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 11

March 28, 2025

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List of Abbreviations in this Document

AAG-assistant attorney general

AHAB-Affordable Housing Advisory Board

ASO-administrative service organization

ASPD-antisocial personality disorder

BHA-Behavioral Health Administration, part of DSHS

BHASO-behavioral health administrative service organization

BHTC-behavioral health & treatment center *(previously RTF-residential treatment facility)*

BPD-borderline personality disorder

CIT-Crisis Intervention Training

CJTC-Criminal Justice Training Commission

CMS-Centers for Medicare and Medicaid Services

CPC-certified peer counselor

CS/CT-crisis stabilization/crisis triage

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

DCR-designated crisis responder

DSHS-Department of Social and Health Services

DOH-Department of Health

DRW-Disability Rights Washington

ESH-Eastern State Hospital

ETP-exception to policy

FDS-Forensic Data System

FRA-forensic risk assessment

HARPS-Housing and Recovery through Peer Services

HCA-Health Care Authority

MCR-mobile crisis response

MOCT-mobile outreach crisis team

MOU-memorandum of understanding

NGRI-Not Guilty by Reason of Insanity

OCRP-Outpatient Competency Restoration Program

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

PATH-Projects for Assistance in Transition from Homelessness

PDAMS-Program Data Acquisition, Management, and Storage Solution

PHS-Pioneer Human Services

RDA-Research and Data Analysis, part of DSHS

RFP-request for proposals

SAR-semi-annual report

SRSC-Spokane Regional Stabilization Center

SUD-substance use disorder

VTC-video technology conferencing

WASPC-Washington Association of Sheriffs and Police Chiefs

WSH-Western State Hospital

Preamble

Each March and September, a semi-annual report is published to review the implementation of the Trueblood Contempt Settlement Agreement. This edition of the SAR primarily covers implementation-related progress during July through December 2024. 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 ongoing as of Dec. 31, 2024.

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 Dec. 31, 2024. 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 59 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 of Social and Health Services was taking too long to provide these competency evaluation and restoration services. As a result of this case, the state was ordered to provide court-ordered in-jail competency evaluations within 14 days and inpatient competency evaluation and restoration services within seven days of receipt of a court order. Now that state-contracted outpatient competency restoration services began July 2020, outpatient restoration services must likewise be provided to class members within seven days of receipt of a court order. Trueblood's class members, referred to throughout this report, are those who are detained in jails awaiting a competency evaluation or restoration services. Many of the programs created as a result of Trueblood also target people who have previously received competency evaluation and restoration services, who are released and at risk for re-arrest or re-institutionalization.

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

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

Phases run parallel to the legislative biennia beginning with the 2019-2021 biennium. Phase 1 completed as of June 30, 2021. Phase 2 concluded on June 30, 2023. Phase 3 is the current

active settlement phase and adds the Thurston/Mason and Salish (Clallam, Jefferson, and Kitsap Counties) regions.

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 Not Guilty by Reason of Insanity patients. Similarly, the forensic BHTC housed on Western State Hospital'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.

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

CJTC or the Commission: Washington State Criminal Justice Training Commission.

Crisis housing vouchers: Allow unhoused or unstably housed 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 Research and Data Analysis 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 in an effort to reduce barriers to accessing care and services.

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

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

Foundational Community Supports or FCS: This is a program that helps Medicaid beneficiaries in Washington state find and maintain housing and employment.

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.

Health Care Authority or HCA: Washington State Health Care Authority.

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

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

Program Data Acquisition Management and Storage (PDAMS). A centralized data collection system managed by the Health Care Authority 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, also necessary for Trueblood class members. Civil conversion cases increased 68.6 percent in 2022 as compared to 2021. This coincides with the system's emergence from pandemic-era criminal court shutdowns, contributing toward increased wait lists and class member wait times. In 2023, civil conversion cases dropped 34.3 percent as compared to 2022. Greater numbers of civil conversion cases occupying hospital beds slow overall patient throughput as civil conversion patients typically turnover beds 4-5 times less often than forensic patients. In Q2 2024, there was a significant increase in the number of civil conversion patients throughout the system, but overall numbers through 2024 remain down relative to 2023.[2]

New Treatment Beds for Forensic and Felony Civil Conversion Patients in Q3 and Q4 2024

The department opened 65 new beds for class members in 2024 as well as 18 additional beds for civil conversion patients. A detailed list of recently opened facilities and currently projected opening dates follows:

- In January 2024, ESH added eight competency restoration beds, and then shortly thereafter converted a unit of beds previously used for NGRI patients into competency restoration beds. The net effect of these two actions created 35 additional beds available for competency restoration services at ESH.

- At WSH, 30 additional competency restoration beds were brought online in January 2024.

- Olympic Heritage Behavioral Health in Tukwila opened 18 additional civil beds in January 2024. This has allowed more civil patients to transfer from WSH to OHBH. OHBH now has 72 civil beds in operation.

- The remodel of Columbia Unit at the Maple Lane Campus opened 30 beds for NGRI patients from WSH. After delays from 2023, the March 2024 opening allowed 30 NGRI

[2] Sources: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated by Research and Data Analysis July 2024; 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 January 11, 2023, p. 9.

patients to transfer from WSH and ESH, creating more opportunities to use beds at the state hospitals for competency restoration services.

- HCA has increased community-based civil conversion bed capacity by amending existing long-term civil commitment contracts. Eighty-six beds across the state are available for civil conversion patients.

- HCA secured a decision package that currently increases the LTCC reimbursement rate from $940 to $1,250 per day.

- On June 28, 2024, Maple Lane Campus' – Cascade Unit closed its 30-bed forensic BHTC as agreed to in the Trueblood Settlement of Contempt Agreement. However, shortly after the closure, DSHS reopened Cascade Unit as a 30-bed facility for NGRI patients. This allowed WSH and ESH to absorb the loss of forensic beds when Cascade Unit closed as a competency restoration BHTC.

BHA added a bed allocation manager to develop and implement a data-driven strategy around bed management and throughput in our facilities. An early success at WSH during Q2 included bed reallocation between civil conversion and Trueblood class members. Too many high acuity civil patients, who could not successfully have roommates, were occupying double-occupancy rooms. By reviewing data, it became clear that shifting civil conversion patients from double-occupancy rooms into the single rooms freed up an additional 20 beds for civil patients. This allowed the department to better manage patient flow and hit record levels of on-time inpatient admissions.

Gaining 65 new beds for class members and 18 new beds for civil conversion patients in 2024 allowed OFMHS and the state hospitals greater capacity and flexibility to provide a more diverse and responsive care environment to meet the needs of each patient. 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. The greater bed space provides additional approaches to treating various patient types, and it begins a period 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. 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 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 August 7 and the court issued a second order on August 14. This order of August 14 clarified the original July 7 order in certain respects. Notably, the August 14 order prohibits defendants charged with non-violent criminal acts from being admitted into either state hospital on a civil conversion commitment order. The state filed notice of appeal to the Ninth Circuit Court of Appeals, and the case awaits further proceedings to resolve the parties' ongoing concerns.

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. BHA 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 BHA has continued this critical focus throughout 2022-2024. Even with these successful actions, BHA continues to face high vacancy rates in several critical patient-centered job classes. As of early January 2025, vacancies in these classes now range between 21-40 percent.

BHA has established a 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

Effective July 1, 2023, several new staff retention measures took effect with implementation of the 2023-2025 biennial budget and collective bargaining agreements.

- Staff who were hired on or before July 1, 2022, and remained employed on July 1, 2023, qualified for a one-time lump sum retention payment. Most employees received $1,000. Certain represented employees received $1,500.

- All employees in Washington General Service and Washington Management Service positions, working at BHA's 24/7 facilities received a five-percent wage premium for hours worked on-site at the facilities.

- All employees received a four-percent cost of living adjustment. Effective July 1, 2024, all employees received an additional three-percent cost of living adjustment.

- Enacted targeted wage scale adjustments for critical positions.

- Extra duty pay for forensic evaluators and psychiatric social workers

- Extra duty pay for ARNPs (1 ¼ times the regular rate)

- Extra duty pay for physicians and psychiatrists (1 ¼ times the regular rate)

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 not guilty by reason of insanity 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.

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 semi-annual report 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 (PDAMS) system for FHARPS in August 2023, crisis housing vouchers in November 2023, and FPATH in June 2024. Merged FPATH data through December 2024 are provided in this report. 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 now 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 continued efforts to streamline and verify case data between Excel data trackers and PDAMS occur. 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 semi-annual report 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:

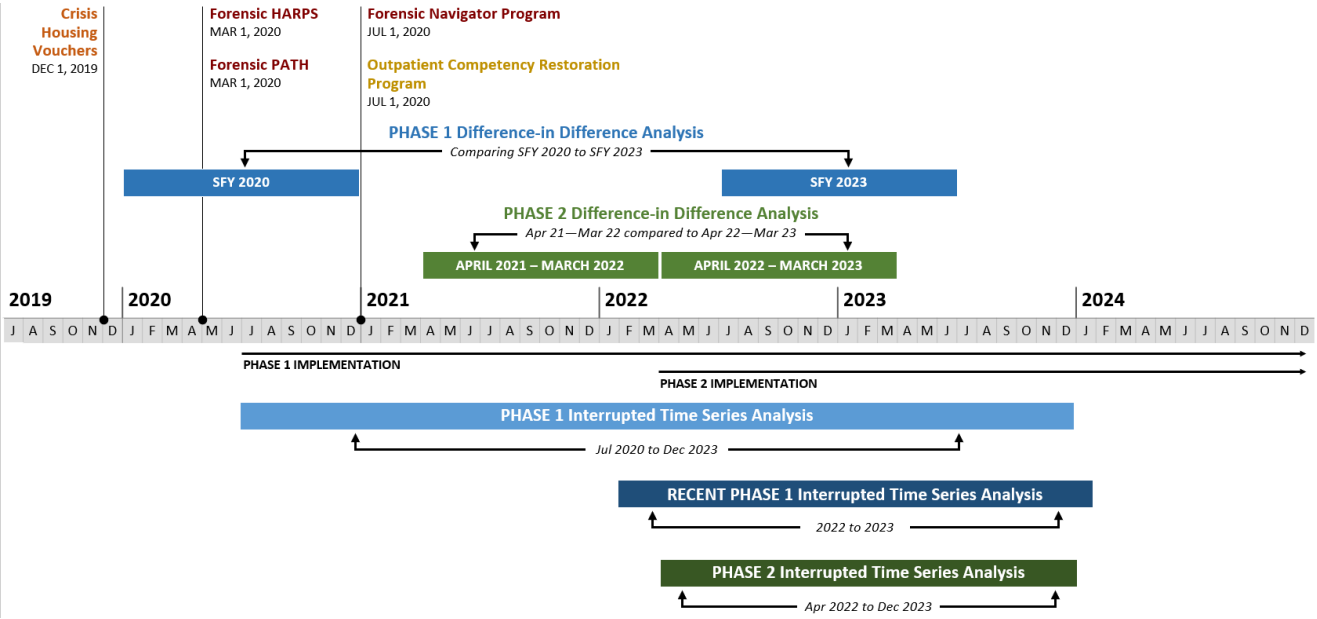
- Use of mental health and substance use disorder treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

Evaluations include assessments of the overall phased regional impact of Settlement Agreement components on outcomes through two methods: (1) an interrupted time series analysis to assess the impact of the Trueblood implementation programs on the number of competency referrals; and (2) a difference-in-difference analysis to assess impacts on behavioral health access and social outcome metrics. The interrupted time series analysis has been updated. RDA is in the process of updating the difference-in-difference analysis. 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)

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

- Competency 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.

    - 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]

- Substance Use Disorder 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.

[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.

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 will be presented to stakeholders and included in the September 2025 SAR.

Individual Outcome Evaluation(s)

FHARPS

The Forensic Housing and Recovery Through Peer Service programs 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.

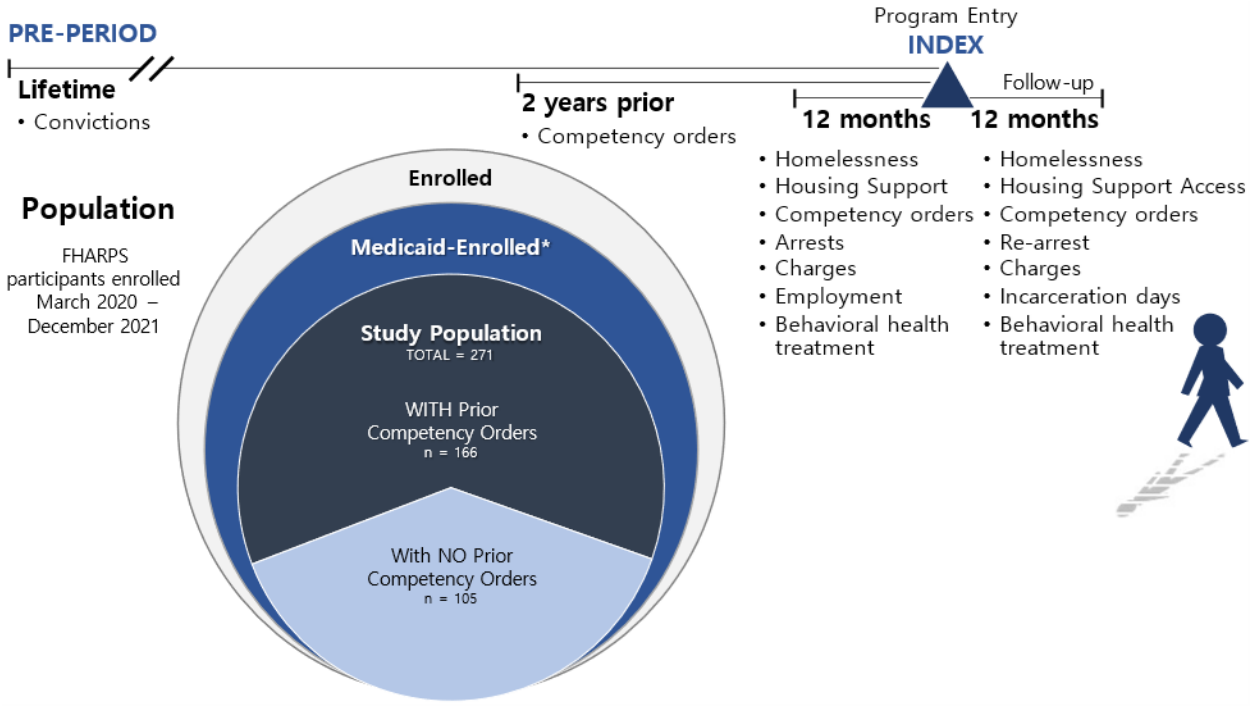
To assess the impact of FHARPS on homelessness and other key measures, the Research and Data Analysis division of DSHS compared outcomes for two groups of Medicaid-enrolled FHARPS program participants enrolled between March 2020 and December 2021, one group with and one group without a competency order 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 substance use disorder 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 substance use disorder treatment in the 12-month outcome period.

There were challenges in evaluating FHARPS program impacts which fall 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), and

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. Click the following link to access the report: The Impact of Forensic Housing and Recovery Through Peer Services (FHARPS) on Homelessness and Housing Support Access – An Outcome Evaluation | DSHS.

FPATH

The Forensic Projects for Assistance in Transition from Homelessness (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:

1. Pierce (Pierce County);

2. Southwest (Clark, Klickitat, and Skamania Counties); and

3. 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 the DSHS Research and Data Analysis Division.

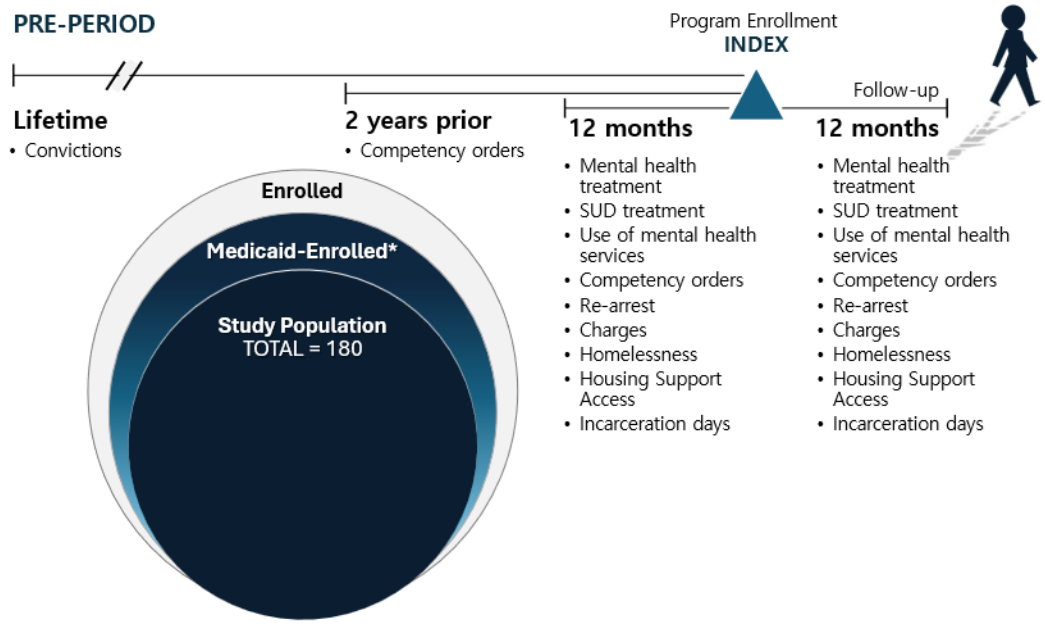
The study population included 180 people enrolled in FPATH between March 2020 and March 2022 who were Medicaid-enrolled for at least one month in the 12 months both pre- and post-FPATH program enrollment, as well as a statistically matched comparison group of people who did not participate in the program (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, substance use disorder (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 (FCS) services (18 percent versus 7 percent of the comparison group) and for a longer period of time (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; and
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 Spring 2025.

OCRP

The OCRP outcome evaluation work is underway. RDA plans to present high-level findings from the OCRP study in September 2025 and release a detailed report in the first quarter of 2026.

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.

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 Dec. 31, 2024, 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. 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 forensic risk assessments for the NGRI population in forensic beds, not guilty by reason of insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). Furthermore, monitoring all of 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 forensic risk assessments, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity as the not guilty by reason of insanity 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 Dec. 31, 2024, 83 of the 93 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 out 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) creating seven out-of-state remote telehealth positions, 4) attending conferences/workshops to recruit, 5) adding more administrative support staff to assist evaluators, and 6) leveraged technology to assist with data tracking/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 labor union for evaluators to allow for contracting. During this time period, OFMHS used up to eight contractors.

During the July-December 2024 reporting period, 72 forensic risk assessments (FRAs) were completed at WSH. Now that there is no longer any backlog of FRAs to complete at WSH, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. Additionally, OFMHS is working with ESH to have all forensic risk assessments caught up and on the same evaluation schedule as WSH. ESH completed 12 FRAs during the July-December 2024 reporting period. 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 forensic risk assessments.

Areas of Concern

Demand for competency services (both in and out of custody) remains near record highs and remains concerning. Furthermore, non-competency forensic evaluations also 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 6,355, which compares to Fiscal Year 2023's, record number of referrals for all competency evaluations (6,787[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-FY23. Subsequently, in FY23-FY24, there has been an actual decline in orders relative to FY22-FY23. While this leveling-off and at least temporary plateau effect is welcome, overall demand remains near historic highs and comes immediately following the FY21-FY22 39 percent year-over-year increase for all competency evaluation orders. This growth came 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 BHA, and the statistically significant impact of Trueblood interventions demonstrated in the Phase 1 regions. Without these programs, demand for evaluations likely would have increased even more. Through the first two quarters of FY25, evaluation demand is again on the increase with higher referrals than normal.

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 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

[6] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2023.

[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.

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 more 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 BHA'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, Okanogan, Pacific, San Juan, 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 Feb. 5, 2025, data reflects that in December 2024, a total of 90 percent of evaluation orders were completed within court-ordered time limits, with 88 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 fall 2025 semi-annual report.

For the FY2025-FY2027 budget cycle, the department examined the number of orders filed by the courts between July 2018 and July 2024 and projected the number of evaluation orders through June 2029 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

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

interpolated to 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.

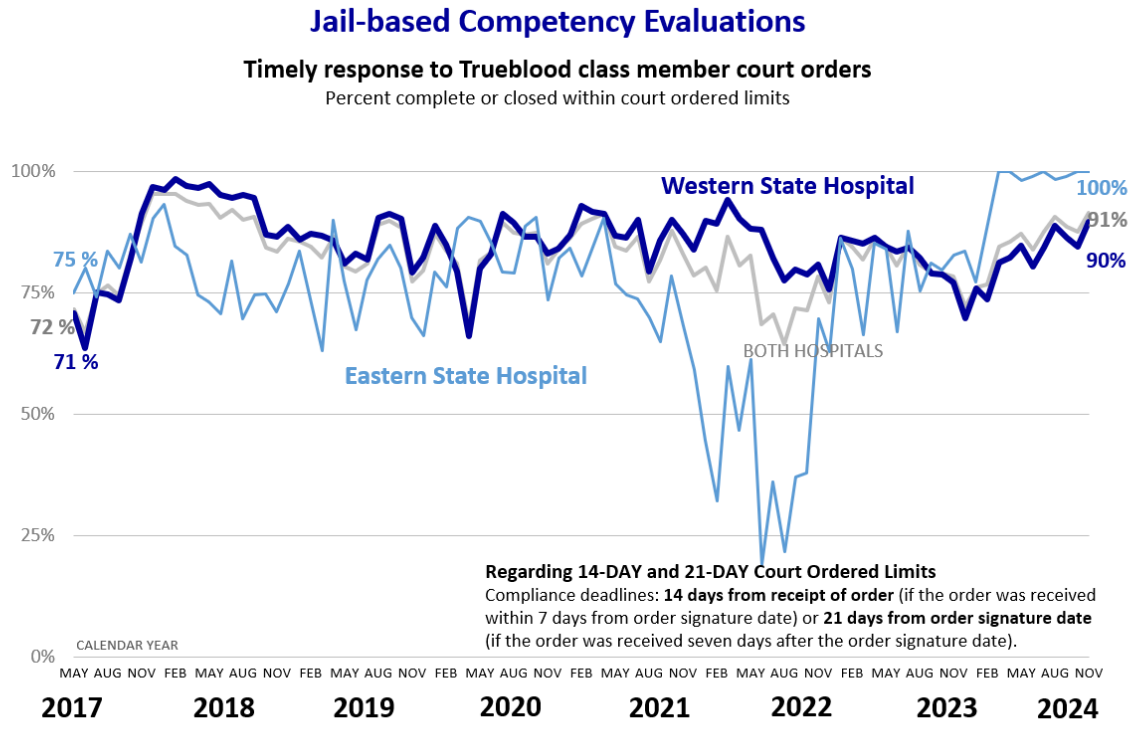
Projections indicate that the number of Trueblood competency evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 93.0 FTE in the FY2024 budget and 93.0 FTE in the FY2027 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal spikes, which may present evaluation capacity challenges in peak months. The department continues to monitor caseloads regularly, and during periods of increased demand, OFMHS management/staff prioritize jail-based cases. These calculations do not account for evaluations for forensic risk assessments (both initial evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks. The department will continue to update the projection analysis in line with the legislative budget cycle and will have an updated forecast in the next semi-annual report for the FY2027-FY2029 budget cycle.

FIGURE 4.

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

Percent complete or closed within court-ordered limits

DECEMBER 2024



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

Data – Competency Restoration-Misdemeanor Restoration Orders

As part of the Settlement Agreement, the state agreed to support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration. The state has since advanced bill proposals and supports legislation toward this goal. ESSB 5444 was signed into law by the governor on May 9, 2019, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. 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 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. The department continues to monitor the number of misdemeanor restoration orders before and after the 2019 law change that required “compelling state interest” (RCW 10.77.088).

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 December 2024. In the two fiscal year period prior to the law change (FY2018-FY2019), courts issued an average of 23 misdemeanor restoration orders. In the two fiscal year period after the law change (FY2020-FY2021), the average number of misdemeanor restoration orders decreased to 14. However, the average number of misdemeanor restoration orders has increased to a level similar to the period before the 2019 law change with an average of 21 misdemeanor restoration orders between FY2022-FY2023. Because this data is updated monthly, the average number of misdemeanor restoration orders in the most recent two fiscal year periods (FY2024-FY2025) is not complete but as of December 2024 shows an average of 23 misdemeanor restoration orders in FY2025 year-to-date. Most recently, in December 2024 there were 31 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.

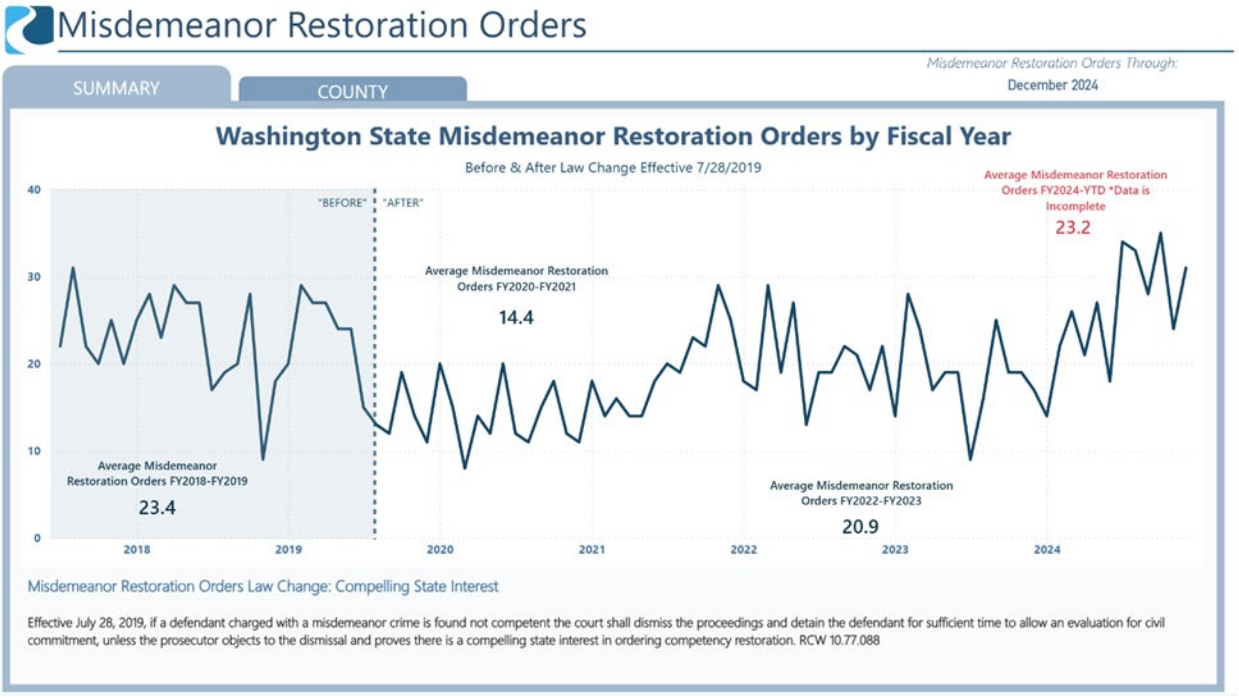
Note that in 2023, RCW 10.77.088 was amended by E2SSB 5440 (signed into law May 15, 2023, and effective July 23, 2023) to require the court to consider "all available and appropriate alternatives to inpatient competency restoration." This included developing a diversion program for defendants charged with nonfelony crimes. While the program is ongoing, the department will be reporting on its status outside of this report. The department will continue to monitor the impacts of this program on misdemeanor restoration orders.

FIGURE 5.

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

Number and average misdemeanor restoration orders by fiscal year

DECEMBER 2024



***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 Outpatient Competency Restoration Program element of the Settlement Agreement is managed by the Health Care Authority in collaboration with the Department of Social and Health Services. 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 Forensic HARPS, 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.

Due to these enhancements, the OCR programs in King, Southwest, and Spokane regions successfully maintained adequate space for every person recommended for OCRP throughout the reporting period. The OCRP provider in Pierce County maintained adequate space for most of this reporting period. HCA continues working with providers to increase service quality and availability.

HCA's Phase 3 contracted OCRP providers, Olympic Health and Recovery Services and Kitsap Mental Health Services, have seen a steady increase in referrals in the programs during this reporting period. Since starting, they have maintained adequate space while collaborating with DSHS to outreach and provide education to court partners about OCRP.

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 complete weekly 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 have piloted a project that allows behavioral health treatment center treatment 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.

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.

Areas of Concern

HCA predicted an increase in participants due to increased staffing and geographic expansion; however, Phase 1 and Phase 2 providers reported a drop in referrals to OCRP. This slowing of referrals led to an underutilization of this resource, but due to adding new providers the overall number of OCRP participants is not significantly lower than previous reporting periods.

Recommendations to Address Concerns

HCA, in coordination with RDA and DSHS, have worked to learn more about the potential reasons behind this decrease, 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.

Data – Competency Restoration-Community Outpatient Services

OCRP services began July 1, 2020, in the Phase 1 regions and October 31, 2022, in the Phase 2 region. The program expanded to the Phase 3 regions on April 30, 2024, where 10 people have been enrolled through December 2024 (not included in the Appendix table). At this time, the OCRP data tables in Appendix B present information from Phase 1 and 2 regions only. Detailed enrollment and services information from Phase 3 will be reported when there are sufficient cases to protect confidentiality.

Between July 1, 2020, and Dec. 31, 2024, 285 clients were enrolled in OCRP Phase 1 and 2 regions: 83 in Pierce, 85 in Southwest, 54 in Spokane, and 63 in King (Appendix B, Table 1). This is an increase of 42 people (17 percent) since June 30, 2024. Across regions, most enrollments were for felony restoration orders (83 percent) and participants were mostly male (71 percent), 30-49 years old (52 percent), non-Hispanic white (61 percent), and unstably housed or homeless (a combined 64 percent).

Of the 246 participants discharged (Appendix B, Table 2), 39 percent were opined competent, 26 percent had their conditional release revoked, and 13 percent had their charges dismissed. About 63 percent were discharged to the community, 19 percent were admitted to inpatient services at either a state hospital or a behavioral health and treatment center, and 10 percent were returned to jail. Among those discharged, the average length of stay in OCRP was 82 days, ranging from 73 days in the King region to 94 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 substance use disorder information and seek information from family and other sources when the client has signed a release of information.

If the court finds that a person is suitable for outpatient competency restoration and agrees to order the client to outpatient restoration, forensic navigators continue to work with these participants. 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 outpatient competency restoration programs. 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 Western State Hospital and Eastern State Hospital. The team meets with Western

State Hospital monthly, and staff have made significant strides in partnership with the social work staff regarding potential suitable clients.

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 was down by one staff member during the reporting period, but the position has subsequently been filled.

Phase 3 staff began forensic navigator engagement on April 15, 2024. The forensic navigator team has been well received due to the ongoing communication established by early outreach in the area. A staff member who was a forensic navigator in another phase, has helped galvanize the team into active engagement with courts and providers. Phase 3 was down by one staff member in the Salish region during the reporting period, but the position has subsequently been filled.

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 10.77.072 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 have worked 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 continues to be consistent with court communication.

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.

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 the hope 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 443 people active in the Forensic Navigator Program at the end of Q4 2024 (Appendix C, Figure 1). Thirty-one of them were enrolled in OCRP as of the last day of the reporting period (Appendix C, Table 2). This number is similar to the previous quarter's enrollment. As can be seen in the full Power BI report, the King region had the highest number of people enrolled in OCRP in Q4 2024. 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, 8,491 people were assigned a forensic navigator between July 1, 2020, (program start) and Dec. 31, 2024, (Appendix C, Figure 1). As can be seen in the online Power BI report, this includes 3,878 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 218 people in the Thurston-Mason region and 171 people in the Salish region were assigned a forensic navigator. Statewide, just under half (45 percent) were charged with a felony, and 55 percent were charged with a misdemeanor (Appendix C, Figure 1). This shift from a majority of felony cases to misdemeanors is attributed primarily to the Phase 2 region. In the King region about 7 in 10 people served by forensic navigators had a misdemeanor offense.

More than half of the people assigned a forensic navigator since the program's start were male (65 percent) and were between the ages of 30 to 49 (56 percent). Half (50 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 accordingly. The program additionally continues to make improvements to data collection and data quality.

Across all regions, forensic navigators had an average of 13 clients in their caseload (Appendix C, Figure 1). This is a decrease from prior quarters but may be impacted by the smaller average caseload in the newer Thurston-Mason and Salish regions. While average caseloads differed by region, all region caseloads were below the program standard of 25 in Q4 2024. (Appendix C, Figure 3). In Q4 2024, the Pierce region had the highest average daily caseload (17), 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 41 percent of clients overall, with the highest rate being in the Southwest region (66 percent) and the lowest being in the King region (23 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 increased by six percent since Q1 2024 (Appendix C, Figure 4). More than one in three (37 percent) received a referral to other community 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 19 percent received a referral to FHARPS (Appendix C, Figure 5).

A total of 8,047 people were discharged during the reporting period, with an average length of stay in the program of 39.2 days, ranging from 23.8 days in the Thurston-Mason region to 59.4 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-nine percent of cases were closed because the person was determined competent, and 22 percent of cases were closed because the person was ordered by the court to receive inpatient restoration (Appendix C, Table 2). Twenty-two percent of cases were closed when people were released from jail on personal recognizance and 16 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 (10 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.

Competency Restoration-Ramp Down of Maple Lane Forensic BHTC

DSHS opened two forensic Behavioral Health and Treatment Centers for Trueblood class members to provide additional inpatient competency restoration services in 2016, the Yakima Competency Restoration Program and Maple Lane's Competency Restoration Program (as Maple Lane's campus has begun to grow, MLCRP is now known as Cascade Unit, and the entire campus is known as DSHS Behavioral Health & Treatment Center – Maple Lane Campus). In 2019, the department opened a third BHTC, DSHS Behavioral Health & Treatment Center – Steilacoom Unit. The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order.

Both YCRP and Cascade Unit were scheduled to close as part of the overall integrated system changes contemplated in the Settlement Agreement. Yakima was scheduled to close by Dec. 31, 2021, but closed on Aug. 14, 2021, due to difficulty recruiting and retaining staff through December 2021. The last patient transferred out on July 26, 2021. Cascade Unit had a hard closure date of July 1, 2024. The DSHS positions at Cascade Unit converted to permanent status on Dec. 16, 2021, providing the staff who stayed until closure layoff rights. During the 2023 Legislature session, funding was secured to keep the building that houses Cascade Unit open permanently. Competency restoration treatment ended at Cascade Unit on June 11, 2024, when the last remaining patient transferred out, and the unit permanently closed to Trueblood patients under the Settlement Agreement. On July 1, 2024, Cascade Unit reopened to serve people found NGRI and began accepting residents transferring from both state hospitals. Cascade Unit's ramp down plan timeline was updated due to this change.

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 (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 advertisement of available services and created relationships with new community providers to improve access to treatment. Despite continuing workforce challenges, SRSC was able to fill vacancies for clinical and medical licensed positions.

During this reporting period, the SRSC served 399 people who also had law enforcement contact in the prior 24-month period; 105 people who were referred to the SRSC by police drop-off; and 276 people with co-occurring disorders.

Additional Crisis Beds – King Phase 2

ConnectionsWA opened the Kirkland crisis stabilization campus in July 2024. ConnectionsWA continued their work on staff recruitment, outreaching with community partners, and collaborating with local law enforcement and first responders. HCA facilitated meetings with ConnectionsWA and the King County FHARPS, FPATH, and OCRP teams to increase utilization of the new regional crisis services.

Additional Crisis Beds – Thurston-Mason Phase 3

In Phase 3, the legislature allocated enhancement funding for crisis bed capacity in the SFY2025 budget to add 16 crisis stabilization beds to the Thurston-Mason region. HCA, Department of Commerce, and the Thurston-Mason BHASO collaborated to release a Notice of Funding Opportunity in November 2024. HCA and Department of Commerce then hosted a Q & A session for potential applicants. Commerce recently extended the RFP application deadline to Feb. 28, 2025 to encourage more agencies to apply for funding.

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. RII was under contract with the Department of Commerce since the June 30, 2022, deadline but never began construction.

In Spring 2024, Commerce sent RII management and contract representatives a letter notice finding RII in breach of their contract requirements and provided RII 30 days to cure the identified breaches. HCA, DSHS, and Commerce are working to identify alternative solutions to fulfill the Phase 2 requirement of a second crisis stabilization facility in King County.

Recommendations to Address Concerns

To address the concerns indicated above, HCA and DSHS in coordination with the Department of Commerce have:

- Continued to coordinate to develop an action plan and next steps for a South King County crisis stabilization facility.

- In conjunction with Commerce, HCA requested capital funds through the decision package process which was included in Governor Inslee's capital budget.

- Met with King County to learn more about their procurement process and timeline for their county funded facilities.

- HCA is also assessing how reimbursement rates affect the sustainability of crisis stabilization facilities to better support crisis stabilization providers.

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 280 people, averaged a 45 percent occupancy rate, and reported an increase of referrals during this reporting period. Of the people served, 71 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. Lastly, Lifeline Connection recently hired a new program director and reports improvements with overall staff retention.

HCA executed an amendment with the Carelon BHASO to reallocate the Pierce County crisis enhancement funds to support crisis response teams with staff retention and training starting in July 2024. During this reporting period, those 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 (PHS) 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. Several staff attended an annual peer conference and the co-occurring disorder treatment conference in Yakima. Eligible staff also attended external clinical supervision training.

Crisis Enhancements – Phase 2

The Downtown Emergency Services Center (DESC) Crisis Solutions Center (CSC) in King County served over 1,100 people this reporting period, including 386 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 will receive the 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 (MHP) positions, which have historically been difficult to fill. With the use of the hiring bonuses, KMHS was able to fill most of their MHP 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 begin planning 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 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 and/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.

Phase 2 FHARPS programs have a higher proportion of participants who were referred by the forensic navigators (92%) 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, as well as a difference in location of first contact with eligible people.

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.

An ongoing practice of FHARPS teams is to connect participants to long-term or permanent housing resources. For example, during this reporting period, six FHARPS enrollees were selected and completed the Spokane Housing Authority (SHA) Housing Choice voucher process to successfully activate their SHA vouchers. These successes are indicative of the program's ability to navigate systemic challenges and secure critical resources for participants.

In order 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 is already identifying potential properties for global leasing opportunities.

HCA continues meeting monthly with Phase 3 providers to provide technical assistance and ensure successful program implementation. The Phase 3 teams continue attending tailored training 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 and are actively serving participants throughout this reporting period.

Emergency Housing Subsidies

During this reporting period, ConnectionsWA opened their Kirkland crisis stabilization campus in the King region. HCA is exploring the possibility of contracting with ConnectionsWA to provide emergency housing subsidies to people exiting their stabilization beds who meet eligibility.

HCA facilitated meetings between emergency housing providers and regional FHARPS providers to facilitate referrals. Data shows that through support and technical assistance, use of the emergency housing subsidies in the King region 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.

With the closure of RII's crisis stabilization facility in the Pierce region, HCA added the emergency housing subsidies to the Carelon BHASO contract beginning July 1, 2024. Carelon is sub-contracting for the emergency housing subsidies in Pierce County and is interested in increasing utilization and diversifying subsidy distribution. Carelon and their subcontractors have each met with the FHARPS providers in Pierce and continue fostering relationships. Emergency housing subsidy use in Pierce County and the Phase 3 regions was lower this reporting period. HCA reached out to providers to continue education on how these subsidies can be used and provided technical assistance including creative placements in the rural regions where access to hotels/motels is limited.

Areas of Concern

A portion of the FHARPS participants discharge from the program due to loss of contact. Most of the FHARPS teams are discharging participants for this reason at a comparable proportion to

other time-limited housing programs. However, HCA is concerned with the high proportion of participants in the King region who are discharging due to loss of contact.

FHARPS teams are required to offer a diversity of housing types in order to be responsive to program participant needs and preference. This can be a challenge in certain regions depending on the availability and diversity of housing resources.

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 client stability, especially for those transitioning from jail.

Lastly, most FHARPS teams are managing high caseloads (more than 15 active participants) and striving to keep up with the high volume of referrals. Even though Phase 3 providers are fully staffed, and the rest of the regions have made significant progress in staffing their teams this year, the demand for FHARPS services continues to be greater than current program capacity.

Recommendations to Address Concerns

HCA is providing intensive and regular technical assistance to the FHARPS providers, particularly in King, to reduce the amount 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 (approximately 50 new referrals per month) and the challenge of balancing existing caseloads while providing timely response to new referrals. HCA is confident that the additional FHARPS provider in King will greatly improve these challenges.

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

HCA is continually working with the FHARPS programs to address workforce challenges including retention of staff. While the FHARPS teams have filled most of their vacant positions during this reporting period, this continues to be an issue throughout the behavioral health field.

During this reporting period, HCA was actively negotiating contracts for the regional ARNPs that would exclusively serve Trueblood element programs and provide necessary prescribing services.

Additionally, HCA is improving coordination with regional legal partners, court-based systems, and hospital settings to ensure successful discharge plans are in place prior to release.

Data – Crisis Triage and Diversion-Residential Supports

Residential supports are provided through two mechanisms: (1) crisis housing vouchers provided by crisis triage and stabilization facilities; and (2) the FHARPS program. Data from HCA's Program Data Acquisition, Management and Storage (PDAMS) system 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

Crisis housing vouchers 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, where 16 vouchers have been issued to 11 recipients through December 2024 (not included in the Appendix table). At this time, the Crisis Housing Voucher (CHV) data tables in Appendix D present information from Phase 1 and 2 regions only. Detailed enrollment and services information from Phase 3 will be reported when there are sufficient cases to protect confidentiality.

Between Dec. 1, 2019, and Dec. 31, 2024, the crisis stabilization and triage facilities and provider teams contracted by HCA distributed 990 housing vouchers to 774 people in Phase 1 and Phase 2 regions (Appendix D, Table 1).[9] The number of vouchers issued increased 18 percent from June to December 2024.

Southwest and King regions each issued more than 30 percent of the vouchers and accounted for nearly two-thirds of voucher recipients combined (32 percent each). The total amount disbursed across Phase 1 and 2 regions was $866,898 and the average amount per recipient was $1,121. 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 and hospitals accounted for half of referrals among those receiving vouchers (30 percent and 20 percent, respectively). Nearly half of King region recipients were referred by law enforcement, which includes police and co-responder programs (46 percent).

Most voucher recipients were male (66 percent), between 30 and 49 years old (54 percent), and non-Hispanic white (59 percent).
Based on matching crisis housing voucher recipients to those within the FHARPS program data, 16 percent of voucher recipients were referred to FHARPS, 14 percent were enrolled, and 13

[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.

percent were housed or sheltered by FHARPS. Most initial housing placements through FHARPS were shelter/emergency placements (81 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 crisis housing vouchers 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, where 63 individuals were enrolled through December 2024 (not included in the Appendix table). At this time, the FHARPS data tables in Appendix E present information from Phase 1 and 2 regions only. Detailed enrollment and services information from Phase 3 will be reported when there are sufficient cases to protect confidentiality.

A total of 2,578 people were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to Dec. 31, 2024 (Appendix E, Table 1).[11] Of these referrals, 1,434 (56 percent) were contacted[12] and 1,195 (46 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 a 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 69 percent of recorded referrals. Forensic navigators made the most

[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.
[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.

referrals, 49 percent overall, and comprised 92 percent of referrals in the King region. FPATH referred 12 percent, and crisis stabilization and triage facilities referred 6 percent.

Most initial contacts were made in jail (34 percent), largely due to the King region conducting 95 percent of their contacts in jail. Thirty 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 (68 percent) enrolled in FHARPS were male, 58 percent were between 18 and 29 years old, and 45 percent were non-Hispanic white. Twenty-two percent of participants identified as Black or African American and 10 percent as Hispanic or Latino. People can identify as more than one race or ethnicity. Most people were without permanent housing at the time of enrollment (59 percent).

Of those enrolled, 70 percent were housed or sheltered at least once (Appendix E, Table 2). About 48 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 44 percent as of Dec. 31, 2024, 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 (96 percent).

Nearly three-quarters (73 percent) of FHARPS participants had been discharged from the program as of Dec. 31, 2024, with an average length of support of 203 days, ranging from 167 days in the Southwest region to 239 days in the Spokane region (Appendix E, Table 3). The average total subsidy support received by those discharged as of Dec. 31, 2024, was $4,290. The change in average total subsidy from June 30, 2024 (more than a $2,000 difference) is likely due to ongoing data clean-up efforts and database challenges.

HCA continues working with providers, particularly in the King region, on entering discharge information and appropriate housing status at discharge. Most discharges from King region providers occurred due to ‘loss of contact’ (70 percent). King reported 71 percent were without permanent housing at time of discharge, down from 81 percent in June 2024 due to data clean-up efforts. Still, since most of these were loss of contact, it is likely these are actually unknown.

Among people discharged, 34 percent of cases were closed due to loss of contact, 14 percent transitioned to other housing support, 11 percent transitioned to self-support, and 12 percent withdrew. Eight percent received the maximum assistance and were discharged without transition to other services. At the time of discharge, 30 percent were stably housed, 18 percent were without permanent housing, and 11 percent were in a facility. Housing status at program discharge was unknown for 34 percent of people (similar to the loss of contact rate); this would be higher if King reported loss of contacts as unknown instead of without permanent housing.

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 in order 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

Phase 1 and 2 FPATH 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. Since many FPATH referrals take time to engage and officially enroll into services, it is more accurate to assume that a portion of the people contacted by FPATH programs but not yet enrolled are on FPATH teams' caseloads and engaging in services. FPATH providers have worked to enhance coordination with the forensic navigators, OCRP, FHARPS, and local jails to strive for warm handoffs into the program when possible.

Phase 1 FPATH teams are increasing outreach to inpatient facilities due to a growing number of FPATH participants with higher acuity of behavioral health conditions. Phase 1 teams are also working closely with local courts and attempting to make connections with people prior to preliminary hearings or before a person is released from custody on personal recognizance. Teams then provide a plan for wraparound services before they release to the community. These services include crisis services, outpatient behavioral health treatment, housing, employment, transportation, and connections to public benefits. FPATH teams continue to work closely with enrolled participants to identify their goals and needs.

During this reporting period, HCA re-connected FPATH teams to regional managed care organizations (MCO) to increase care coordination. Teams have been coordinating with MCOs to provide warm handoffs as people discharge from inpatient care or release from jail. For example, FPATH teams recently had questions on how to connect undocumented people to healthcare, and MCOs provided guidance and resources.

As a part of HCA's effort to improve data quality and oversight, FPATH data transitioned from Excel trackers to HCA's new data capture system, Program Data Acquisition, Management and

Storage, in May 2024. Through contract amendments, HCA added data entry staff to the FPATH teams. During this reporting period, providers have filled these positions. HCA is providing technical assistance and support to the FPATH providers to reduce data-entry challenges and improve data quality.

All Phase 3 teams are actively taking referrals and providing services in the community. Teams have been coordinating with forensic navigators as referrals continue to rise. Teams have been proactive with meeting court partners and providing an overview of FPATH services so that potential participants can be diverted from the criminal legal system.

Areas of Concern

As seen in FPATH discharge data, there is a proportion of participants who are discharged due to loss of contact. HCA is continuing to review data and learn more about the factors surrounding loss of contact.

The volume of referrals continues to grow in all regions, and the demand for FPATH services continues to be greater than the current program capacity.

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.

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

Lastly, legal coordination on behalf of FPATH participants is challenging due to lack of attorney responsiveness, which leaves the FPATH teams without updated information on current charges, release dates, and potential diversion options.

Recommendations to Address Concerns

HCA is continuing to provide technical assistance and program oversight to learn more about the discharge data. HCA's data program manager is meeting with each provider on a monthly basis to assess if current data is accurate. HCA also continues offering technical assistance and support to FPATH teams to encourage ongoing outreach to those who are disengaged. This will help HCA determine if this is a data entry issue, program service gap, or a reflection of the population served by FPATH.

During this reporting period, HCA executed contract amendments to expand the King County and Spokane FPATH teams in order to respond to the high volume of referrals and serve more program participants.

HCA is working with the forensic navigators and the FPATH programs to improve jail release planning including asking courts to include orders for a specific release time to ensure a warm handoff into FPATH services. HCA is facilitating connections between FPATH teams and their regional courts to improve outreach, engagement, and connection to services.

FPATH teams have made connections with Department of Corrections (DOC) liaisons at Western and Eastern state hospitals. Teams have had success with release planning from state hospitals for people on DOC supervision.

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 and April 1, 2022, in the Phase 2 region. The program expanded to the Phase 3 regions on April 30, 2024, where 38 individuals were enrolled through December 2024 (not included in the Appendix table). At this time, the FPATH data tables in Appendix F present information from Phase 1 and 2 regions only. Detailed enrollment and services information from Phase 3 will be reported when there are sufficient cases to protect confidentiality.

Program suitability is based on an eligibility list of people who had two or more competency evaluation referrals within the prior 24 months. Between March 1, 2020, and Dec. 31, 2024, 4,170 people were eligible for FPATH services across the Phase 1 and Phase 2 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), number of referrals (four or more in the past 24 months), and county of residence (prioritizing rural counties). The number of people in the prioritized group was 2,721, or 65 percent of the total eligibility list.

Of all people on the eligibility lists for Phase 1 and Phase 2, FPATH providers attempted to contact 1,581 (38 percent) and successfully contacted 1,456 (35 percent). As of Dec. 31, 2024, a total of 841 people (20 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Enrollments among the prioritized population were 25 percent of the prioritized list.

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 18 percent of their eligibility list. The Phase 2 King region has had 284 enrollees since the program started in April 2022, which was 16 percent of its eligibility list. Of these, 191 were from the prioritized population.

Among enrolled people, the majority were male (71 percent overall) and between 30 and 49 years old (61 percent). More than half of enrollees (58 percent) were without permanent housing at program enrollment, while 19 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among the 527 people discharged from the FPATH program through Dec. 31, 2024, the average length of stay in the program was 313 days. People in the Spokane region had the longest length of stay at 478 days, while the King region had the shortest at 153 days. (Appendix F, Table 1). Loss of contact was the most common reason for FPATH discharge throughout all four regions (46 percent overall).

It should be noted that the number of people discharged from the FPATH program through Dec. 31, 2024 (n=527) was lower than the number of discharges reported in the September 2024 semi-annual report (n=575, see Semi-Annual Report 10). This decrease is due to FPATH providers incorrectly exiting some active participants from previous data collection systems (e.g., Excel trackers, HMIS) before transitioning to PDAMS for data collection. Active participants who were not truly discharged from FPATH have been recategorized as active in the current semi-annual report.

Services

There have been 18,409 service encounters between FPATH providers and participants over the duration of the program, with an average of 2.7 services per participant, per month (Appendix F, Table 2). Averages ranged from 2.2 services per month in the Spokane region to 3.7 in the Southwest region. Across all FPATH regions, the most common service encounter was case management (1.4 per person, per month, on average), followed by outreach services, peer services, and service coordination (0.3 per person, per month) (Appendix F, Table 2).

Referrals

Of the 841 FPATH enrollees, 332 (40 percent) had received at least one referral through December 2024 (Appendix F, Table 2). FPATH enrollees in the Spokane region had the highest rate of referrals, with 62 percent of participants having at least one, followed by 50 percent in the Southwest region and 36 percent in the Pierce region. In the Phase 2 King region, 26 percent of enrollees had received at least one referral.

The most common referral program-wide was to FHARPS housing, with 19 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Community mental health referrals were also common, particularly in the Spokane region where 23 percent of enrollees had at least one referral (compared to 12 percent statewide).

Education and Training – Crisis Intervention Training

For all the phased regions through Dec. 31, 2024, 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 Dec. 31, 2024, 3,200 law enforcement officers have completed this training. As of Dec. 31, 2024, 33 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 the 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, 1,219 corrections officers have received at least the minimum eight-hour CIT for corrections training.

Phase 1 and 2 regions remain eligible to receive up to 40 hours of cost coverage for backfill as a result 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 98 percent compliant in Phase 1 areas, 83 percent compliant in the Phase 2 region and already 95 percent compliant in Phase 3.

For Phase 2, the King region continues running a robust 40-hour CIT program. Because of this, of the 3,221 certified peace officers in the King region, 1,604 have completed the training (50 percent). By June 30, 2023, 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 575 correctional officers. To date, 549 officers (96 percent) have completed the required eight-hour CIT for corrections training. These courses have been offered exclusively in an interactive webinar format.

The Salish region has 161 telecom/911 dispatchers. Of these, 153 (95 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, we have needed to cancel three classes. We have nine additional 40-hour CIT courses scheduled between mid-March 2025 and June 30, 2025, across the Trueblood Phased regions. We are still on track to complete the 25 percent requirement for Phase 3 agencies.

Recommendations to Address Concerns

We are actively exploring options to mitigate potential disruptions and ensure continuity of our training programs. The present legislature has proposed bills to assist in funding for additional officers across the state to mitigate shortages in staffing. We have received approval to recruit three full-time mental health professionals to assist with instruction for these courses. We are actively communicating regularly with agency administrations to educate them on available training and incentives that are built into these trainings. We will provide updates on our progress as more information becomes available.

Data – Education and Training-CIT

Phase 1

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

Appendix G, Figure 1 displays training completion rates for each individual law enforcement agency in Phase 1. As of Dec. 31, 2024, 33 (61 percent) law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies continued to achieve higher training completion rates (44 percent overall) than small agencies (28 percent) in all three regions (Appendix G, Table 1). It should be noted that the CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022. Training rates will continue to shift, however, as the number of officers in each agency fluctuates over time.

As shown in Appendix G, Table 1, the overall training completion rate for all law enforcement agencies in Phase 1 was 39 percent as of Dec. 31, 2024. In the Pierce region, 24 percent of

officers were trained, compared to 50 percent in the Southwest region, and 52 percent in the Spokane region. Washington State Patrol units in the Phase 1 regions have achieved a training rate of 34 percent.

The Settlement Agreement also requires 911 dispatchers and correctional officers in the Trueblood Phase 1 regions to complete an eight-hour CIT course. In June 2022, the CIT program achieved 100 percent compliance with the 911 dispatchers training requirement in the Phase 1 regions. As of Dec. 31, 2024, 98 percent of Phase 1 911 dispatchers had completed CIT training, with the Pierce region remaining 100 percent compliant (Appendix G, Table 3). In addition, 94 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 91percent in the Spokane region to 99 percent in the Southwest region (Appendix G, Table 2).

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 Dec. 31, 2024, 26 (93 percent) law enforcement agencies exceeded the 25 percent benchmark, with an overall training completion rate of 50 percent (Appendix G, Table 1). Washington State Patrol units in Phase 2 had a training completion rate of 41percent. Unlike Phase 1, small law enforcement agencies in King County had the highest overall training rate (59 percent) while medium-sized agencies had a lower overall rate of 38 percent.

Most (96 percent) correctional officers in King County had completed the eight-hour CIT course by Dec. 31, 2024 (Appendix G, Table 2), as well as 83 percent of 911 dispatchers (Appendix G, Table 3). Dispatchers and correctional officers in the Phase 2 region had until June 30, 2023, to meet the 100 percent training requirement.

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 Dec. 31, 2024, 11 (50 percent) law enforcement agencies had met or exceeded the 25 percent training requirement, with an overall training rate of 33 percent. Large law enforcement agencies had higher training rates than small agencies (40 percent and 14 percent, respectively), and Washington State Patrol units had a training completion rate of 21 percent (Appendix G, Table 1).

Among correctional officers in the Phase 3 regions, 19 percent had completed the eight-hour CIT course by Dec. 31, 2024 (Appendix G, Table 2), as well as 95 percent of 911 dispatchers (Appendix G, Table 3). Dispatchers and correctional officers in the Phase 3 region have until June 30, 2025, to meet the 100 percent training requirement.

The Settlement Agreement states that the 25 percent training target should prioritize law enforcement agencies that serve areas with higher population densities. As of Dec. 31, 2024, large agencies serving the areas of greater population density within the Southwest and Spokane regions had higher rates of training completion (58 percent and 62 percent, respectively; Appendix G, Table 1). This pattern was not observed in the Pierce or King regions, however, where large agencies with higher population densities had lower training completion rates than small agencies with lower population densities. In the Phase 3 regions, large agencies had a higher training completion rate than small agencies (40 percent and 14 percent, respectively; Appendix G, Table 1).

Education and Training – Technical Assistance for Jails

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 anticipated date of completion for the revised edition is March 2025.

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 17 statewide training events toward the minimum of twenty required during this phase.

The learning events presented from July 1, 2024, through Dec. 31, 2024, were:

- July: Motivational Interviewing
- August: An Overview of the NGRI Program
- September: University of Washington Psychiatry Consultation Line
- October: Forensic Navigator Program Overview
- November: Statewide Reentry Council Expands to Include County, City, and Tribal Jails.
- December: No Event

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.

Recommendations to Address Concerns

It is recommended that JTA staff complete 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.

Data – Jail Technical Assistance

In July 2021, JTA staff began tracking the number of participants in each JTA Monthly Learning Event. For the six-month period from July 2021-December 2021, average attendance was 5.5 people per event. During calendar year 2022 and 2023, the average number of participants was 16 people per event. The average number of attendees for calendar year 2024 was 23. Overall, the number of attendees has increased since 2021 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

Workforce development staff put forth significant effort during 2022 to develop an online training series specifically designed to address the need to enhance basic forensic literacy. They ultimately created a five-module online training series that covers:

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

These online training 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. 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. In April 2024, a review and update to this series was initiated, with an expected completion date of May 2025.

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 the history, rules, laws, services, and practices pertaining to forensic mental health. The workforce development team plans to update the guidebook in parallel with the training series and has begun working on the revisions. The team is also working on an additional module, civil commitment, to be included in both the guidebook and the online training series. The anticipated completion date for these is mid-year 2025.

In 2023, the workforce development team procured a contract with Groundswell Services Inc. to conduct focus groups and interviews as a follow-up to a survey the team initiated. The goal of the survey was to learn more about the perspectives of prosecutors, defense counsel, and judges regarding the continuing increase in demand for pretrial competency services.
Groundswell has substantial expertise related to forensic mental health services, particularly forensic evaluation, competency restoration services, forensic mental health systems, workforce development, and training. Its employees have previously served as consultants for Washington's forensic mental health system and were the lead consultants and an expert witness in the Trueblood vs. Washington State Department of Social and Health Services federal class action lawsuit. After gathering the input provided by the legal system partners, Groundswell analyzed the information and compiled material pertaining to promising practices and programs throughout the county. They issued a report on their findings and included four recommendations. These recommendations 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.

Workforce development convened a workgroup with subject matter experts from both DSHS and HCA and met regularly to move these recommendations forward. In October 2024, the workgroup engaged with experts in Colorado in an immersive learning tour of innovative programs built around competency services, including Mental Health Transitional Living Homes, the RISE program, and OCRP. The group also met with Groundswell to discuss approaches and how they might work in Washington state. In November 2024, the workgroup met with staff from Harris County, Texas to learn about their competency programs and services including OCRP, Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, the joint processing center, intellectual and developmental disabilities in relation to competency, jail-based restoration, and a discussion pertaining to their Respite, Rehab, and Reentry Center.

The workgroup anticipates completion of its recommendation report in March 2025.

Workforce development staff continue to be centrally involved in providing guidance and technical assistance statewide with the BHA 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 BHA 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 is responsible for collecting and compiling data for the telehealth key performance indicators and the site status databases. This committee is a newly established workgroup 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 early 2024, the BHA telehealth committee identified a set of key performance indicators to gauge success. By July 2024, mechanisms to track these indicators were identified and tracking had begun. A new charter was also drawn up in July to reflect the change from a project status for telehealth to an operational status. Site tracking and prioritization was also initiated, and the Snohomish County jail telehealth installation was completed in October 2024. The Chelan County jail was the next priority and telehealth installation there was near completion in December 2024. Evaluations via telehealth are now being completed at both locations. In 2024, the committee also visited Skagit County jail and Clark County Jail to assess their capability and is working with their staff to get equipment installed. The telehealth committee and state IT staff continue to work with county partners as it troubleshoots 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 DSHS Employer of Choice Workgroup, the Washington State Association of Sheriffs and Police Chiefs, the Health Care Authority'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 Employee Engagement Survey Workgroup, the BHA 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. Workforce development has also designed and deployed NEO surveys which are delivered to new employees on their 30-day, 90-day, six-month and eleven-month anniversaries. These surveys will assist in determining if new staff are well supported in their first year of employment and will identify any gaps or issues for OFMHS to address. In July 2024, staff began offering a virtual check-in for survey respondents to provide feedback directly to workforce development staff.

This option has proven to be the preferred method for respondents, as new employees feel more of a connection. Workforce development began regular check-ins with senior leadership in mid-2024 to review and evaluate results of the new employee surveys.

From July 2024 to the end of the year, 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.

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 a training in October 2024. Staff have recorded an online version of this training to be used as new OCRP staff onboard. Final edits are being made, and this version is expected to be completed in early 2025. Workforce development staff have also completed a training related to the topic of belonging as part of equity, diversity, access and inclusion awareness. Related to training and staff support, 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.

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 review content on this site.

Promoting Careers in Behavioral Health (supporting recruitment)

In October 2024, the team participated in several career fair events hosted at area colleges: Clark College's WSU-Vancouver campus, Washington State University in the Tri Cities, Gonzaga University in Spokane, and Central Washington University in Ellensburg. At these schools, staff

engaged with students and answered questions about jobs in behavioral health. In August 2024, staff also hosted a booth at the American Psychological Association conference and in November at the WAADAC Workforce Summit Conference. They were able to interact with potential job candidates and discuss different careers and pathways in forensic mental health. It is recommended that staff continue to participate in educational outreach and events which support recruitment.

Develop Trainings for Staff (supporting retention)

Previously, the workforce development team-initiated work on an online version of the Breaking Barriers curriculum for use in OCRP. This version has been recorded and final edits to include accessibility audits and written transcripts are being made. Breaking Barriers has 10 modules, and staff anticipate completion in early 2025.

Workforce development is also developing a training for forensic navigators on using the case management system. This training will be comprised of three modules, the first of which has been completed. This will then be loaded into the Learning Center making it available for assignment to OFMHS staff.

Workforce development continues working 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

In June 2024, OFMHS workforce development began collecting data on new employee job satisfaction within OFMHS. This is accomplished through surveys which are delivered to new employees on their 30-day, 90-day, six-month and eleven-month anniversaries. These surveys assist us in determining if new staff are well supported in their first year of employment and will also identify any gaps or issues for OFMHS to address. Two of the questions that are common to all four surveys are:

1. “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).

2. “My overall satisfaction with my job is:” (response options are excellent, good, fair, or poor).

In December 2024, for the 30-day survey, 16 of 30 staff responding to the first survey question replied *excellent,* another 11 replied *good,* two reported *fair* and one replied *poor*. For the second question, 18 of 30 staff responding to the survey replied *excellent,* another 10 replied *good,* and one each replied *fair* and *poor*. For the 90-day survey, 11 of 25 staff responding to the first survey question replied *excellent*, 12 replied *good* and two reported *fair*. For the second question, 12 of 25 staff responding to the survey replied *excellent*, 11 replied *good,* and two reported *fair*. Upon 30 days, 90 percent of new staff responding to the survey felt that they had received *good* or *excellent* job-related training and communication, and about 93 percent had *good* or *excellent* satisfaction with their job. Upon 90 days, 92 percent of new staff responding to the survey felt that they had received *good* or *excellent* job-related training and communication, and 92 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 Final Implementation Plan. 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. As of Dec. 31, 2023, 92 of 93 Phase 2 task items remain complete,[14] and most Trueblood programming in the Phase 2 King region is already operational. The Phase 2 implementation period ran from July 1, 2021, through June 30, 2023.

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 and 2. Phase 1 programs continue to gain experience serving their clients, and the more recently implemented Phase 2 programming continues rapidly gaining experience in the field and benefiting from the knowledge already gained from Phase 1 implementation and operations. Phase 3 implementation is now underway in five counties and two BHASO regions including the Thurston Mason Behavioral Health ASO, which incorporates Thurston and Mason counties and the Salish Behavioral Health Organization, which comprises Kitsap, Clallam, and Jefferson counties. Phase 3 implementation continues through June 30, 2025. As of December 31, 2024, 45 of the 73 Phase 3 implementation

[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 January 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 January 11, 2023.

tasks were completed on time or early, including 35 that were completed early. Twenty-three implementation tasks remain to complete.

Appendix A – Related Resources

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

State Agency Resources:

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

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

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

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

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

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

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

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

OCRP Dashboard

Outpatient Competency Restoration Program

CUMULATIVE UPDATE

The program objective of the Outpatient Competency Restoration Program (OCRP), administered by the Health Care Authority (HCA), is to provide timely and effective outpatient competency restoration services to individuals determined by the court as a) not competent to stand trial and b) appropriate for community-based services to restore competency. The intent of the OCRP is to reduce the number of people waiting to receive inpatient competency restoration, to provide competency services in a safe and cost-effective environment, and to provide the most appropriate level of care to the individual. OCRP services began on July 1, 2020 in the Phase 1 Regions: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). OCRP began in the Phase 2 Region (King County) on October 31, 2022. From July 2020 to December 2024, OCRP enrolled 285 individuals in the Phase 1 and Phase 2 Regions. OCRP services began on April 30, 2024 in the Phase 3 Regions: Salish (Kitsap, Jefferson, and Clallam Counties) and Thurston-Mason (Thurston and Mason Counties). Detailed information from Phase 3 will be available in the next semi-annual report, with data reported through June 30, 2025.

REPORTING PERIOD

Cumulative: July 1, 2020 to December 31, 2024

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

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TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - December 31, 2024

	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	285	100%	83	100%	85	100%	54	100%	63	100%
Among Enrolled Individuals…										
RESTORATION ORDER TYPE (unduplicated)										
Felony	237	83%	64	77%	64	75%	--	--	--	--
Misdemeanor	48	17%	19	23%	21	25%	--	--	--	--
GENDER										
Female	56	20%	--	--	--	--	12	22%	--	--
Male	203	71%	56	67%	63	74%	42	78%	42	67%
Other/Unknown	26	9%	--	--	--	--	0	0%	--	--
AGE GROUP										
18-29 yrs	77	27%	25	30%	30	35%	--	--	--	--
30-49 yrs	149	52%	35	42%	39	46%	31	57%	44	70%
50+ yrs	59	21%	23	28%	16	19%	--	--	--	--
RACE/ETHNICITY*										
Non-Hispanic White	173	61%	46	55%	60	71%	45	83%	22	35%
Black, Indigenous, and People of Color	85	30%	--	--	--	--	--	--	--	--
Unknown	27	9%	--	--	--	--	--	--	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	87	31%	37	45%	11	13%	17	31%	22	35%
Unstably Housed	141	49%	26	31%	62	73%	16	30%	37	59%
Homeless	42	15%	--	--	11	13%	19	35%	--	--
In a Facility	14	5%	11	13%	--	--	--	--	--	--
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 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - December 31, 2024

	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
CLIENT STATUS (on last day of reporting period)										
Enrolled	285	100%	83	100%	85	100%	54	100%	63	100%
Active	39	14%	12	14%	--	--	--	--	15	24%
Discharged	246	86%	71	86%	--	--	--	--	48	76%
Among Discharged Individuals…										
DISCHARGE REASON										
Charges Dismissed	31	13%	15	21%	--	--	--	--	--	--
Opined Competent	96	39%	15	21%	35	45%	21	42%	25	52%
Opined Not Competent	6	2%	--	--	--	--	--	--	0	0%
Opined Not Restorable	5	2%	--	--	0	0%	0	0%	--	--
Returned to Jail	9	4%	--	--	--	--	0	0%	0	0%
Inpatient Medical Care	2	1%	--	--	0	0%	0	0%	--	--
Inpatient Civil Psychiatric Care	15	6%	--	--	0	0%	--	--	--	--
Revoked Conditional Release	64	26%	12	17%	25	32%	15	30%	12	25%
Legal Authority Ended	10	4%	--	--	--	--	0	0%	--	--
Death	4	2%	0	0%	0	0%	--	--	--	--
Other	4	2%	--	--	--	--	0	0%	0	0%
DISCHARGE LOCATION										
Community	156	63%	50	70%	46	60%	29	58%	31	65%
Behavioral Health & Treatment Center*	5	2%	--	--	0	0%	0	0%	--	--
State Hospital	42	17%	--	--	12	16%	16	32%	--	--
Jail	24	10%	--	--	--	--	--	--	--	--
Unknown	19	8%	--	--	--	--	--	--	0	0%
LENGTH OF STAY										
Average Length of Stay in Program (days)	82	N/A	82	N/A	78	N/A	94	N/A	73	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	95	39%	30	42%	23	30%	26	52%	16	33%
Unstably Housed	77	31%	24	34%	--	--	--	--	30	63%
Homeless	28	11%	--	--	19	25%	--	--	--	--
In a Facility	25	10%	--	--	--	--	12	24%	0	0%
Unknown/Missing	21	9%	--	--	11	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.

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.
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.
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.

VARIABLE NAME	DEFINITION
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 Administration Forensic Navigator Program

CUMULATIVE UPDATE

The Forensic Navigator Program is administered by the Behavioral Health Administration and is designed to support individuals navigating the state's community-based competency evaluation services and outpatient restoration programs. The program began July 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane region (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). The Forensic Navigator Program began in the Phase 2 Region (King County) on January 1, 2022. Phase 3 Thurston-Mason region (Thurston and Mason counties) and Salish region (Clallam, Kitsap, and Jefferson counties) began April 15, 2024. From July 2020 to December 2024, the Forensic Navigator program served 8,491 individuals.

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 December 31, 2024

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

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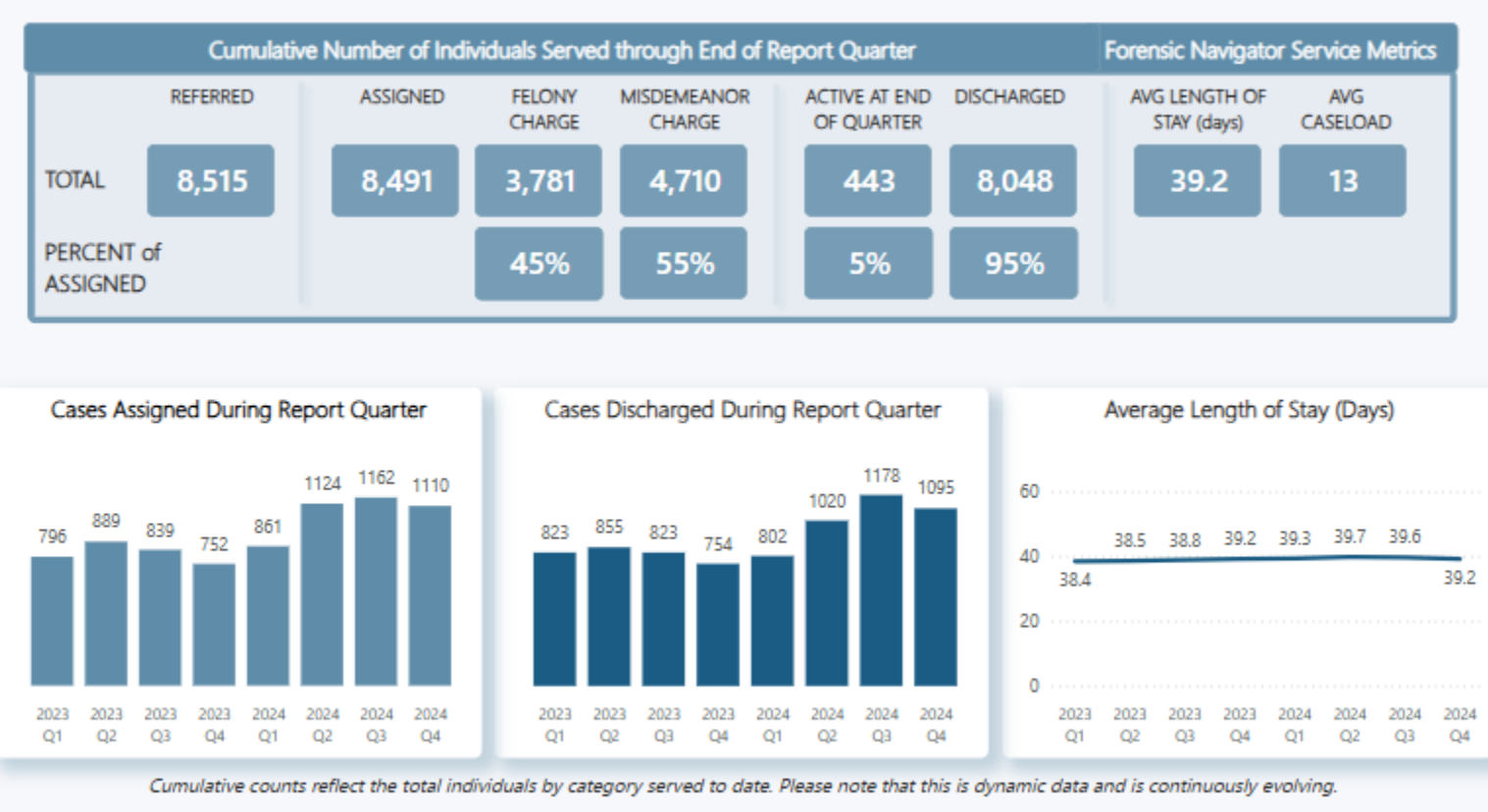
***FULL ONLINE POWER BI DASHBOARD: https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program-0**

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	2020 Q3	2020 Q4	2021 Q1	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
Active	110	137	127	135	168	148	334	383	372	379	332	378	388	370	417	497	445	443
Pre-Competency Hearing	106	128	117	125	155	135	318	367	342	339	289	325	334	325	364	441	402	387
OCRP Enrolled	3	7	9	8	10	11	12	12	19	25	24	30	31	19	30	27	29	31
Post OCRP	1	2	1	2	3	2	4	3	3	5	7	2	2	9	6	7	4	6
Reassess for OCRP	0	0	0	0	0	0	0	1	8	9	8	10	17	8	11	11	6	15
In Process of OCRP Removal	0	0	0	0	0	0	0	0	0	1	4	11	4	9	6	11	4	4

Figure 3.

Forensic Navigator Program Measures
Caseload by Region

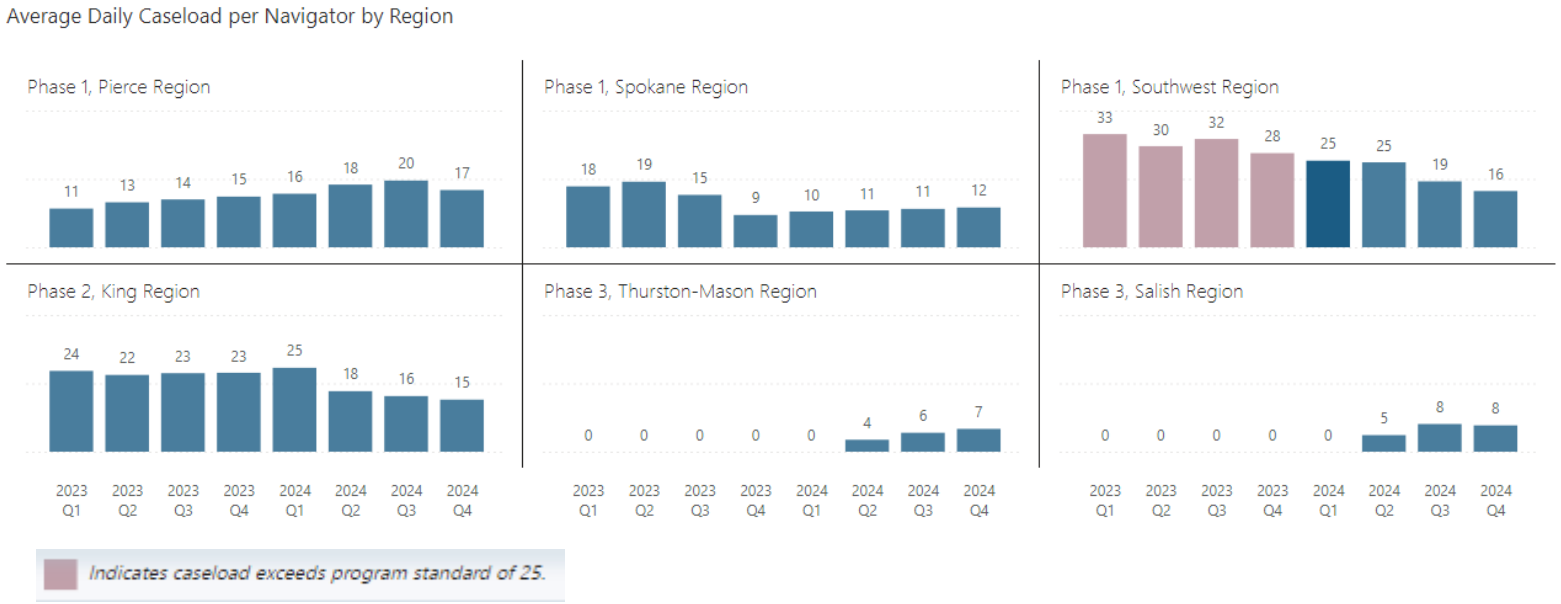


Table 1.

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	451	25%	303	22%	267	26%	834	22%	39	18%	23	13%	**1,917**	**23%**
30-49	972	54%	768	56%	578	55%	2,181	56%	126	58%	102	60%	**4,727**	**56%**
50 +	385	21%	302	22%	198	19%	863	22%	53	24%	46	27%	**1,847**	**22%**
Gender														
Female	394	22%	345	25%	224	21%	801	21%	61	28%	56	33%	**1,881**	**22%**
Male	1,180	65%	998	73%	718	69%	2,411	62%	145	67%	103	60%	**5,555**	**65%**
Other/Unknown	234	13%	30	2%	101	10%	666	17%	12	6%	12	7%	**1,055**	**12%**
Race-Ethnicity														
American Indian or Alaska Native	39	2%	40	3%	*		52	1%	*		*		**141**	**2%**
Asian	59	3%	14	1%	35	3%	192	5%	*		*		**311**	**4%**
Black or African American	456	25%	111	8%	120	12%	1,073	28%	21	10%	20	12%	**1,801**	**21%**
Hispanic or Latino	37	2%	14	1%	43	4%	192	5%	*		*		**297**	**3%**
Native Hawaiian or Other Pacific Islander	59	3%	*		20	2%	40	1%	*		*		**130**	**2%**
White Only, Non-Hispanic	858	47%	1,011	74%	639	61%	1,426	37%	150	69%	124	73%	**4,208**	**50%**
Other Race	25	1%	*		28	3%	163	4%	*		*		**237**	**3%**
Unknown	299	17%	174	13%	167	16%	851	22%	23	11%	12	7%	**1,526**	**18%**

Figure 4.

Forensic Navigator Program Measures
Services

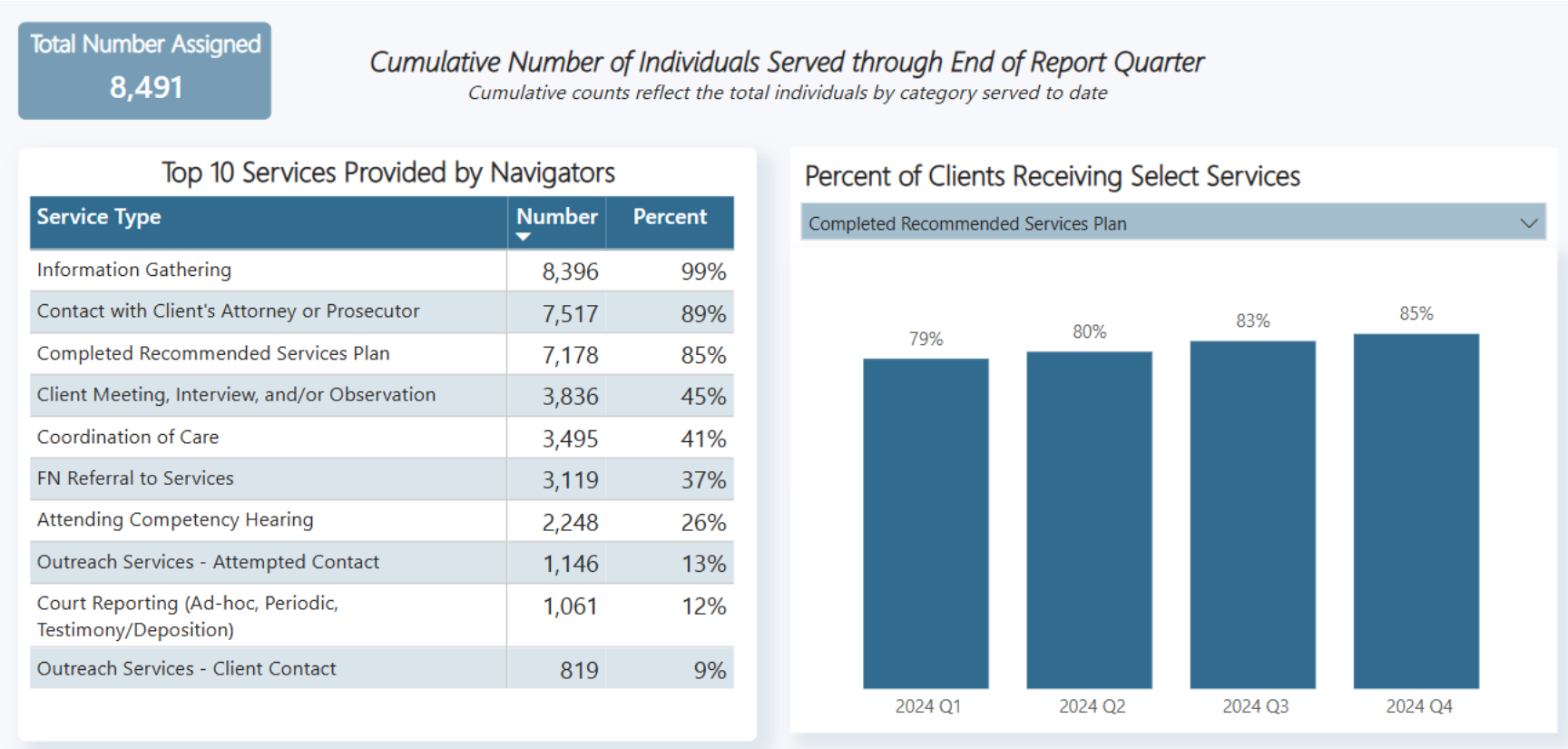


Figure 5.

Forensic Navigator Program Measures

Referrals

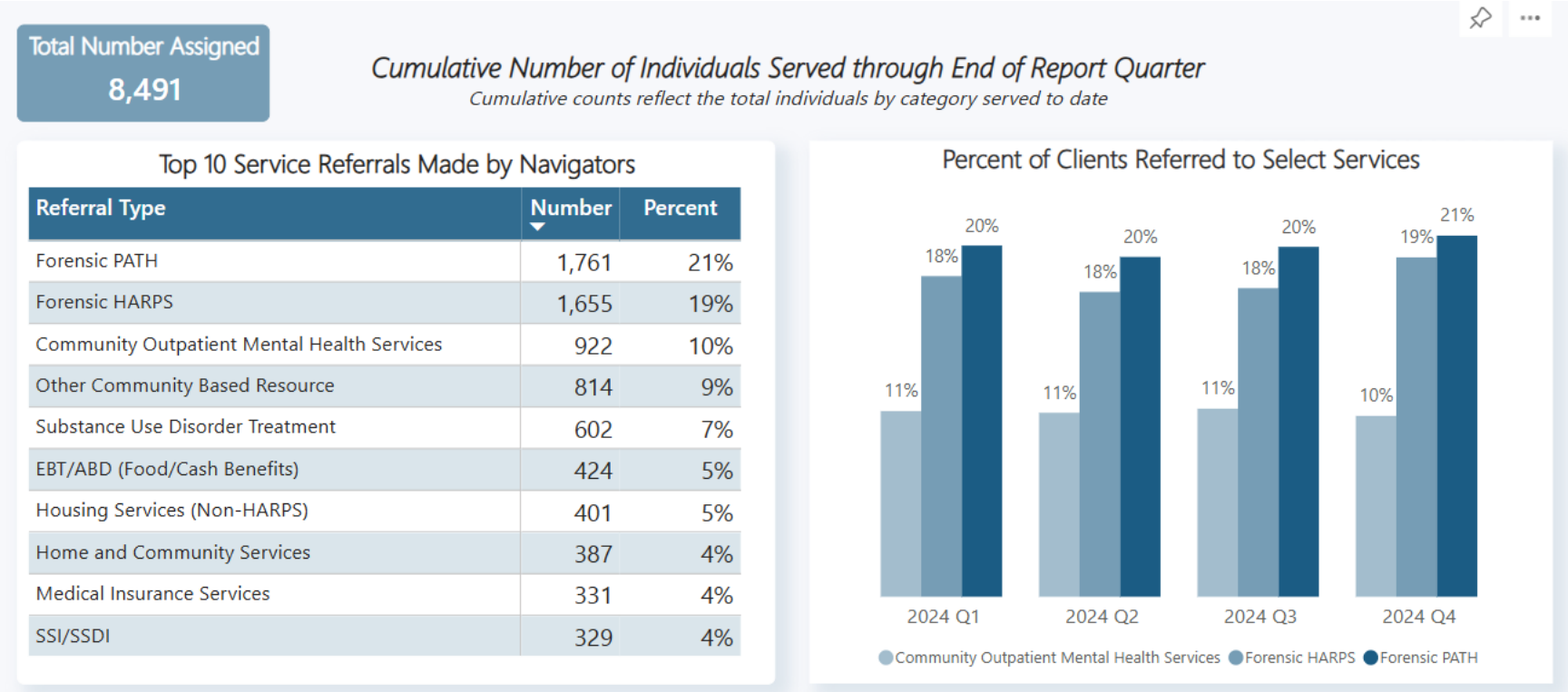


Table 2.

Forensic Navigator Program Measures

Discharges

Number of Clients Discharged	Number with Warm Hand-Off	Percent with Warm Hand-Off	Average Length of Stay (days)
8,048	2,447	30%	39.2

Discharge Reason	Number	% Discharged
Client Determined Competent	2,301	29%
Inpatient Restoration	1,740	22%
Released From Jail on Personal Recognizance (PR)	1,729	21%
Charges Dismissed	1,320	16%
Dismiss & Refer (to Designated Crisis Responder)	379	5%
Order Cancelled or Withdrawn	191	2%
Refused Forensic Navigator Program Services	116	1%
Successful OCRP Completion - Coordinated Transition Completed	54	1%
Not Restorable - Pre-Hearing/OCRP	38	0%
Felony (Up to 120 Hours) Civil Conversion	31	0%
Violation of OCRP Conditions of Participation/Court Ordered CR	31	0%
Felony (Up to 120 Hours) Civil Conversion - FN Completed Warm Hand Off	23	0%
Client Death	16	0%
Not Restorable - Developmental Disability	13	0%
Successful OCRP Completion - Summary of Treatment Completed	11	0%
Civil Conversion - Removal from OCRP	8	0%

Appendix D – Crisis Housing Vouchers Dashboard

Crisis Housing Vouchers

Crisis Housing Voucher Disbursals

CUMULATIVE UPDATE

Beginning December 2019, Washington State Health Care Authority (HCA) contracted funds for select crisis triage and stabilization facilities. The intent of the program was to provide crisis housing vouchers for persons leaving a facility without housing. To better meet community needs, contracts were expanded to allow teams to distribute vouchers outside crisis triage and stabilization facilities. Vouchers became available on December 1, 2019 in the Phase 1 Regions of the Trueblood settlement agreement: Pierce (Pierce County), Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). Vouchers became available in the Phase 2 Region (King County) in July 2022. From December 2019 to December 2024, 990 vouchers were disbursed to 774 individuals in the Phase 1 and Phase 2 regions. Vouchers became available on January 1, 2024 in the Phase 3 Regions: Salish (Kitsap, Jefferson, and Clallam Counties) and Thurston-Mason (Thurston and Mason Counties), and 16 vouchers were issued to 11 people (Not Shown). Detailed information from Phase 3 will be available in the next semi-annual report, with data reported through June 30, 2025.

REPORTING PERIOD

Cumulative: December 1, 2019 to December 31, 2024

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

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TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to December 31, 2024

	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	990	100%	130	13%	316	32%	236	24%	308	31%
Recipients (unduplicated)	774	100%	129	17%	247	32%	153	20%	245	32%
Total Amount Disbursed	$866,898	N/A	$166,063	N/A	$336,282	N/A	$199,360	N/A	$165,193	N/A
Average Amount Per Recipient	$1,121	N/A	$1,293	N/A	$1,362	N/A	$1,303	N/A	$674	N/A
FACILITY REFERRAL SOURCE										
Crisis Call Center	3	0%	0	0%	--	--	--	--	0	0%
Family/Friend	11	1%	--	--	--	--	0	0%	--	--
Hospital	153	20%	51	40%	--	--	63	41%	--	--
Mobile Crisis Response	36	5%	--	--	--	--	32	21%	--	--
Designated Crisis Responder	42	5%	0	0%	--	--	41	27%	--	--
Tribe or Indian Healthcare Provider	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Responder	8	1%	--	--	--	--	0	0%	--	--
Community Behavioral Health Agency	52	7%	--	--	25	10%	--	--	20	8%
Other Healthcare Provider	7	1%	--	--	--	--	0	0%	--	--
Law Enforcement (Police, Co-Responders)	133	17%	14	11%	--	--	--	--	112	46%
Court/Criminal Justice Referred	34	4%	--	--	--	--	0	0%	32	13%
Self	233	30%	31	24%	176	71%	--	--	--	--
Other	62	8%	21	16%	--	--	--	--	35	14%
GENDER										
Female	254	33%	31	24%	--	--	--	--	--	--
Male	508	66%	98	76%	163	66%	98	64%	149	61%
Other/Unknown	12	2%	0	0%	--	--	--	--	--	--
AGE GROUP										
18-29	166	21%	29	22%	51	21%	30	20%	66	27%
30-49	416	54%	65	50%	137	55%	84	55%	130	53%
50+	192	25%	35	27%	59	24%	39	25%	59	24%

	TOTAL - ALL REGIONS		Started December 1, 2019						Started July 1, 2022	
			PIERCE*		SOUTHWEST		SPOKANE		KING	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
RACE/ETHNICITY**										
Non-Hispanic White	453	59%	70	54%	188	76%	96	63%	99	40%
Black, Indigenous, and People of Color	288	37%	58	45%	57	23%	44	29%	129	53%
Unknown	33	4%	--	--	--	--	13	8%	17	7%
Among Voucher Recipients…										
FORENSIC HARPS (FHARPS) STATUS***										
Referred to FHARPS	127	16%	--	--	31	13%	63	41%	--	--
Contacted by FHARPS staff	113	15%	--	--	25	10%	60	39%	--	--
Enrolled in FHARPS	112	14%	--	--	25	10%	60	39%	--	--
Housed or sheltered by FHARPS	98	13%	--	--	24	10%	50	33%	--	--
Among Individuals Housed or Sheltered by FHARPS…										
FIRST FHARPS HOUSING TYPE*										
Permanent	4	4%	--	--	0	0%	--	--	0	0%
Transitional	15	15%	--	--	--	--	--	--	--	--
Shelter/emergency	79	81%	18	82%	--	--	42	84%	--	--
Other	0	0%	0	0%	0	0%	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.

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.
VOUCHERS TABLE, Cumulative	
Voucher Summary	Voucher information including counts, recipients, and amounts.
Vouchers Disbursed	Total number of vouchers disbursed during the reporting period. Regional percentages for Voucher Summary section are calculated based on each region count divided by the 'All Regions' total.
Recipients (unduplicated)	Number of unique individuals receiving vouchers during the reporting period. Individuals in receipt of vouchers from more than one region will be counted in the region that distributed the most recent voucher. Regional percentages for Voucher Summary section are calculated based on each region count divided by the 'All Regions' total.
Total Amount Disbursed	Total amount of voucher monies spent during the reporting period.
Average Amount Per Recipient	Average (mean) voucher amount per recipient. Calculated by the total amount disbursed divided by the number of unduplicated recipients during the reporting period. A region that disbursed a vouchers to a recipient who later received a voucher in another region will not include that individual in the calculation, resulting in a slightly higher average per recipient for that region.
Facility Referral Source	Source that referred the individual to the crisis triage and stabilization facility.
Crisis Call Center	Center that provides support from persons trained in crisis intervention.
Family/Friend	Family member or friend.
Hospital	Facility providing medical and surgical treatment and nursing care for sick or injured people.
Mobile Crisis Response	Mobile Crisis Response team providing community services to individuals experiencing, or are at imminent risk of experiencing, a behavioral health crisis.
Designated Crisis Responder	Person or team that determines a person presents a harm to self/others/property, or is gravely disabled and is at imminent risk, or if there is a nonemergent risk due to a substance use disorder or mental disorder, or is in need of assisted outpatient behavioral health treatment.
Tribe or Indian Healthcare Provider	A tribe member or health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.
Emergency Responder	Person authorized to render emergency medical care (e.g. emergency medical technician).
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.
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).

Variable name	DESCRIPTION
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), 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 FHARPS program began on March 1, 2020 in the Phase 1 Regions of the Trueblood settlement agreement: Pierce (Pierce County), Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). FHARPS services began in the Phase 2 Region (King County) on April 12, 2022. From March 2020 to December 2024, FHARPS enrolled 1,195 individuals in the Phase 1 and Phase 2 regions. FHARPS services began on April 30, 2024 in the Phase 3 Regions: Salish (Kitsap, Jefferson, and Clallam Counties) and Thurston-Mason (Thurston and Mason Counties). FHARPS enrolled 63 individuals in the Phase 3 Regions through December 2024 (Not Shown). Detailed information from Phase 3 will be available in the next semi-annual report, with data reported through June 30, 2025.

REPORTING PERIOD

Cumulative: March 1, 2020 to December 31, 2024

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

TABLE 1.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - December 31, 2024

	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	2,578	100%	885	100%	473	100%	479	100%	741	100%
Contacted	1,434	56%	608	69%	384	81%	242	51%	200	27%
Enrolled	1,195	46%	448	51%	352	74%	236	49%	159	21%
Among Referred Individuals…										
REFERRAL SOURCE										
Trueblood partner programs	1,774	69%	406	46%	330	70%	352	73%	686	93%
Forensic Navigator	1,269	*49%*	*208*	*24%*	*256*	*54%*	*120*	*25%*	*685*	*92%*
Forensic PATH	299	*12%*	*126*	*14%*	--	--	*134*	*28%*	--	--
OCRP	36	*1%*	*16*	*2%*	--	--	*19*	*4%*	--	--
Crisis Stabilization Center	150	*6%*	*49*	*6%*	*33*	*7%*	*68*	*14%*	*0*	*0%*
Co-Response Team	20	*1%*	--	--	--	--	--	--	*0*	*0%*
Mobile Crisis Response	2	0%	--	--	0	0%	--	--	0	0%
Diversion Navigator	11	0%	0	0%	0	0%	0	0%	11	1%
Behavioral Health Facility - Outpatient	295	11%	142	16%	99	21%	54	11%	0	0%
Inpatient Facility	68	3%	46	5%	--	--	12	3%	--	--
Family/Self	52	2%	34	4%	--	--	16	3%	--	--
Other	376	15%	256	29%	36	8%	44	9%	40	5%
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT										
Phone	426	30%	233	38%	162	42%	31	13%	0	0%
Court	3	0%	--	--	--	--	0	0%	0	0%
Hotel/Motel	37	3%	31	5%	--	--	--	--	0	0%
Jail	488	34%	88	14%	172	45%	39	16%	189	95%
Crisis Stabilization Center	63	4%	14	2%	--	--	48	20%	--	--
Behavioral Health Facility - Outpatient	185	13%	76	13%	32	8%	77	32%	0	0%
Inpatient Facility	37	3%	22	4%	--	--	13	5%	--	--
Shelter	17	1%	15	2%	0	0%	--	--	--	--

	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
Street/encampment	13	1%	12	2%	0	0%	--	--	--	--
Temporary Residence	11	1%	--	--	--	--	--	--	0	0%
Other	154	11%	110	18%	--	--	26	11%	--	--
Among Enrolled Individuals…										
PARTICIPANT STATUS (on last day of reporting period)										
Active	326	27%	109	24%	89	25%	73	31%	55	35%
Discharged	869	73%	339	76%	263	75%	163	69%	104	65%
GENDER										
Female	341	29%	--	--	86	24%	--	--	--	--
Male	813	68%	277	62%	250	71%	171	72%	115	72%
Other/Unknown	41	3%	--	--	16	5%	--	--	--	--
AGE GROUP										
18-29	689	58%	218	49%	214	61%	154	65%	103	65%
30-49	287	24%	118	26%	92	26%	38	16%	39	25%
50+	219	18%	112	25%	46	13%	44	19%	17	11%
RACE/ETHNICITY*										
American Indian or Alaska Native	76	6%	30	7%	28	8%	--	--	--	--
Asian	23	2%	--	--	--	--	--	--	--	--
Black or African American	264	22%	157	35%	39	11%	38	16%	30	19%
Hispanic or Latino	116	10%	47	10%	36	10%	--	--	--	--
Native Hawaiian or Pacific Islander	16	1%	--	--	--	--	--	--	0	0%
White Only, Non-Hispanic	543	45%	197	44%	161	46%	155	66%	30	19%
Other Race	71	6%	18	4%	43	12%	--	--	--	--
Unknown	183	15%	--	--	70	20%	--	--	83	52%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Unstably Housed	493	41%	122	27%	213	61%	60	25%	98	62%
Homeless	702	59%	326	73%	139	39%	176	75%	61	38%

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 August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA 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

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - December 31, 2024

	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	1,195	100%	448	100%	352	100%	236	100%	159	100%
Housed or Sheltered	839	70%	385	86%	177	50%	183	78%	94	59%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies only	38	3%	12	3%	0	0%	26	11%	0	0%
Support Services and Subsidies	1,157	97%	436	97%	352	100%	210	89%	159	100%
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	65	8%	44	11%	--	--	--	--	--	--
Transitional	365	44%	171	44%	58	33%	46	25%	90	96%
Shelter/emergency	406	48%	170	44%	--	--	124	68%	--	--
Other	3	0%	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 August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA 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 3.

FHARPS Discharges

CUMULATIVE: March 1, 2020 - December 31, 2024

	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	1,195	100%	448	100%	352	100%	236	100%	159	100%
Active (on last day of reporting period)	326	27%	109	24%	89	25%	73	31%	55	35%
Discharged (during reporting period)	869	73%	339	76%	263	75%	163	69%	104	65%
Among Individuals Discharged…										
SUBSIDY										
Average total subsidy since enrollment	$4,290	N/A	$6,003	N/A	$3,819	N/A	$3,773	N/A	$1,283	N/A
DISCHARGE REASON										
Transitioned to other housing support	121	14%	98	29%	--	--	19	12%	--	--
Received maximum subsidy	*27*	*22%*	*14*	*14%*	--	--	--	--	--	--
Did not receive maximum subsidy	*94*	*78%*	*84*	*86%*	--	--	--	--	--	--
Transitioned to self-support	98	11%	46	14%	28	11%	--	--	--	--
Admitted to a facility	55	6%	--	--	20	8%	23	14%	--	--
Received maximum assistance (no transition)	73	8%	28	8%	32	12%	13	8%	0	0%
Withdrew	107	12%	33	10%	44	17%	19	12%	11	11%
Loss of contact	298	34%	65	19%	105	40%	55	34%	73	70%
Served by another FHARPS team	4	0%	--	--	--	--	0	0%	0	0%
Other	113	13%	56	17%	32	12%	14	9%	11	11%
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	203	N/A	226	N/A	167	N/A	239	N/A	183	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	260	30%	152	45%	56	21%	--	--	--	--
Unstably Housed	64	7%	25	7%	28	11%	--	--	--	--
Homeless	155	18%	46	14%	22	8%	13	8%	74	71%
In a Facility	94	11%	17	5%	28	11%	--	--	--	--
Unknown	296	34%	99	29%	129	49%	54	33%	14	13%

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 August 2023. Data are subject to change due to challenges tracking individuals across data sources. RDA and HCA will collaborate on improvements.

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.

FHARPS Definitions

VARIABLE NAMES	DEFINITION
ALL TABLES	
Total - All Regions	Includes Phase 1 and 2 Regions: Pierce, Southwest, Spokane, King.
Phase 1 Regions	Phase 1 Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties.
Phase 2 Region	Phase 2 Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
ENROLLMENT TABLES, Cumulative	
Total Population (unduplicated)	Participant counts are unduplicated. If an individual is referred, contacted, or enrolled more than once during a reporting period, the most recent case information is reported in the total, and within the region that most recently served them.
Referred	Individuals referred to FHARPS during the reporting period.
Contacted	Individuals contacted to attempt to enroll in the program during the reporting period.
Enrolled	Participants enrolled during the reporting period.
Referral source	Source of the referral to FHARPS services. If more than one source referred the participant for FHARPS services, providers are instructed to enter the first referral source.
Trueblood Partner Programs	Programs implemented as part of Trueblood settlement 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.
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.

VARIABLE NAMES	DEFINITION
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.
Subsidies Only	Participant agreed to receive only subsidy support.

VARIABLE NAMES	DEFINITION
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), offers enhanced engagement and connection to services for individuals identified as most at risk of being referred for a competency evaluation within the next six months. Teams within behavioral health agencies will connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The FPATH program began on March 1, 2020 in the Phase 1 Regions of the Trueblood settlement agreement: Pierce (Pierce County), Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). FPATH services began in the Phase 2 Region (King County) on April 1, 2022. From March 2020 to December 2024, FPATH enrolled 841 individuals in the Phase 1 and Phase 2 regions. FPATH services began on April 30, 2024 in the Phase 3 Regions: Salish (Kitsap, Jefferson, and Clallam Counties) and Thurston-Mason (Thurston and Mason Counties). FPATH enrolled 38 individuals in the Phase 3 Regions through December 2024 (Not Shown). Detailed information from Phase 3 will be available in the next semi-annual report, with data reported through June 30, 2025.

REPORTING PERIOD
March 1, 2020 to December 31, 2024

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

CUMULATIVE: March 1, 2020 - December 31, 2024

	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	4,170	100%	1,199	100%	440	100%	794	100%	1,737	100%
Attempted Contacts	1,581	38%	640	53%	131	30%	426	54%	384	22%
Contacted	1,456	35%	309	26%	193	44%	318	40%	636	37%
Enrolled	841	20%	248	21%	166	38%	143	18%	284	16%
PRIORITIZED POPULATION										
Prioritized Eligibility List	2,721	65%	810	68%	242	55%	603	76%	1,066	61%
Attempted Contacts	933	34%	417	51%	59	24%	291	48%	166	16%
Contacted	1,157	43%	275	34%	179	74%	290	48%	413	39%
Enrolled	674	25%	205	25%	142	59%	136	23%	191	18%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	314	37%	76	31%	54	33%	43	30%	141	50%
Discharged	527	63%	172	69%	112	67%	100	70%	143	50%
Average Length of Stay in Program (days)	313	N/A	369	N/A	305	N/A	478	N/A	153	N/A
DISCHARGE REASON										
Successful exit	89	17%	36	21%	17	15%	19	19%	17	12%
Loss of contact	242	46%	51	30%	42	38%	55	55%	94	66%
Needs could not be met by program	22	4%	--	--	--	--	--	--	--	--
Withdrew	29	6%	--	--	--	--	--	--	11	8%
Incarceration	55	10%	--	--	29	26%	12	12%	--	--
Admitted to hospital	15	3%	--	--	--	--	--	--	--	--
Transferred to another FPATH program	3	1%	--	--	0	0%	0	0%	--	--
Death	13	2%	--	--	--	--	--	--	0	0%
Other	18	3%	--	--	--	--	--	--	--	--
Missing	41	8%	38	22%	0	0%	--	--	--	--
GENDER										
Female	173	21%	55	22%	--	--	--	--	52	18%
Male	599	71%	174	70%	129	78%	106	74%	190	67%
Other/Unknown	69	8%	19	8%	--	--	--	--	42	15%

	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	199	24%	66	27%	37	22%	33	23%	63	22%
30-49	516	61%	132	53%	107	64%	95	66%	182	64%
50+	126	15%	50	20%	22	13%	15	10%	39	14%
RACE/ETHNICITY*										
American Indian or Alaskan Native	39	5%	--	--	13	8%	11	8%	--	--
Asian	25	3%	--	--	--	--	--	--	--	--
Black or African American	200	24%	71	29%	25	15%	17	12%	87	31%
Hispanic or Latino	62	7%	16	6%	21	13%	--	--	--	--
Native Hawaiian and Other Pacific Islander	15	2%	--	--	--	--	0	0%	--	--
White Only, Non-Hispanic	318	38%	87	35%	88	53%	76	53%	67	24%
Other Race	35	4%	--	--	--	--	--	--	20	7%
Unknown	191	23%	65	26%	14	8%	28	20%	84	30%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	53	6%	18	7%	--	--	18	13%	--	--
Unstably Housed	158	19%	52	21%	32	19%	43	30%	31	11%
Homeless	486	58%	133	54%	101	61%	78	55%	174	61%
In a Facility	39	5%	12	5%	23	14%	--	--	--	--
Unknown	105	12%	33	13%	--	--	--	--	70	25%
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	95	18%	40	23%	19	17%	18	18%	18	13%
Unstably Housed	30	6%	--	--	--	--	--	--	--	--
Homeless	58	11%	--	--	29	26%	--	--	15	10%
In a Facility	75	14%	20	12%	36	32%	--	--	--	--
Unknown	269	51%	91	53%	--	--	--	--	100	70%

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

CUMULATIVE: March 1, 2020 - December 31, 2024

	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	18,409		6,559		3,614		4,450		3,786	
Average Service Encounters (per participant, per month)	2.7		2.5		3.7		2.2		2.5	
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services	0.3		0.1		0.3		0.6		0.2	
Re-engagement	0.0		0.0		0.0		0.1		0.0	
Screening	0.1		0.2		0.0		0.0		0.2	
Clinical assessment	0.0		0.0		0.0		0.0		0.0	
Habilitation/rehabilitation	0.0		0.0		0.2		0.0		0.0	
Community mental health	0.1		0.0		0.7		0.0		0.0	
Substance use treatment	0.0		0.0		0.0		0.0		0.0	
Case management	1.4		1.8		1.4		1.0		1.2	
Residential supportive services	0.1		0.1		0.3		0.1		0.2	
Peer services	0.3		0.1		0.1		0.0		0.5	
Service coordination	0.3		0.2		0.6		0.2		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	332	39.5%	88	35.5%	83	50.0%	88	61.5%	73	25.7%
Referral Type										
Community mental health	101	12.0%	27	10.9%	24	14.5%	33	23.1%	17	6.0%
Substance use treatment	49	5.8%	13	5.2%	--	--	22	15.4%	--	--
Primary health/dental care	46	5.5%	--	--	--	--	25	17.5%	--	--
Job training	3	0.4%	--	--	--	--	--	--	--	--
Educational services	3	0.4%	--	--	--	--	--	--	0	0.0%
FHARPS housing	156	18.5%	42	16.9%	53	31.9%	31	21.7%	30	10.6%
Permanent housing (non-FHARPS)	35	4.2%	11	4.4%	--	--	--	--	18	6.3%

	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
Temporary housing (non-FHARPS)	54	6.4%	16	6.5%	--	--	--	--	22	7.7%
Other Housing Services (non-FHARPS)	54	6.4%	18	7.3%	29	17.5%	--	--	--	--
Housing services (pre-August 2021)	28	3.3%	12	4.8%	--	--	12	8.4%	--	--
Income assistance	14	1.7%	--	--	--	--	--	--	0	0.0%
Employment assistance	19	2.3%	--	--	--	--	--	--	--	--
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	63	7.5%	--	--	15	9.0%	38	26.6%	--	--

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 and Phase Two Regions: Pierce, Southwest, Spokane, King.**
Phase One Regions	Phase One Regions, as determined by the Trueblood settlement agreement, listed below.
Pierce Region	Pierce County.
Southwest Region	Clark, Klickitat, and Skamania Counties.
Spokane Region	Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties.
Phase Two Region	Phase Two Region, as determined by the Trueblood settlement agreement, listed below.
King Region	King County.
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).
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.

Variable Name	DEFINITION
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.
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.

Variable Name	DEFINITION
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.
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.

Variable Name	DEFINITION
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 settlement agreement, Crisis Intervention Training (CIT) is offered to law enforcement, 911 dispatch, and corrections officers throughout Washington State. At a minimum, 25% of patrol officers in the Phase 1, 2, and 3 regions are required to complete 40 hours of enhanced CIT, while 100% 911 dispatchers and correctional officers are required to complete an eight-hour course. Contempt settlement-mandated crisis intervention trainings began on July 1, 2019 for Phase 1; July 1, 2021 for Phase 2; and July 1, 2023 for Phase 3 - however, trainings prior to this date have been included for some 911 dispatchers.

REPORTING PERIOD

Monthly: December 2024

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

Contents

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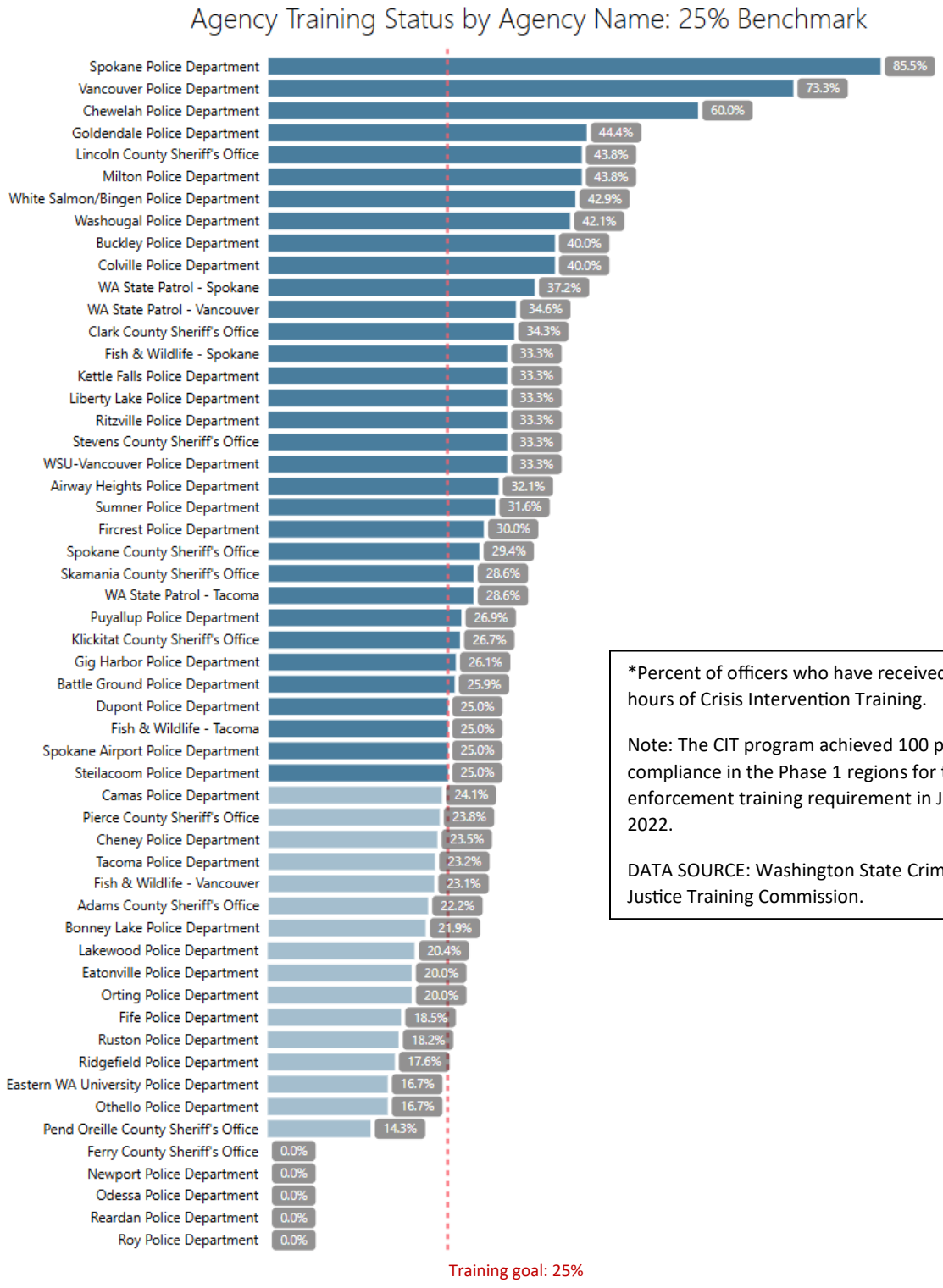
Figure 1.

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

DECEMBER 31, 2024



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

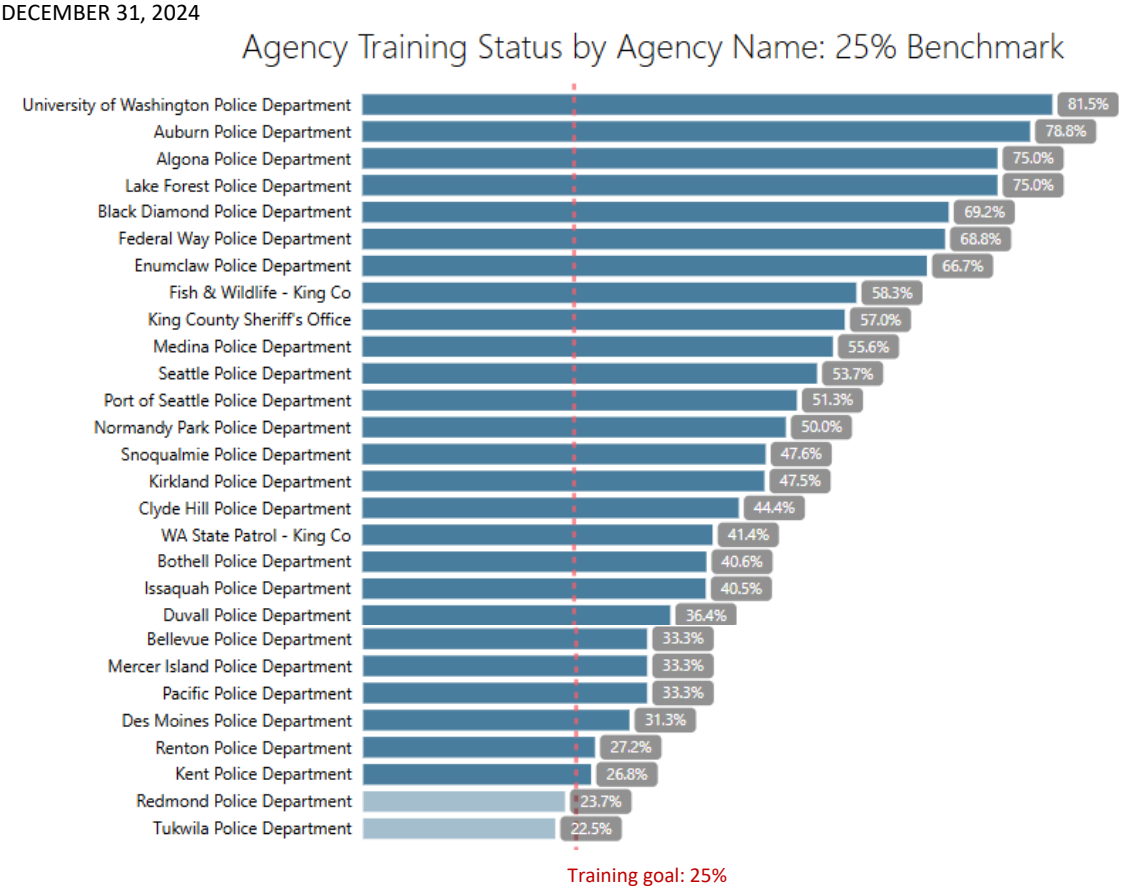
Note: The CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

DECEMBER 31, 2024



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

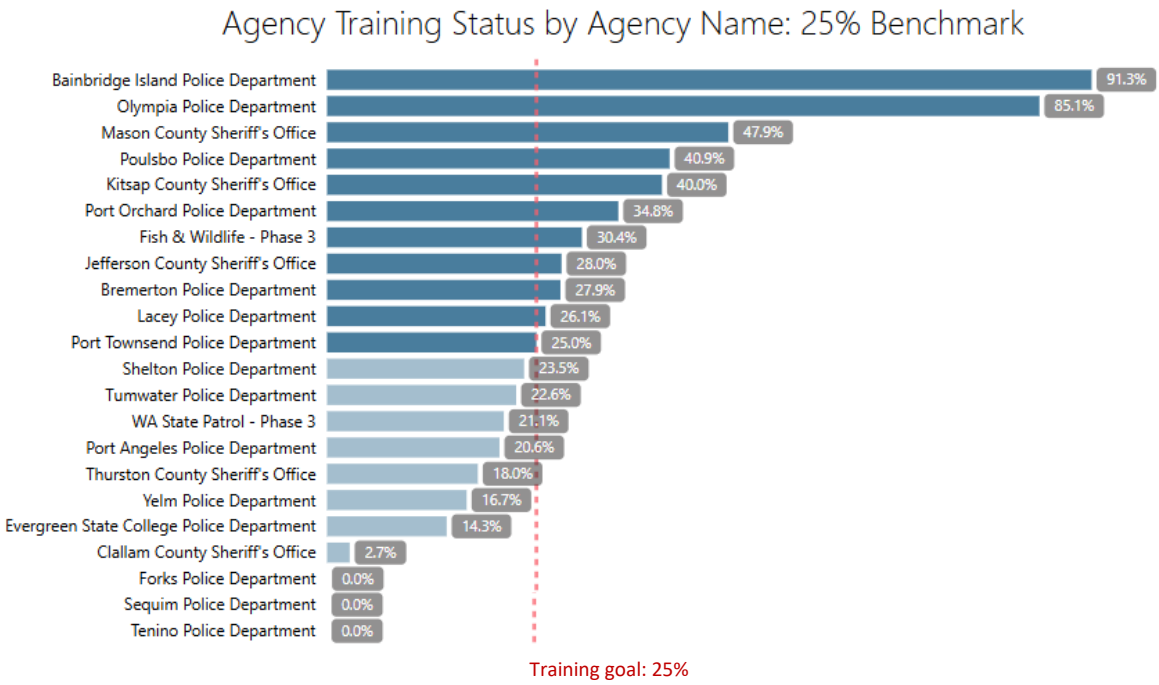
Note: The CIT program achieved 100 percent compliance in the Phase 2 region for the law enforcement training requirement in June 2023.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 3.

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

DECEMBER 31, 2024



*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

DECEMBER 31, 2024

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	**1,647**	**723**	**43.9%**	**519**	**155**	**29.9%**	**360**	**100**	**27.8%**	2,526	978	38.7%
Fish & Wildlife - Phase 1							33	9	27.3%	**33**	**9**	**27.3%**
Pierce Region	737	170	23.1%	149	36	24.2%	107	31	29.0%	**993**	**237**	**23.9%**
Southwest Region	358	209	58.4%	56	14	25.0%	84	27	32.1%	**498**	**250**	**50.2%**
Spokane Region	552	344	62.3%	85	28	32.9%	136	33	24.3%	**773**	**405**	**52.4%**
WA State Patrol - Phase 1				229	77	33.6%				**229**	**77**	**33.6%**
Phase 2	**2,645**	**1,360**	**51.4%**	**457**	**174**	**38.1%**	**119**	**70**	**58.8%**	3,221	1,604	49.8%
Fish & Wildlife - Phase 2							12	7	58.3%	**12**	**7**	**58.3%**
King Region	2,512	1,305	52.0%	457	174	38.1%	107	63	58.9%	**3,076**	**1,542**	**50.1%**
WA State Patrol - Phase 2	133	55	41.4%							**133**	**55**	**41.4%**
Phase 3	**120**	**48**	**40.0%**	**653**	**219**	**33.5%**	**80**	**11**	**13.8%**	853	278	32.6%
Fish & Wildlife - Phase 3				23	7	30.4%				**23**	**7**	**30.4%**
Salish Region	120	48	40.0%	225	70	31.1%	34	3	8.8%	**379**	**121**	**31.9%**
Thurston-Mason Region				315	123	39.0%	46	8	17.4%	**361**	**131**	**36.3%**
WA State Patrol - Phase 3				90	19	21.1%				**90**	**19**	**21.1%**
Total	**4,412**	**2,131**	**48.3%**	**1,629**	**548**	**33.6%**	**559**	**181**	**32.4%**	6,600	2,860	43.3%

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).

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

DECEMBER 31, 2024

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	**573**	**561**	**97.9%**				**89**	**64**	**71.9%**	662	625	94.4%
Pierce Region	238	232	97.5%				13	8	61.5%	**251**	**240**	**95.6%**
Southwest Region	132	132	100.0%				27	25	92.6%	**159**	**157**	**98.7%**
Spokane Region	203	197	97.0%				49	31	63.3%	**252**	**228**	**90.5%**
Phase 2	**526**	**504**	**95.8%**				**49**	**45**	**91.8%**	575	549	95.5%
King Region	526	504	95.8%				49	45	91.8%	**575**	**549**	**95.5%**
Phase 3				**190**	**44**	**23.2%**	**51**	**1**	**2.0%**	241	45	18.7%
Salish Region				97	44	45.4%	33	1	3.0%	**130**	**45**	**34.6%**
Thurston-Mason Region				93	0	0.0%	18	0	0.0%	**111**	**0**	**0.0%**
Total	**1,099**	**1,065**	**96.9%**	**190**	**44**	**23.2%**	**189**	**110**	**58.2%**	1,478	1,219	82.5%

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

DECEMBER 31, 2024

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	**146**	**146**	**100.0%**	**200**	**192**	**96.0%**	**119**	**116**	**97.5%**	465	454	97.6%
Spokane Region				112	104	92.9%	60	58	96.7%	**172**	**162**	**94.2%**
Pierce Region	146	146	100.0%							**146**	**146**	**100.0%**
Southwest Region				67	67	100.0%	23	22	95.7%	**90**	**89**	**98.9%**
WA State Patrol - Phase 1				21	21	100.0%	36	36	100.0%	**57**	**57**	**100.0%**
Phase 2	**236**	**188**	**79.7%**	**126**	**102**	**81.0%**	**78**	**76**	**97.4%**	440	366	83.2%
King Region	236	188	79.7%	126	102	81.0%	60	58	96.7%	**422**	**348**	**82.5%**
WA State Patrol - Phase 2							18	18	100.0%	**18**	**18**	**100.0%**
Phase 3				**114**	**112**	**98.2%**	**47**	**41**	**87.2%**	161	153	95.0%
Salish Region				54	54	100.0%	26	25	96.2%	**80**	**79**	**98.8%**
Thurston-Mason Region				60	58	96.7%	6	3	50.0%	**66**	**61**	**92.4%**
WA State Patrol - Phase 3							15	13	86.7%	**15**	**13**	**86.7%**
Total	**382**	**334**	**87.4%**	**440**	**406**	**92.3%**	**244**	**233**	**95.5%**	1,066	973	91.3%

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.