a Leave of Absence for inpatient psychiatric care.
Revoked Conditional Release	Court revoked conditional release order.
Death	Participant passed away while in the program.
Missing/Unknown	Discharge reason is sometimes unknown by providers at time of discharge and left blank in excel trackers. Providers are encouraged to update this field when a reason is determined.
Discharge Location	Location of participant at time of program end.
Community	Participant was not in a facility at the time of discharge. Some participants may be pending inpatient treatment.
Behavioral Health & Treatment Center	Maple Lane, Yakima, and Steilacoom competency restoration facilities. Previously referred to as Residential Treatment Facilities (RTFs). Yakima Competency Restoration Program closed in August 2021. Maple Lane Campus - Cascade Unit closed for competency restoration patients in June 2024.
State Hospital	Western and Eastern State Hospitals.
Jail	County, city, or tribal jail facility.
Unknown	Discharge location unknown.
Length of Stay	Length of stay at time of program end.
Average Length of Stay in Program (days)	The average (mean) length of stay, in days, from the most recent OCRP enrollment date to OCRP discharge date, among participants discharged. Leaves of absence from the program are excluded.

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

Appendix C – Forensic Navigator Dashboard

Forensic Navigator Dashboard

Behavioral Health and Habilitation Administration

Forensic Navigator Program

CUMULATIVE UPDATE

The Forensic Navigator Program, administered by the Behavioral Health and Habilitation Administration (BHHA), is designed to support individuals navigating the state's community-based competency evaluation services and outpatient restoration programs. The program was implemented in the following phased approach:

- Phase 1: services began July 2020 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: services began January 2022 in King Region.
- Phase 3: Services began April 2024 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

As of June 30, 2025, the Forensic Navigator Program served 9,760 individuals across Phases 1, 2, and 3 regions. An online Power BI report provides both quarterly and cumulative data that can be broken down by region to track program data and illustrate trends. The data presented here represents selected figures and tables from this Power BI report. The full report, including all data and definitions, can be accessed online here*.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2025

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

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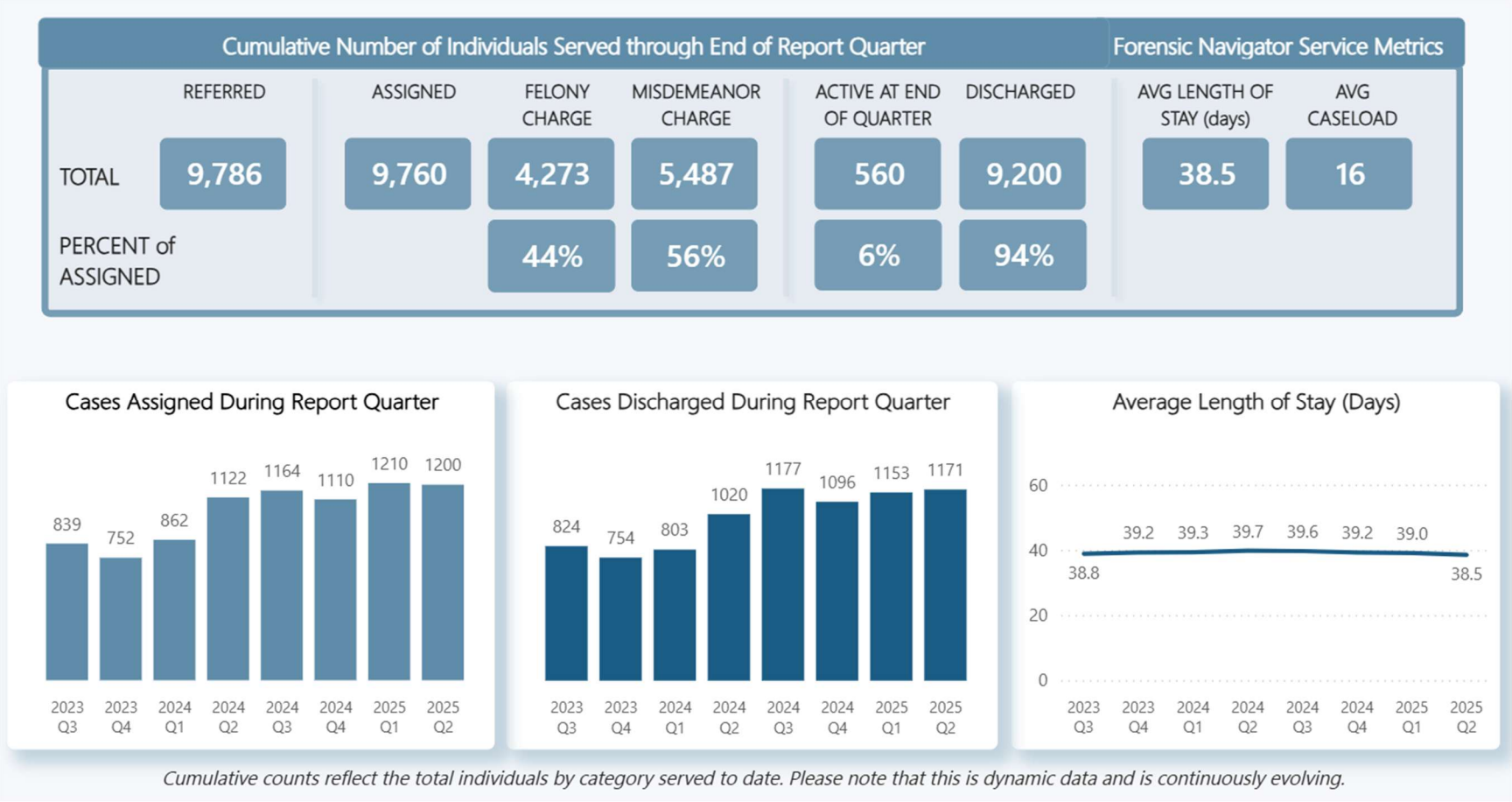
Contents

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

Figure 1.

Forensic Navigator Program Measures

Enrollment Summary



Cumulative counts reflect the total individuals by category served to date. Please note that this is dynamic data and is continuously evolving.

Figure 2.

Forensic Navigator Program Measures
Case Status

Active Case Status at End of Quarter (Last Day of Report Period)

Case Status	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4	2025 Q1	2025 Q2
Active	135	168	148	334	383	372	379	332	378	388	370	417	496	446	443	505	560
Pre-Competency Hearing	125	155	135	318	367	342	339	289	325	334	325	364	440	403	387	433	448
OCRP Enrolled	8	10	11	12	12	19	25	24	30	31	19	30	27	29	31	39	56
Post OCRP	2	3	2	4	3	3	5	7	2	2	9	6	7	4	6	6	4
Reassess for OCRP	0	0	0	0	1	8	9	8	10	17	8	11	11	6	15	21	45
In Process of OCRP Removal	0	0	0	0	0	0	1	4	11	4	9	6	11	4	4	6	7

Figure 3.

Forensic Navigator Program Measures
Caseload by Region

Average Daily Caseload per Navigator by Region

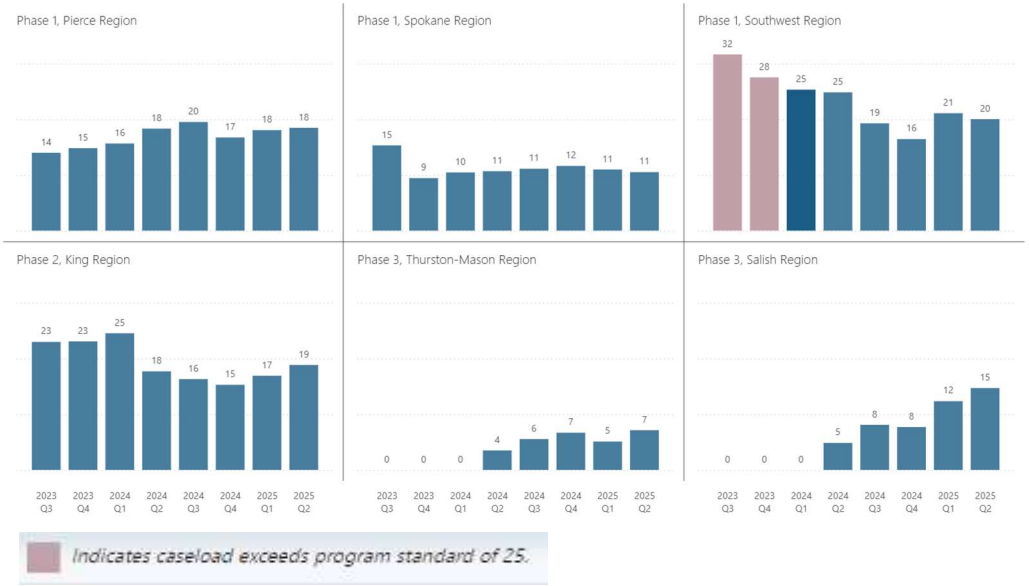


Table 1.

Forensic Navigator Program Measures
Cumulative Counts of Participant Demographics by Region

Region	Pierce Region		Spokane Region		Southwest Region		King Region		Thurston-Mason Region		Salish Region		Total	
Category	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age														
18-29	465	24%	343	22%	293	25%	922	21%	56	16%	35	13%	**2,114**	**22%**
30-49	1,077	55%	846	55%	647	55%	2,506	56%	205	57%	160	58%	**5,441**	**56%**
50+	433	22%	342	22%	238	20%	1,013	23%	97	27%	82	30%	**2,205**	**23%**
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	**0**	**0%**
Gender														
Female	437	22%	395	26%	262	22%	950	21%	107	30%	77	28%	**2,228**	**23%**
Male	1,311	66%	1,105	72%	812	69%	2,856	64%	237	66%	177	64%	**6,498**	**67%**
Other/Unknown	227	11%	31	2%	104	9%	635	14%	14	4%	23	8%	**1,034**	**11%**
Race-Ethnicity														
American Indian or Alaska Native	42	2%	48	3%	*		73	2%	*		*		**182**	**2%**
Asian	70	4%	20	1%	40	3%	226	5%	*		*		**372**	**4%**
Black or African American	500	25%	126	8%	131	11%	1,267	29%	39	11%	31	11%	**2,094**	**21%**
Hispanic or Latino	41	2%	20	1%	45	4%	227	5%	*		*		**351**	**4%**
Native Hawaiian or Pacific Islander	66	3%	*		23	2%	46	1%	*		*		**149**	**2%**
Other Race	28	1%	13	1%	33	3%	202	5%	13	4%	12	4%	**301**	**3%**
Unknown	287	15%	171	11%	170	14%	822	19%	29	8%	22	8%	**1,501**	**15%**
White Only, Non-Hispanic	967	49%	1,130	74%	740	63%	1,701	38%	247	69%	199	72%	**4,984**	**51%**

Figure 4.

Forensic Navigator Program Measures
Services

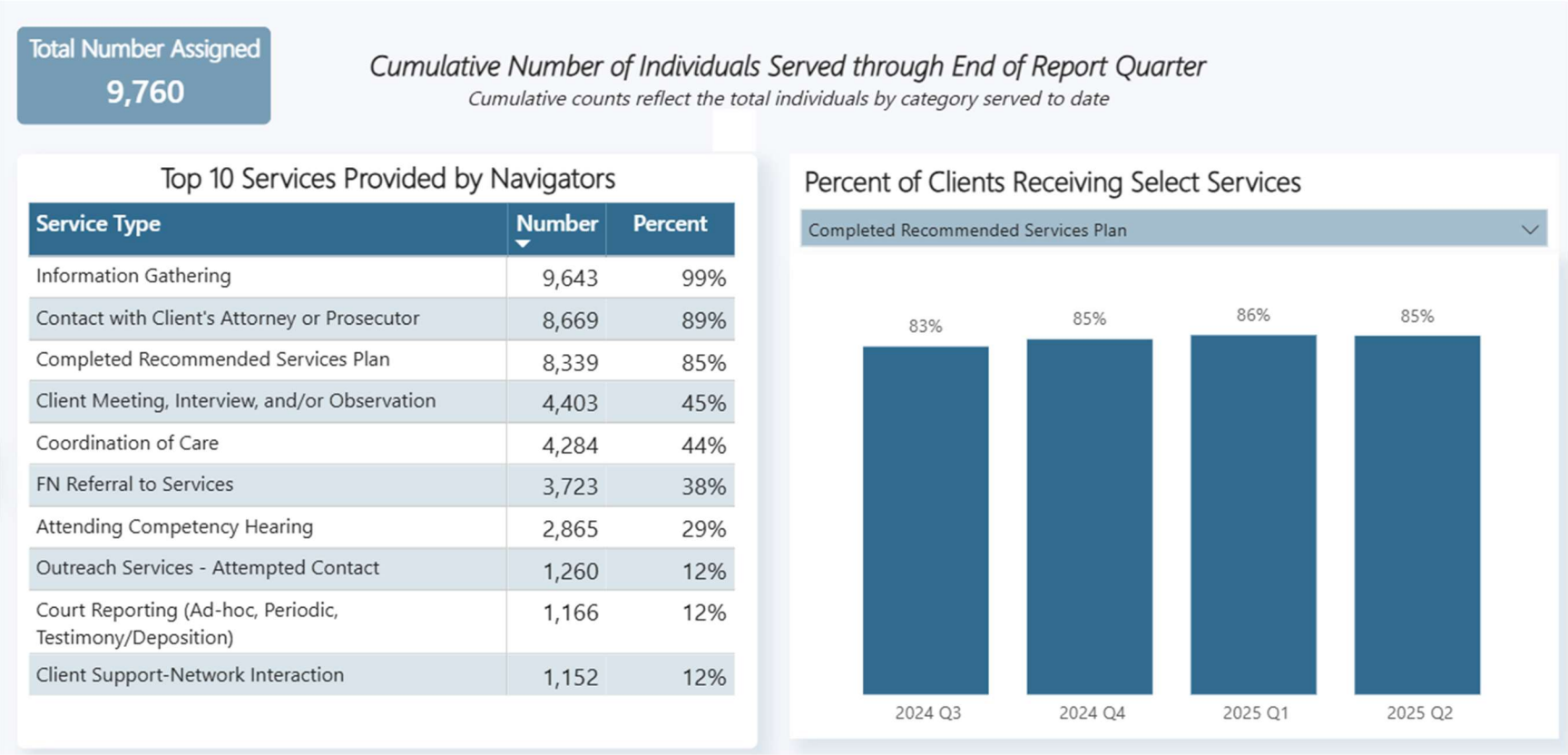


Figure 5.

Forensic Navigator Program Measures
Referrals

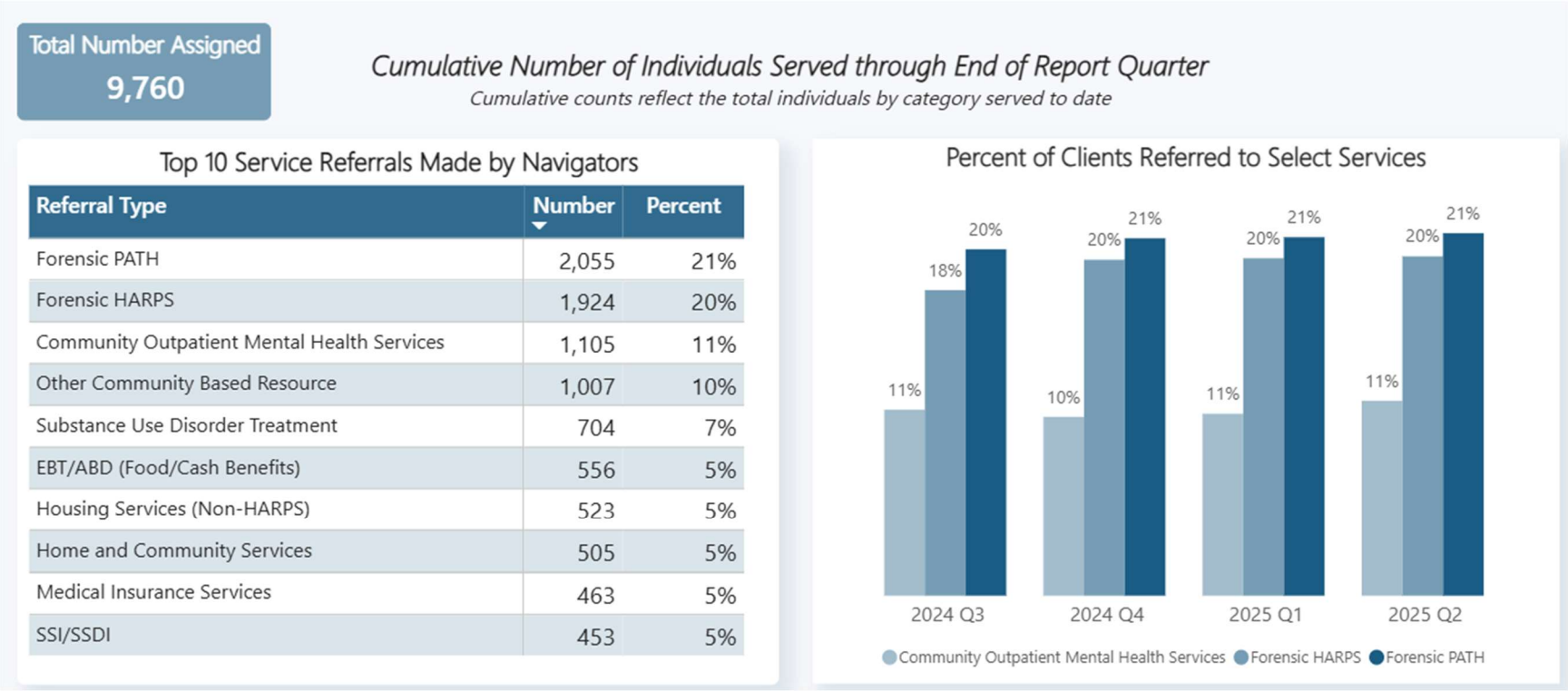


Table 2.

Forensic Navigator Program Measures

Discharges

Number of Clients Discharged	Number with Warm Hand-Off	Percent with Warm Hand-Off	Average Length of Stay (days)
9,200	2,763	30%	38.5

Discharge Reason	Number	% Discharged
Client Determined Competent	2,581	28%
Released From Jail on Personal Recognizance (PR)	2,051	22%
Inpatient Restoration	2,004	22%
Charges Dismissed	1,496	16%
Dismiss & Refer (to Designated Crisis Responder)	436	5%
Order Cancelled or Withdrawn	222	2%
Refused Forensic Navigator Program Services	123	1%
Successful OCRP Completion - Coordinated Transition Completed	65	1%
Not Restorable - Pre-Hearing/OCRP	36	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	33	0%
Felony (Up to 120 Hours) Civil Conversion	31	0%
Felony (Up to 120 Hours) Civil Conversion - FN Completed Warm Hand Off	27	0%
Client Death	19	0%
Civil Conversion - Removal from OCRP	11	0%
Not Restorable - Developmental Disability	11	0%

Appendix D – Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Crisis Housing Voucher Disbursals

CUMULATIVE UPDATE

The Crisis Housing Voucher component of the Trueblood Settlement Agreement, administered by the Health Care Authority (HCA) through contracted funds for select crisis triage and stabilization facilities, is designed to provide crisis housing vouchers for individuals leaving a facility without housing. To better meet community needs, contracts were expanded to allow teams to distribute vouchers outside crisis triage and stabilization facilities. Vouchers became available in the following phased approach:

- Phase 1: services began December 2019 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: services began July 2022 in King Region.
- Phase 3: services began January 2024 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

As of June 30, 2025, 1,233 vouchers were issues to 905 individuals across Phase 1, 2, and 3 regions. Due to small numbers, Phase 3 regions are combined until there are sufficient numbers to report them separately.

REPORTING PERIOD

Cumulative: December 1, 2019 to June 30, 2025

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.

Crisis Housing Vouchers - Phase 1 and 2

CUMULATIVE: December 1, 2019 to June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started December 1, 2019*						PHASE 2 REGION *Started July 1, 2022*	
			PIERCE*		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY										
Vouchers Disbursed	1,223	100%	135	11%	369	30%	275	22%	412	34%
Recipients (unduplicated)	905	100%	130	14%	279	31%	164	18%	310	34%
Total Amount Disbursed	$1,043,368	N/A	$171,163	N/A	$402,971	N/A	$238,856	N/A	$214,752	N/A
Average Amount Per Recipient	$1,153	N/A	$1,317	N/A	$1,444	N/A	$1,456	N/A	$693	N/A
REFERRAL SOURCE										
Crisis Call Center	3	0%	0	0%	--	--	--	--	0	0%
Family/Friend	15	2%	--	--	--	--	0	0%	--	--
Hospital	154	17%	51	39%	30	11%	63	38%	--	--
Mobile Crisis Response	42	5%	--	--	--	--	37	23%	--	--
Designated Crisis Responder	49	5%	0	0%	0	0%	43	26%	--	--
Tribe or Indian Healthcare Provider	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Responder	9	1%	--	--	--	--	0	0%	--	--
Community Behavioral Health Agency	83	9%	--	--	28	10%	--	--	32	10%
Other Healthcare Provider	13	1%	--	--	--	--	--	--	--	--
Law Enforcement (Police, Co-Responders)	152	17%	14	11%	0	0%	--	--	131	42%
Court/Criminal Justice Referred	45	5%	--	--	--	--	--	--	43	14%
Self	269	30%	31	24%	200	72%	--	--	36	12%
Other	71	8%	21	16%	--	--	--	--	42	14%
GENDER										
Female	300	33%	32	25%	--	--	--	--	--	--
Male	578	64%	--	--	176	63%	107	65%	194	63%
Other/Unknown	27	3%	--	--	--	--	--	--	--	--
AGE GROUP										
18-29	181	20%	--	--	52	19%	--	--	64	21%
30-49	495	55%	--	--	158	57%	90	55%	174	56%
50+	229	25%	35	27%	69	25%	--	--	72	23%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started December 1, 2019*						PHASE 2 REGION *Started July 1, 2022*	
			PIERCE*		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Non-Hispanic White	530	59%	71	55%	208	75%	103	63%	131	42%
Black, Indigenous, and People of Color	330	36%	--	--	--	--	44	27%	158	51%
Unknown	45	5%	--	--	--	--	17	10%	21	7%
Among Voucher Recipients…										
Referred to FHARPS			30	23%	35	13%	68	41%	--	--
Contacted by FHARPS staff			27	21%	30	11%	64	39%	--	--
Enrolled in FHARPS			25	19%	29	10%	64	39%	--	--
Housed or sheltered by FHARPS			21	16%	26	9%	55	34%	--	--
FIRST FHARPS HOUSING TYPE*										
Permanent			--	--	--	--	--	--	--	--
Transitional			--	--	--	--	18	33%	--	--
Shelter/emergency			--	--	14	54%	30	55%	--	--
Other			0	0%	--	--	--	--	0	0%

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

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

*Pierce Region data are missing up to approximately three weeks of data due to RI International not submitting their final excel tracker.

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

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

TABLE 1.

Crisis Housing Vouchers - Phase 3

CUMULATIVE: December 1, 2019 to June 30, 2025

	TOTAL - ALL REGIONS	PHASE 3 REGIONS *Started January 1, 2024* SALISH/THURSTON-MASON	
		NUMBER	PERCENT
Vouchers Disbursed		32	3%
Recipients (unduplicated)		22	2%
Total Amount Disbursed		$15,626	N/A
Average Amount Per Recipient		$710	N/A
REFERRAL SOURCE			
Crisis Call Center		0	0%
Family/Friend		0	0%
Hospital		--	--
Mobile Crisis Response		--	--
Designated Crisis Responder		--	--
Tribe or Indian Healthcare Provider		0	0%
Emergency Responder		0	0%
Community Behavioral Health Agency		13	59%
Other Healthcare Provider		--	--
Law Enforcement (Police, Co-Responders)		--	--
Court/Criminal Justice Referred		0	0%
Self		--	--
Other		0	0%
Female		--	--
Male		--	--
Other/Unknown		--	--
AGE GROUP			
18-29		--	--
30-49		--	--
50+		--	--

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started January 1, 2024* SALISH/THURSTON-MASON	
	NUMBER	PERCENT	NUMBER	PERCENT
RACE/ETHNICITY**				
Non-Hispanic White	530	59%	17	77%
Black, Indigenous, and People of Color	330	36%	--	--
Unknown	45	5%	--	--
Among Voucher Recipients…				
FORENSIC HARPS (FHARPS) STATUS***				
Referred to FHARPS	150	17%	--	--
Contacted by FHARPS staff	132	15%	--	--
Enrolled in FHARPS	128	14%	--	--
Housed or sheltered by FHARPS	109	12%	--	--
Among Individuals Housed or Sheltered by FHARPS…				
FIRST FHARPS HOUSING TYPE*				
Permanent			--	--
Transitional			--	--
Shelter/emergency			0	0%
Other			0	0%

DATA SOURCE: Excel trackers submitted to the Washington State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage system (PDAMS), which became available November 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. N/A is not applicable. Counts and percentages may not sum due to unreported data and/or rounding. Cells with '--' are suppressed to protect confidentiality.
*Pierce Region data are missing up to approximately three weeks of data due to RI International not submitting their final excel tracker.
**Race/ethnicity categories will be expanded when there are sufficient numbers to report by region.
***Not all voucher recipients are eligible for FHARPS, and may be referred to other housing resources not captured in the data.

Crisis Housing Voucher Definitions

Variable name	DESCRIPTION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
Phase 3 Regions	Phase 3 Regions, as determined by the Trueblood settlement agreement, listed below.
Salish Region	Kitsap, Jefferson, Clallam Counties.
Thurston-Mason Region	Mason, Thurston 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.
Referral Source	Source that referred the individual to the crisis triage and stabilization facility or to teams contracted to distribute vouchers.
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).
Community Behavioral Health Agency	Organization that provides behavioral health services within a specified locality.
Other Healthcare Provider	A healthcare provider not included in the other category options.

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

Appendix E – FHARPS Dashboard

FHARPS Dashboard

Forensic Housing and Recovery Through Peer Services

CUMULATIVE UPDATE

Forensic Housing and Recovery Through Peer Services (FHARPS), administered by the Health Care Authority (HCA) through provider contracts, is designed to provide residential support to unstably housed individuals with former or current involvement with the forensic mental health system, or individuals at risk of becoming involved in the system due to mental health needs. The program was implemented in the following phased approach:

- Phase 1: services began March 2020 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: services began April 2022 in King Region.
- Phase 3: services began April 2024 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

As of June 30, 2025, FHARPS enrolled 1,422 individuals across Phase 1, 2, and 3 regions.

REPORTING PERIOD

Cumulative: March 1, 2020 to June 30, 2025

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

CONTACTS

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Contents

TABLE 1.

FHARPS Enrollment and Participant Characteristics - Phase 1 and 2

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Referred	3,143	100%	922	100%	494	100%	495	100%	1,000	100%
Contacted	1,700	54%	613	66%	412	83%	254	51%	298	30%
Enrolled	1,422	45%	445	48%	380	77%	248	50%	251	25%
Among Referred Individuals…										
REFERRAL SOURCE										
Trueblood partner programs	2,232	71%	434	47%	329	67%	362	73%	896	90%
Forensic Navigator	*1,618*	*51%*	*230*	*25%*	*256*	*52%*	*123*	*25%*	*879*	*88%*
Forensic PATH	*392*	*12%*	*133*	*14%*	*38*	*8%*	*141*	*28%*	*14*	*1%*
OCRP	*45*	*1%*	*16*	*2%*	--	--	*20*	*4%*	--	--
Crisis Stabilization Center	*156*	*5%*	*48*	*5%*	*32*	*6%*	*67*	*14%*	*0*	*0%*
Co-Response Team	*21*	*1%*	--	--	--	--	*11*	*2%*	*0*	*0%*
Mobile Crisis Response	6	0%	--	--	0	0%	--	--	0	0%
Diversion Navigator	25	1%	0	0%	0	0%	--	--	19	2%
Behavioral Health Facility - Outpatient	314	10%	144	16%	109	22%	57	12%	--	--
Inpatient Facility	70	2%	46	5%	--	--	12	2%	--	--
Family/Self	73	2%	34	4%	--	--	16	3%	21	2%
Other	423	13%	263	29%	47	10%	44	9%	61	6%
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT										
Phone	430	25%	228	37%	160	39%	31	12%	--	--
Court	4	0%	--	--	--	--	0	0%	0	0%
Hotel/Motel	40	2%	31	5%	--	--	--	--	0	0%
Jail	610	36%	104	17%	194	47%	39	15%	220	74%
Crisis Stabilization Center	68	4%	14	2%	--	--	49	19%	0	0%
Behavioral Health Facility - Outpatient	215	13%	76	12%	35	8%	83	33%	11	4%
Inpatient Facility	70	4%	23	4%	--	--	13	5%	--	--
Shelter	23	1%	15	2%	0	0%	--	--	0	0%
Street/encampment	16	1%	12	2%	--	--	--	--	0	0%
Temporary Residence	14	1%	--	--	--	--	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Other	210	12%	103	17%	--	--	28	11%	54	18%
Among Enrolled Individuals…										
PARTICIPANT STATUS (on last day of reporting period)										
Active	416	29%	109	24%	86	23%	67	27%	96	38%
Discharged	1,006	71%	336	76%	294	77%	181	73%	155	62%
GENDER										
Female	401	28%	--	--	92	24%	--	--	52	21%
Male	948	67%	275	62%	267	70%	180	73%	170	68%
Other/Unknown	73	5%	--	--	21	6%	--	--	29	12%
AGE GROUP										
18-29	313	22%	115	26%	97	26%	39	16%	53	21%
30-49	848	60%	219	49%	233	61%	163	66%	166	66%
50+	261	18%	111	25%	50	13%	46	19%	32	13%
RACE/ETHNICITY*										
American Indian or Alaska Native	85	6%	30	7%	31	8%	20	8%	--	--
Asian	27	2%	--	--	--	--	--	--	--	--
Black or African American	290	20%	158	36%	45	12%	37	15%	48	19%
Hispanic or Latino	124	9%	47	11%	38	10%	23	9%	14	6%
Native Hawaiian or Pacific Islander	17	1%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	611	43%	194	44%	176	46%	164	66%	39	16%
Other Race	74	5%	18	4%	42	11%	--	--	--	--
Unknown	297	21%	22	5%	74	19%	--	--	139	55%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Unstably Housed			120	27%	223	59%	62	25%	171	68%
Homeless			325	73%	157	41%	186	75%	80	32%

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. Individuals may report more than one race/ethnicity.

TABLE 1.

FHARPS Enrollment and Participant Characteristics - Phase 3

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)						
Referred	3,143	100%	126	100%	106	100%
Contacted	1,700	54%	67	53%	56	53%
Enrolled	1,422	45%	66	52%	32	30%
Among Referred Individuals…						
REFERRAL SOURCE						
Trueblood partner programs	2,232	71%	121	96%	90	85%
Forensic Navigator	*1,618*	*51%*	*93*	*74%*	*37*	*35%*
Forensic PATH	*392*	*12%*	*24*	*19%*	*42*	*40%*
OCRP	*45*	*1%*	--	--	--	--
Crisis Stabilization Center	*156*	*5%*	--	--	--	--
Co-Response Team	*21*	*1%*	--	--	*0*	*0%*
Mobile Crisis Response	6	0%	0	0%	--	--
Diversion Navigator	25	1%	--	--	--	--
Behavioral Health Facility - Outpatient	314	10%	--	--	--	--
Inpatient Facility	70	2%	0	0%	--	--
Family/Self	73	2%	--	--	0	0%
Other	423	13%	--	--	--	--
Among Contacted Individuals…						
LOCATION OF INITIAL CONTACT						
Phone	430	25%	0	0%	--	--
Court	4	0%	0	0%	--	--
Hotel/Motel	40	2%	0	0%	--	--
Jail	610	36%	32	48%	21	38%
Crisis Stabilization Center	68	4%	0	0%	--	--
Behavioral Health Facility - Outpatient	215	13%	--	--	--	--
Inpatient Facility	70	4%	24	36%	--	--
Shelter	23	1%	--	--	--	--
Street/encampment	16	1%	0	0%	--	--
Temporary Residence	14	1%	0	0%	--	--

	TOTAL - ALL REGIONS	PHASE 3 REGIONS *Started April 30, 2024*			
		THURSTON-MASON		SALISH	
		NUMBER	PERCENT	NUMBER	PERCENT
Other		--	--	--	--
Among Enrolled Individuals…					
Active		37	56%	21	66%
Discharged		29	44%	11	34%
GENDER					
Female		--	--	--	--
Male		40	61%	16	50%
Other/Unknown		--	--	--	--
AGE GROUP					
18-29		--	--	--	--
30-49		47	71%	20	63%
50+		--	--	--	--
RACE/ETHNICITY*					
American Indian or Alaska Native		--	--	--	--
Asian		0	0%	0	0%
Black or African American		--	--	--	--
Hispanic or Latino		--	--	--	--
Native Hawaiian or Pacific Islander		0	0%	0	0%
White Only, Non-Hispanic		22	33%	16	50%
Other Race		0	0%	0	0%
Unknown		42	64%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT					
Unstably Housed		--	--	--	--
Homeless		--	--	--	--

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.
*Race/ethnicity will sum to more than 100 percent because the groups are not mutually exclusive, with the exception of White Only, Non-Hispanic. Individuals may report more than one race/ethnicity.

TABLE 2.

FHARPS Housing Support - Phase 1 and 2

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)										
Enrolled	1,422	100%	445	100%	380	100%	248	100%	251	100%
Housed or Sheltered	966	68%	388	87%	195	51%	189	76%	156	62%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies only	58	4%	15	3%	0	0%	26	10%	--	--
Support Services and Subsidies	1,364	96%	430	97%	380	100%	222	90%	249	99%
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	75	8%	45	12%	--	--	--	--	--	--
Transitional	432	45%	171	44%	61	31%	50	26%	142	91%
Shelter/emergency	440	46%	172	44%	124	64%	127	67%	--	--
Other	19	2%	0	0%	--	--	--	--	--	--

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

TABLE 2.

FHARPS Housing Support - Phase 3

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION (unduplicated)						
Enrolled	1,422	100%	66	100%	32	100%
Housed or Sheltered	966	68%	24	36%	14	44%
Among Enrolled Individuals…						
SERVICES PARTICIPANT AGREED TO						
Subsidies only	58	4%	13	20%	--	--
Support Services and Subsidies	1,364	96%	53	80%	30	94%
Among Housed/Sheltered Individuals…						
FIRST HOUSING TYPE						
Permanent	75	8%	--	--	--	--
Transitional	432	45%	--	--	--	--
Shelter/emergency	440	46%	--	--	--	--
Other	19	2%	--	--	--	--

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

TABLE 3.

FHARPS Discharges - Phase 1 and 2

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 12, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS										
Enrolled	1,422	100%	445	100%	380	100%	248	100%	251	100%
Active (on last day of reporting period)	416	29%	109	24%	86	23%	67	27%	96	38%
Discharged (during reporting period)	1,006	71%	336	76%	294	77%	181	73%	155	62%
Among Individuals Discharged…										
SUBSIDY										
Average total subsidy since enrollment	$4,564	N/A	$6,609	N/A	$4,464	N/A	$4,279	N/A	$1,679	N/A
DISCHARGE REASON										
Transitioned to other housing support	129	13%	97	29%	--	--	22	12%	--	--
Received maximum subsidy	24	2%	*13*	*4%*	--	--	--	--	--	--
Did not receive maximum subsidy	105	10%	*84*	*25%*	--	--	--	--	--	--
Transitioned to self-support	111	11%	47	14%	35	12%	22	12%	--	--
Admitted to a facility	95	9%	--	--	29	10%	32	18%	--	--
Received maximum assistance (no transition)	74	7%	27	8%	33	11%	13	7%	--	--
Withdrew	140	14%	32	10%	44	15%	21	12%	40	26%
Loss of contact	324	32%	65	19%	114	39%	56	31%	78	50%
Served by another FHARPS team	3	0%	--	--	--	--	--	--	0	0%
Other	130	13%	56	17%	37	13%	15	8%	17	11%
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	217	N/A	243	N/A	201	N/A	268	N/A	159	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	283	28%	151	45%	66	22%	46	25%	14	9%
Unstably Housed	69	7%	25	7%	28	10%	--	--	--	--
Homeless	160	16%	45	13%	21	7%	--	--	74	48%
In a Facility	142	14%	17	5%	42	14%	55	30%	--	--
Unknown	352	35%	98	29%	137	47%	56	31%	50	32%

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

TABLE 3.

FHARPS Discharges - Phase 3

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PARTICIPANT STATUS						
Enrolled	1,422	100%	66	100%	32	100%
Active (on last day of reporting period)	416	29%	37	56%	21	66%
Discharged (during reporting period)	1,006	71%	29	44%	11	34%
Among Individuals Discharged…						
SUBSIDY						
Average total subsidy since enrollment	$4,564	N/A	$171	N/A	$1,690	N/A
DISCHARGE REASON						
Transitioned to other housing support	129	13%	--	--	--	--
Received maximum subsidy	24	2%	*0*	*0%*	*0*	*0%*
Did not receive maximum subsidy	105	10%	--	--	--	--
Transitioned to self-support	111	11%	--	--	--	--
Admitted to a facility	95	9%	--	--	--	--
Received maximum assistance (no transition)	74	7%	--	--	--	--
Withdrew	140	14%	--	--	--	--
Loss of contact	324	32%	--	--	--	--
Served by another FHARPS team	3	0%	0	0%	0	0%
Other	130	13%	--	--	--	--
LENGTH OF SUPPORT						
Average Length of Stay in Program (days)	217	N/A	97	N/A	129	N/A
HOUSING STATUS AT DISCHARGE						
Stably Housed	283	28%	--	--	--	--
Unstably Housed	69	7%	--	--	--	--
Homeless	160	16%	--	--	--	--
In a Facility	142	14%	--	--	--	--
Unknown	352	35%	--	--	--	--

DATA SOURCE: Excel trackers submitted to the WA State Health Care Authority (HCA) and HCA's Program Data Acquisition Management and Storage System (PDAMS) starting August 2023.
NOTES: See 'Definitions' for more detailed information on each reporting category. Cells with '--' are suppressed to protect confidentiality. Counts and percentages may not sum due to unreported data and/or rounding.

FHARPS Definitions

VARIABLE NAMES	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
Phase 3 Regions	Phase 3 Regions, as determined by the Trueblood settlement agreement, listed below.
Salish Region	Kitsap, Jefferson, Clallam Counties.
Thurston-Mason Region	Mason, Thurston 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 activities.
Forensic Navigator	Staff from the Forensic Navigator program, a program that seeks to divert forensically-involved criminal defendants out of jails and inpatient treatment settings, and into community-based treatment settings.
Forensic PATH	Staff from a Forensic Projects for Assistance in Transition from Homelessness (PATH), a program that connects people to treatment and recovery services.
OCRP	Staff from an Outpatient Competency Restoration Program (OCRP), a program that helps defendants achieve the ability to participate in his or her own defense in a community-based setting.
Crisis Stabilization Center	Staff from a Crisis Stabilization Center that provides services to adults who are experiencing a mental health crisis, or who are in need of withdrawal management services, and helps them restore and stabilize their health.
Mobile Crisis Response	Staff from a Mobile Crisis Response team providing community services to individuals experiencing, or are at imminent risk of experiencing, a behavioral health crisis.
Co-Response Team	Staff from a Co-Responder or Co-Deployment team, made up of law enforcement and mental health staff to professionally, humanely, and safely respond to crises involving persons with behavioral health issues.
Behavioral Health Facility - Outpatient	Staff from a Community behavioral health agency that provides outpatient mental health or substance use services (outside of others listed here, e.g., FPATH and OCRP); excludes Crisis Stabilization Center.
Inpatient Facility	Staff from an Inpatient facility providing treatment for mental health, substance use, or medical needs; exclude crisis stabilization centers and outpatient services.

VARIABLE NAMES	DEFINITION
Family/Self	Family member or guardian of participant referral, or participant initiated contact. May include cases in which family or participant contacted FHARPS after receiving referral information from another source.
Other	Other referral sources not listed as a referral source option, including non-government organizations offering support and recovery services.
Location of Initial Contact	Point of initial contact between participant and FHARPS staff.
Phone	Telephone conversation not including voicemail messages.
Court	Superior, District, or Municipal Court within the region.
Hotel/Motel	Establishment for lodging on a short-term basis.
Jail	County, city, or tribal correctional facility.
Crisis Stabilization Center	A short-term residential stabilization service for individuals with mental health and/or substance use disorders.
Behavioral Health Facility - Outpatient	A community behavioral health agency that provides outpatient mental health or substance use services; excludes Crisis Stabilization Center.
Inpatient Facility	Any inpatient facility providing treatment for mental health, substance use, or medical needs; excludes crisis stabilization centers and outpatient services.
Shelter	Service agency that provides temporary residence for homeless individuals and families.
Street/Encampment	On the street or in a homeless camp/encampment site (an area with multiple homeless individuals).
Temporary Residence	Shelter or other temporary shared quarters (couch surfing, doubled up); excludes hotel/motel.
Other	Other locations not listed as a location option.
Participant Status	Participant program enrollment status.
Active (on last day of reporting period)	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged (during reporting period)	Participants who were discharged during the reporting period.
Gender	Participant's self-reported gender.
Age Group	Age at enrollment, based on date of birth and enrollment date, grouped into categories.
Race/Ethnicity	Race and Ethnicity information is based on client self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
HOUSING SUPPORT TABLE, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Enrolled	Participants enrolled during the reporting period.
Housed or Sheltered	Participants who accepted at least one housing placement since enrollment. Includes temporary housing in shelters and motels.
Services Participant Agreed To	Participants may choose to receive subsidy assistance only, or subsidies with support services.

VARIABLE NAMES	DEFINITION
Subsidies Only	Participant agreed to receive only subsidy support.
Support Services and Subsidies	Participant agreed to support services (e.g., transportation, seeking housing, assisting with lease and landlord relations, referrals to additional services, etc.) from an FHARPS peer or housing specialist and subsidy support.
First Housing Type	First housing type placement after program enrollment. Includes temporary housing in shelters and hotels/motels.
Permanent	Includes the following housing types: Scattered site, Project site, alternative housing (e.g., rental or purchase of mobile home, RV, tiny home, etc.).
Transitional	Includes the following housing types: Transitional, Oxford House, Recovery Residence, Sober Living, Shared Living, Single Site, Tiny Home Villages, Master Leasing.
Shelter/Emergency	Includes the following housing types: shelter, hotel/motel.
Other	Other housing types not listed as a housing type option or missing/unknown first housing type(s).
DISCHARGE TABLE, Cumulative	
Participant Status	Participant program enrollment status.
Enrolled	Participants enrolled during the reporting period.
Active	Participants enrolled during the reporting period and active on the last day of the reporting period.
Discharged	Participants who were discharged during the reporting period.
Subsidy	The average total subsidy amount per person based on the most recent enrollment and discharge. Subsidies may be approved for a variety of uses, including but not limited to credit checks, application fees, rent, and utilities.
Average Total Subsidy Since Enrollment	Based on total subsidies provided for all discharged participants, divided by the number discharged. Only discharged recipients who received subsidies are included in the calculation.
Discharge Reason	Reason participant is no longer receiving FHARPS subsidies.
Transitioned to Other Housing Support	Transitioned to non-FHARPS subsidy support, either prior to or after receiving maximum FHARPS subsidy.
Received Maximum Subsidy	Received maximum FHARPS subsidy and transitioned to non-FHARPS subsidy support.
Did Not Receive Maximum Subsidy	Did not receive maximum FHARPS subsidy and transitioned to non-FHARPS subsidy support.
Transitioned to Self-Support	Transitioned to self-support (non-subsidized housing placement).
Admitted to a Facility	Became ineligible for FHARPS due to extended facility stay.
Received Maximum Assistance (no transition)	Unstably housed or homeless after receiving maximum FHARPS assistance.
Withdrew	Participant decided they no longer wanted FHARPS subsidies or support, ability to support self is unknown; excludes transition to self support and loss of contact.
Loss of Contact	Did not receive maximum FHARPS subsidy and whereabouts are unknown for > 60 days.
Served by Another FHARPS Team	Participant is enrolled with another FHARPS team.
Other	Other reason participant is no longer receiving FHARPS subsidies not listed as a discharge reason option.
Length of Support	FHARPS subsidies and support services provided from the time of enrollment to discharge.
Average Length of Stay in Program (days)	The average (mean) length of stay, in days, from the time of enrollment to discharge, among participants discharged from the program during the reporting period. Calculation is limited to the duration of most recent enrollment.
Housing Status at Discharge	Self-reported housing status at time of program end.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.

VARIABLE NAMES	DEFINITION
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

The Forensic PATH program, administered by the Health Care Authority (HCA) through provider contracts, is designed to offer 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 connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The program was implemented in the following phased approach:

- Phase 1: services began March 2020 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: services began April 2022 in King Region.
- Phase 3: services began April 2024 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

As of June 30, 2025, FPATH enrolled 1,030 individuals across the Phase 1, 2, and 3 regions.

REPORTING PERIOD
March 1, 2020 to June 30, 2025

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.

Forensic PATH Enrollment and Participant Characteristics - Phase 1 and 2

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION										
Number on Eligibility List	4,917	100%	1,251	100%	507	100%	884	100%	1,947	100%
Attempted Contacts	1,920	39%	660	53%	140	28%	484	55%	492	25%
Contacted	1,804	37%	327	26%	209	41%	370	42%	747	38%
Enrolled	1,030	21%	265	21%	195	38%	177	20%	330	17%
PRIORITIZED POPULATION										
Prioritized Eligibility List	3,197	65%	844	67%	263	52%	689	78%	1,207	62%
Attempted Contacts	1,131	35%	442	52%	61	23%	341	49%	228	19%
Contacted	994	31%	211	25%	120	46%	258	37%	348	29%
Enrolled	522	16%	139	16%	92	35%	114	17%	158	13%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	364	35%	90	34%	76	39%	59	33%	103	31%
Discharged	666	65%	175	66%	119	61%	118	67%	227	69%
Average Length of Stay in Program (days)	308	N/A	368	N/A	305	N/A	505	N/A	182	N/A
DISCHARGE REASON										
Successful exit	118	18%	40	23%	19	16%	25	21%	28	12%
Loss of contact	283	42%	70	40%	42	35%	56	47%	109	48%
Needs could not be met by program	27	4%	--	--	--	--	--	--	--	--
Withdrew	78	12%	--	--	--	--	--	--	53	23%
Incarceration	69	10%	--	--	28	24%	16	14%	13	6%
Admitted to hospital	16	2%	--	--	--	--	--	--	--	--
Transferred to another FPATH program	4	1%	--	--	0	0%	0	0%	--	--
Death	20	3%	--	--	--	--	--	--	0	0%
Other	34	5%	--	--	--	--	--	--	--	--
Missing	17	3%	14	8%	0	0%	0	0%	--	--
GENDER										
Female	227	22%	61	23%	--	--	--	--	59	18%
Male	736	71%	186	70%	149	76%	130	73%	229	69%
Other/Unknown	67	7%	18	7%	--	--	--	--	42	13%

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
AGE GROUP										
18-29	230	22%	67	25%	40	21%	38	21%	72	22%
30-49	642	62%	147	55%	129	66%	--	--	212	64%
50+	158	15%	51	19%	26	13%	--	--	46	14%
RACE/ETHNICITY*										
American Indian or Alaskan Native	46	4%	--	--	15	8%	14	8%	--	--
Asian	27	3%	--	--	--	--	--	--	11	3%
Black or African American	224	22%	76	29%	29	15%	22	12%	93	28%
Hispanic or Latino	79	8%	16	6%	26	13%	11	6%	19	6%
Native Hawaiian and Other Pacific Islander	17	2%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	399	39%	98	37%	106	54%	96	54%	67	20%
Other Race	39	4%	--	--	--	--	--	--	21	6%
Unknown	255	25%	66	25%	17	9%	33	19%	121	37%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	68	7%	22	8%	--	--	21	12%	--	--
Unstably Housed	221	21%	52	20%	40	21%	52	29%	70	21%
Homeless	559	54%	161	61%	106	54%	86	49%	189	57%
In a Facility	107	10%	19	7%	39	20%	--	--	--	--
Unknown	75	7%	11	4%	--	--	--	--	60	18%
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	125	19%	47	27%	21	18%	23	19%	28	12%
Unstably Housed	38	6%	12	7%	--	--	--	--	--	--
Homeless	88	13%	27	15%	33	28%	--	--	20	9%
In a Facility	107	16%	23	13%	37	31%	23	19%	--	--
Unknown	308	46%	66	38%	--	--	62	53%	156	69%

DATA SOURCES: (1) FPATH Excel trackers submitted by each provider to the Washington State Health Care Authority (HCA); (2) FPATH program data from the Washington State Department of Commerce Housing Management Information System (HMIS); (3) HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available June 2024. Data are subject to change due to challenges tracking individuals across data sources. DSHS and HCA will collaborate on improvements.

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

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics - Phase 3

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION						
Number on Eligibility List	4,917	100%	233	100%	95	100%
Attempted Contacts	1,920	39%	79	34%	65	68%
Contacted	1,804	37%	89	38%	62	65%
Enrolled	1,030	21%	14	6%	49	52%
PRIORITIZED POPULATION						
Prioritized Eligibility List	3,197	65%	134	58%	60	63%
Attempted Contacts	1,131	35%	36	27%	23	38%
Contacted	994	31%	--	--	--	--
Enrolled	522	16%	--	--	--	--
Among Enrolled Individuals…						
PARTICIPANT STATUS						
Active (on last day of reporting period)	364	35%	--	--	--	--
Discharged	666	65%	--	--	--	--
Average Length of Stay in Program (days)	308	N/A	120	N/A	148	N/A
DISCHARGE REASON						
Successful exit	118	18%	0	0%	--	--
Loss of contact	283	42%	--	--	--	--
Needs could not be met by program	27	4%	0	0%	--	--
Withdrew	78	12%	0	0%	--	--
Incarceration	69	10%	--	--	--	--
Admitted to hospital	16	2%	0	0%	0	0%
Transferred to another FPATH program	4	1%	0	0%	0	0%
Death	20	3%	0	0%	--	--
Other	34	5%	--	--	--	--
Missing	17	3%	--	--	0	0%
GENDER						
Female	227	22%	--	--	--	--
Male	736	71%	11	79%	31	63%
Other/Unknown	67	7%	--	--	--	--

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
AGE GROUP						
18-29	230	22%	--	--	--	--
30-49	642	62%	--	--	28	57%
50+	158	15%	--	--	--	--
RACE/ETHNICITY*						
American Indian or Alaskan Native	46	4%	0	0%	--	--
Asian	27	3%	0	0%	0	0%
Black or African American	224	22%	--	--	--	--
Hispanic or Latino	79	8%	--	--	--	--
Native Hawaiian and Other Pacific Islander	17	2%	0	0%	--	--
White Only, Non-Hispanic	399	39%	--	--	--	--
Other Race	39	4%	0	0%	--	--
Unknown	255	25%	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT						
Stably Housed	68	7%	0	0%	--	--
Unstably Housed	221	21%	--	--	--	--
Homeless	559	54%	--	--	--	--
In a Facility	107	10%	--	--	22	45%
Unknown	75	7%	--	--	--	--
HOUSING STATUS AT PROGRAM EXIT						
Stably Housed	125	19%	--	--	--	--
Unstably Housed	38	6%	0	0%	--	--
Homeless	88	13%	--	--	--	--
In a Facility	107	16%	--	--	--	--
Unknown	308	46%	--	--	--	--

DATA SOURCES: (1) FPATH Excel trackers submitted by each provider to the Washington State Health Care Authority (HCA); (2) FPATH program data from the Washington State Department of Commerce Housing Management Information System (HMIS); (3) HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available June 2024. Data are subject to change due to challenges tracking individuals across data sources. DSHS and HCA will collaborate on improvements.

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

TABLE 2.

Forensic PATH Services - Phase 1 and 2

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
			PIERCE		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS										
Total Forensic PATH Service Encounters	24,384		6,635		4,703		5,346		5,210	
Average Service Encounters (per participant, per month)	2.8		2.3		2.9		2.3		2.6	
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services	0.3		0.1		0.2		0.6		0.2	
Re-engagement	0.1		0.0		0.1		0.0		0.1	
Screening	0.1		0.2		0.0		0.1		0.2	
Clinical assessment	0.0		0.0		0.0		0.0		0.0	
Habilitation/rehabilitation	0.0		0.0		0.1		0.0		0.0	
Community mental health	0.1		0.0		0.5		0.0		0.0	
Substance use treatment	0.0		0.0		0.0		0.0		0.0	
Case management	1.3		1.7		1.1		1.0		1.3	
Residential supportive services	0.2		0.1		0.3		0.1		0.3	
Peer services	0.3		0.1		0.2		0.1		0.5	
Service coordination	0.3		0.1		0.4		0.3		0.1	
Other	0.0		0.0		0.0		0.0		0.0	
Among Enrolled Individuals…										
REFERRALS - *Number of participants with at least one referral*										
Any Referral	373	36.2%	87	32.8%	89	45.6%	104	58.8%	78	23.6%
Referral Type										
Community mental health	122	11.8%	27	10.2%	25	12.8%	45	25.4%	20	6.1%
Substance use treatment	58	5.6%	13	4.9%	12	6.2%	23	13.0%	--	--
Primary health/dental care	58	5.6%	--	--	--	--	32	18.1%	13	3.9%
Job training	3	0.3%	--	--	0	0.0%	--	--	--	--
Educational services	4	0.4%	--	--	0	0.0%	--	--	0	0.0%
FHARPS housing	168	16.3%	42	15.8%	57	29.2%	33	18.6%	30	9.1%
Permanent housing (non-FHARPS)	39	3.8%	11	4.2%	--	--	--	--	18	5.5%
Temporary housing (non-FHARPS)	66	6.4%	16	6.0%	--	--	15	8.5%	22	6.7%
Other Housing Services (non-FHARPS)	47	4.6%	16	6.0%	26	13.3%	--	--	0	0.0%

	TOTAL - ALL REGIONS	PHASE 1 REGIONS *Started March 1, 2020*						PHASE 2 REGION *Started April 1, 2022*	
		PIERCE		SOUTHWEST		SPOKANE		KING	
		NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Housing services (pre-August 2021)		12	4.5%	--	--	12	6.8%	0	0.0%
Income assistance		--	--	--	--	--	--	0	0.0%
Employment assistance		--	--	--	--	--	--	--	--
Medical insurance		0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other		--	--	19	9.7%	43	24.3%	--	--

DATA SOURCES: (1) FPATH Excel trackers submitted by each provider to the Washington State Health Care Authority (HCA); (2) FPATH program data from the Washington State Department of Commerce Housing Management Information System (HMIS); (3) HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available June 2024. Data are subject to change due to challenges tracking individuals across data sources. DSHS and HCA will collaborate on improvements.

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

TABLE 2.

Forensic PATH Services - Phase 3

CUMULATIVE: March 1, 2020 - June 30, 2025

	TOTAL - ALL REGIONS		PHASE 3 REGIONS *Started April 30, 2024*			
			THURSTON-MASON		SALISH	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
PROGRAM TOTALS						
Total Forensic PATH Service Encounters	24,384		795		1,672	
Average Service Encounters (per participant, per month)	2.8		5.2		7.3	
Among Enrolled Individuals…						
FORENSIC PATH SERVICES - *Average number of services per participant, per month*						
Outreach services	0.3		0.1		1.4	
Re-engagement	0.1		0.0		0.2	
Screening	0.1		0.0		0.1	
Clinical assessment	0.0		0.1		0.0	
Habilitation/rehabilitation	0.0		0.0		0.0	
Community mental health	0.1		0.0		0.2	
Substance use treatment	0.0		0.0		0.1	
Case management	1.3		1.6		2.2	
Residential supportive services	0.2		0.0		0.4	
Peer services	0.3		2.1		1.7	
Service coordination	0.3		1.2		0.9	
Other	0.0		0.0		0.2	
Among Enrolled Individuals…						
REFERRALS - *Number of participants with at least one referral*						
Any Referral	373	36.2%	--	--	--	--
Referral Type						
Community mental health	122	11.8%	--	--	--	--
Substance use treatment	58	5.6%	0	0.0%	--	--
Primary health/dental care	58	5.6%	--	--	--	--
Job training	3	0.3%	0	0.0%	0	0.0%
Educational services	4	0.4%	0	0.0%	0	0.0%
FHARPS housing	168	16.3%	--	--	--	--
Permanent housing (non-FHARPS)	39	3.8%	--	--	--	--
Temporary housing (non-FHARPS)	66	6.4%	--	--	--	--
Other Housing Services (non-FHARPS)	47	4.6%	--	--	0	0.0%

	TOTAL - ALL REGIONS	PHASE 3 REGIONS *Started April 30, 2024*			
		THURSTON-MASON		SALISH	
		NUMBER	PERCENT	NUMBER	PERCENT
Housing services (pre-August 2021)		--	--	0	0.0%
Income assistance		0	0.0%	0	0.0%
Employment assistance		--	--	--	--
Medical insurance		0	0.0%	0	0.0%
Other		--	--	--	--

DATA SOURCES: (1) FPATH Excel trackers submitted by each provider to the Washington State Health Care Authority (HCA); (2) FPATH program data from the Washington State Department of Commerce Housing Management Information System (HMIS); (3) HCA's Program Data Acquisition Management and Storage system (PDAMS) which became available June 2024. Data are subject to change due to challenges tracking individuals across data sources. DSHS and HCA will collaborate on improvements.

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

FPATH Definitions

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

Variable Name	DEFINITION
Needs could not be met by program	Participant's needs were unable to be met by services or referrals from the Forensic PATH program.
Withdrew	Participant decided they no longer wanted Forensic PATH services or support, ability to support self is unknown.
Incarceration	Participant is no longer in the Forensic PATH program due to incarceration.
Admitted to hospital	Participant is no longer in the Forensic PATH program as a result of being admitted to a state psychiatric hospital or residential competency restoration facility.
Transferred to another FPATH program	Participant was transferred from one Forensic PATH program to another.
Death	Participant is no longer in the Forensic PATH program due to death.
Other	Participant was exited for reason(s) not listed above.
Gender	Participant's self-reported gender.
Age	Age at enrollment, based on date of birth and enrollment date.
Race/Ethnicity	Race and Ethnicity information is based on an individual's self-report or administrative records. Race/ethnicity groups are not mutually exclusive, with the exception of White Only, Non-Hispanic.
Housing Status at Program Enrollment	Participant's self-reported housing status at time of program entry; for those in a facility (e.g., jail/prison, medical, mental health, and substance use inpatient treatment facilities, crisis stabilization facility, and nursing home, adult family home, and assisted living), based on housing status prior to facility admission.
Stably Housed	Not at risk of homelessness; includes both subsidized and non-subsidized housing such as rapid re-rehousing, permanent housing, permanent supportive housing, voucher-supported housing, and living independently without state/federal subsidies or support in a housing unit.
Unstably Housed	At risk of homelessness; includes transitional housing, short-term stays with family/friends (doubled up or couch surfing), in process of eviction, hotel/motel paid for by self.
Homeless	Living outside or in a place not fit for human habitation (abandoned building, car); those housed temporarily in a shelter, or in a hotel/motel paid for by a third party are also considered homeless.
In a facility	In one of the following facility types: correctional facility, inpatient facility providing treatment (for mental health, substance use, or medical needs), nursing home, adult family home, or assisted living.
Unknown	Housing situation indeterminate at time of program enrollment.
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.

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

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

Appendix G – Crisis Intervention Training Dashboard

CIT Dashboard

Crisis Intervention Training (CIT)

CUMULATIVE UPDATE

Per the Trueblood Contempt Septtlement Agreement, Crisis Intervention Training (CIT) is offered to law enforcement, 911 dispatch, and corrections officers throughout Washington state. The training provides skills designed to increase the safety of both the emergency response personnel and people in crisis. Law enforcement agencies are already familiar with CIT and several corrections agencies began training as early as 2014. Contempt settlement-mandated crisis intervention trainings were implemented in the following phased approach:

- Phase 1: Trainings began July 2019 in Pierce, Southwest (Clark, Klickitat, Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties) Regions.
- Phase 2: Trainings began July 2021 in King Region.
- Phase 3: Trainings began July 2023 in Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason (Thurston, Mason Counties) Regions.

The full report, including all data and definitions, can be accessed online here.*

REPORTING PERIOD

Monthly: JUNE 2025

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

Contents

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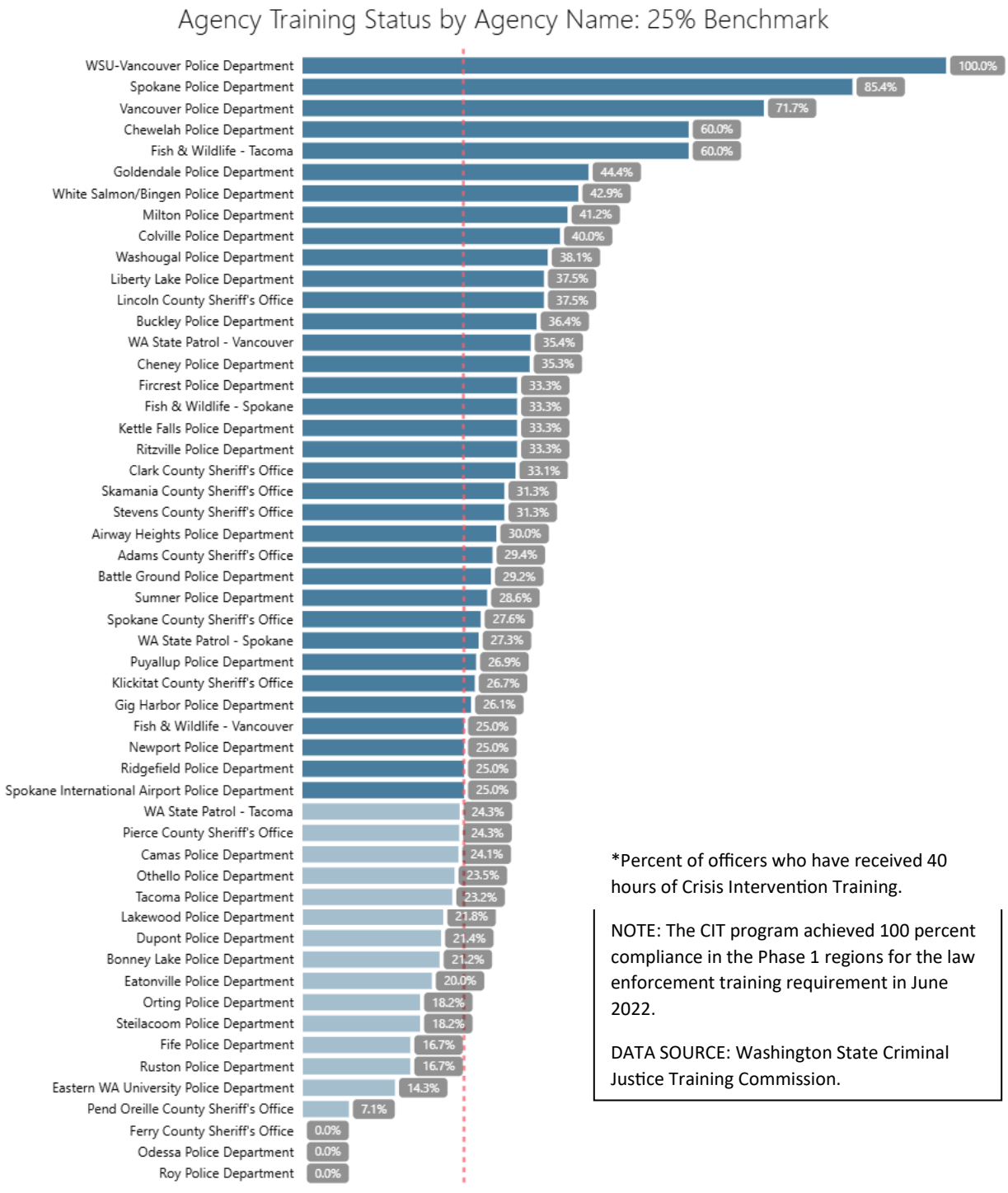
Figure 1.

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

JUNE 30, 2025



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

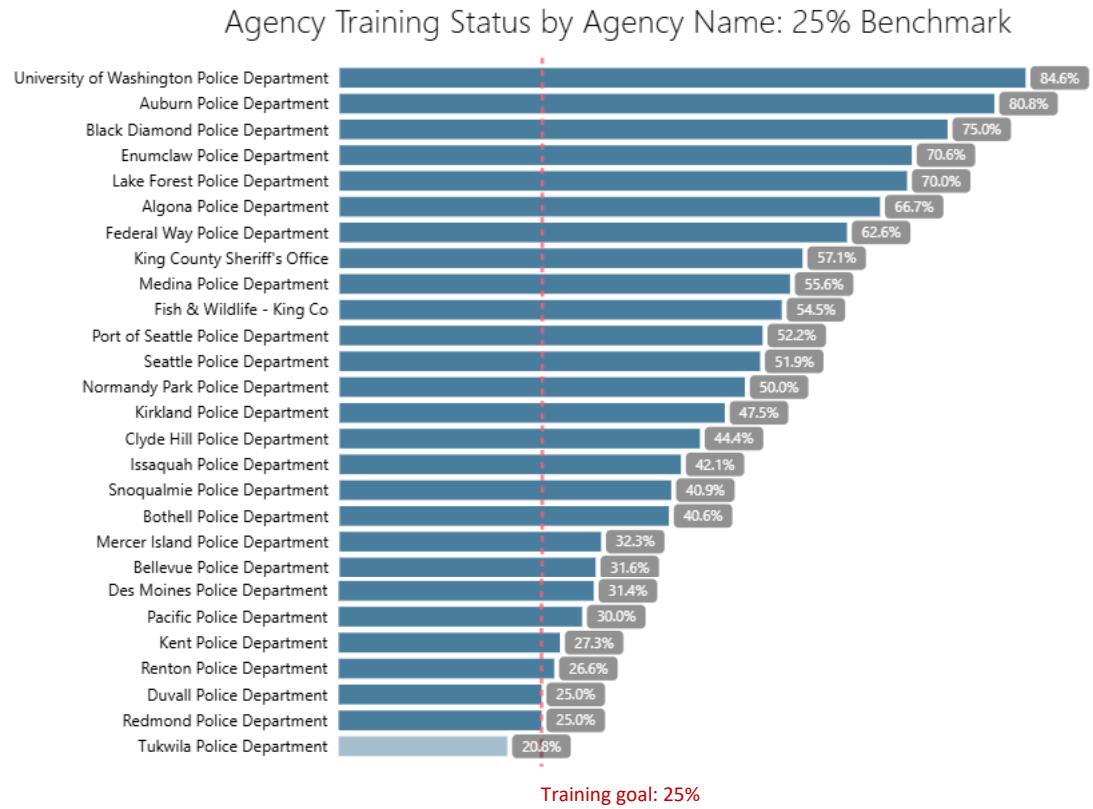
NOTE: The CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

JUNE 30, 2025



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

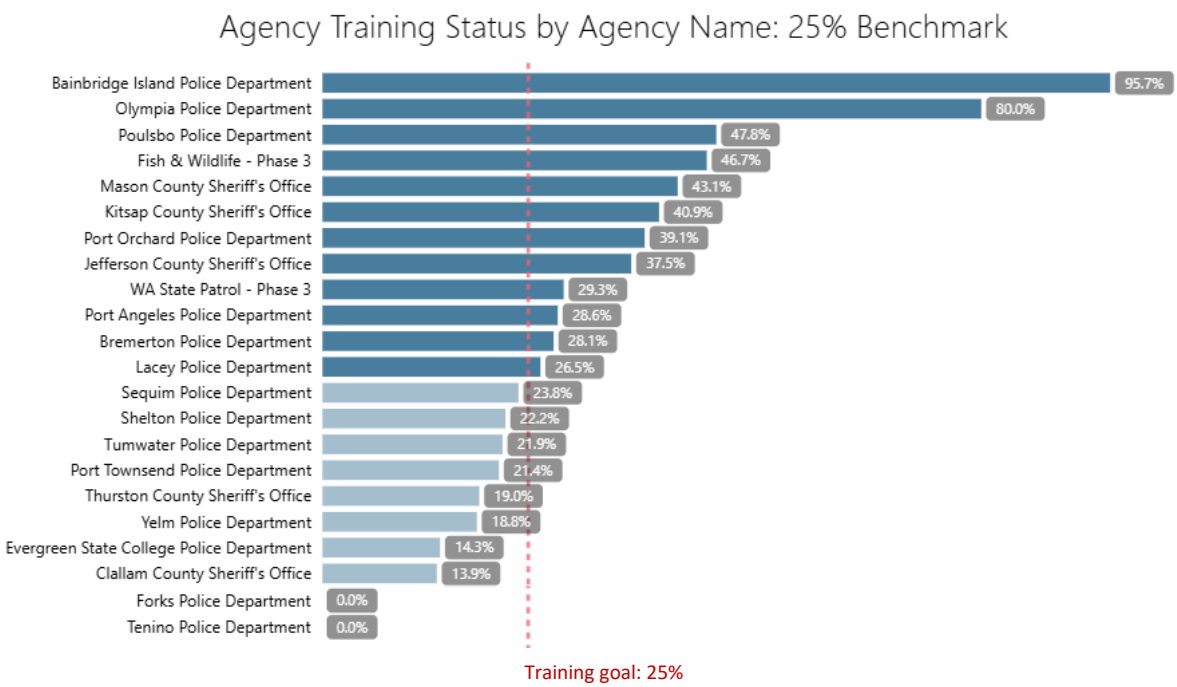
NOTE: Washington State Patrol training rates are not included in Figure 2, as updated records were received after the reporting deadline.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 3.

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

JUNE 30, 2025



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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 1.

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

JUNE 30, 2025

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**1,655**	**717**	**43.3%**	**564**	**159**	**28.2%**	**318**	**91**	**28.6%**	2,537	967	38.1%
Fish & Wildlife - Phase 1							29	10	34.5%	**29**	**10**	**34.5%**
Pierce Region	734	172	23.4%	174	42	24.1%	92	24	26.1%	**1,000**	**238**	**23.8%**
Southwest Region	355	202	56.9%	74	22	29.7%	64	21	32.8%	**493**	**245**	**49.7%**
Spokane Region	566	343	60.6%	86	28	32.6%	133	36	27.1%	**785**	**407**	**51.8%**
WA State Patrol - Phase 1				230	67	29.1%				**230**	**67**	**29.1%**
Phase 2	**2,652**	**1,348**	**50.8%**	**369**	**129**	**35.0%**	**119**	**67**	**56.3%**	3,140	1,544	49.2%
Fish & Wildlife - Phase 2							11	6	54.5%	**11**	**6**	**54.5%**
King Region	2,652	1,348	50.8%	369	129	35.0%	108	61	56.5%	**3,129**	**1,538**	**49.2%**
Phase 3	**220**	**67**	**30.5%**	**562**	**219**	**39.0%**	**77**	**18**	**23.4%**	859	304	35.4%
Fish & Wildlife - Phase 3							15	7	46.7%	**15**	**7**	**46.7%**
Salish Region	115	47	40.9%	242	87	36.0%	18	3	16.7%	**375**	**137**	**36.5%**
Thurston-Mason Region	105	20	19.0%	221	103	46.6%	44	8	18.2%	**370**	**131**	**35.4%**
WA State Patrol - Phase 3				99	29	29.3%				**99**	**29**	**29.3%**
Total	**4,527**	**2,132**	**47.1%**	**1,495**	**507**	**33.9%**	**514**	**176**	**34.2%**	6,536	2,815	43.1%

NOTES: As part of the Agreement, Crisis Intervention Training is being offered to law enforcement and corrections officers throughout Washington State. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1, 2, and 3 regions are required to complete 40 hours of enhanced CIT. Large agencies are defined as having 101+ officers, while medium agencies have 21-100 officers, and small agencies have 1-20 officers. The CIT program achieved 100 percent compliance for the law enforcement training requirement in June 2022 (Phase 1 regions) and June 2023 (Phase 2 region). Washington State Patrol training data for Phase 2 are excluded, as updated records were received after the reporting deadline.

DATA SOURCE: Washington State Criminal Justice Training Commission

Table 2.

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

JUNE 30, 2025

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**588**	**580**	**98.6%**				**81**	**56**	**69.1%**	669	636	95.1%
Pierce Region	238	237	99.6%				12	9	75.0%	**250**	**246**	**98.4%**
Southwest Region	137	130	94.9%				25	11	44.0%	**162**	**141**	**87.0%**
Spokane Region	213	213	100.0%				44	36	81.8%	**257**	**249**	**96.9%**
Phase 2	**585**	**548**	**93.7%**	**23**	**20**	**87.0%**	**34**	**33**	**97.1%**	642	601	93.6%
King Region	585	548	93.7%	23	20	87.0%	34	33	97.1%	**642**	**601**	**93.6%**
Phase 3				**190**	**165**	**86.8%**	**35**	**32**	**91.4%**	225	197	87.6%
Salish Region				85	74	87.1%	35	32	91.4%	**120**	**106**	**88.3%**
Thurston-Mason Region				105	91	86.7%				**105**	**91**	**86.7%**
Total	**1,173**	**1,128**	**96.2%**	**213**	**185**	**86.9%**	**150**	**121**	**80.7%**	1,536	1,434	93.4%

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

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

JUNE 30, 2025

Agency Size	Large			Medium			Small			TOTAL - ALL SIZES		
Phase	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained	# of Officers	# Trained	% Trained
Phase 1	**267**	**258**	**96.6%**	**101**	**101**	**100.0%**	**81**	**80**	**98.8%**	449	439	97.8%
Spokane Region	104	104	100.0%	26	26	100.0%	57	57	100.0%	**187**	**187**	**100.0%**
Pierce Region	163	154	94.5%							**163**	**154**	**94.5%**
Southwest Region				75	75	100.0%	24	23	95.8%	**99**	**98**	**99.0%**
Phase 2	**245**	**245**	**100.0%**	**130**	**125**	**96.2%**	**62**	**61**	**98.4%**	437	431	98.6%
King Region	245	245	100.0%	130	125	96.2%	62	61	98.4%	**437**	**431**	**98.6%**
Phase 3				**109**	**109**	**100.0%**	**44**	**29**	**65.9%**	153	138	90.2%
Salish Region				54	54	100.0%	33	27	81.8%	**87**	**81**	**93.1%**
Thurston-Mason Region				55	55	100.0%	11	2	18.2%	**66**	**57**	**86.4%**
Total	**512**	**503**	**98.2%**	**340**	**335**	**98.5%**	**187**	**170**	**90.9%**	1,039	1,008	97.0%

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

DATA SOURCE: Washington State Criminal Justice Training Commission.