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

Semi-Annual Report 10

September 30, 2024

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Criminal Justice Training Commission Washington

Table of Contents

List of Abbreviations in this Document

AAG-assistant attorney general

AHAB-Affordable Housing Advisory Board

ASO-administrative service organization

ASPD-antisocial personality disorder

BHA-Behavioral Health Administration, part of DSHS

BHASO-behavioral health administrative service organization

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 January through June 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 completed by June 2023 or earlier and Phase 2 programming operations remains ongoing. Phase 3 of the Settlement Agreement became effective on July 1, 2023. Implementation work in the five counties of the two Phase 3 regions is ongoing as of June 30, 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 June 30, 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.

An additional development for this SAR's reporting period is that 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: DSHS usage 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 will be known as Cascade Unit. Cascade is the building that 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 charge 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 a referral list generated by Research and Data Analysis have two or more competency evaluation orders in the last two years. Assertive outreach and engagement to assist those 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.

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.

COVID-19 Procedures Update for Q1 & Q2 2024

Washington state officially re-opened from pandemic-related closures on June 30, 2021, subject to limited restrictions, and the Governor's COVID-19 State of Emergency ended on Oct. 31, 2022. As of June 2024, BHA's Western State Hospital, Eastern State Hospital, and DSHS Behavioral Health & Treatment Center – Steilacoom Unit. DSHS Behavioral Health & Treatment Center – Maple Lane Campus discharged its last Trueblood patient on June 11, 2024, and the facility no longer treats competency restoration patients. As of June 30, 2024, all BHA facilities are operating without any COVID-19-related admissions restrictions.

COVID-19 Cases All BHA Facilities

Clients and Staff

- As of June 27, 2024, there were 1,948 cumulative cases of COVID-19 in BHA clients and 2,949 cumulative cases in BHA staff across all facilities.

- COVID-19 remains present in BHA facilities. Between Dec. 29, 2023, and June 27, 2024, there were 273 COVID-19 cases among clients in BHA facilities and 289 cases among staff.

- The Washington State Department of Health no longer requires COVID-19 data tracked at the facility or at the county-level. Data is now aggregated to larger regional areas. ***This report will no longer include patient-level COVID-19 infection numbers by facility. However, if a BHA facility has admissions impacted by COVID-19 or another infectious disease in the future, any restrictions or closures will be reported.***

Data Source: BHA Case Snapshot by Facility: BHA 24/7 Facilities – Clients-Staff.

Note: "All facilities" includes several BHA facilities that do not serve Trueblood clients. However, as of June 27, 2024, 84 percent of all COVID-19 staff cases and 89 percent of all COVID-19 client cases involve the state hospitals or BHTCs.

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 the first six months of calendar year 2024 remain down relative to 2023.[2]

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

The department has opened 65 new beds for class members so far 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. 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 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 civic conversion bed capacity by amending existing long-term civil commitment contracts. Eighty-six beds across the state are available for civil conversion patients.

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[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.

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

- 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 recently hired 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 Q1 and Q2 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 these new facilities, new bed space opens for Trueblood class members at WSH and ESH. Critically, this 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 realizing the governor's vision for 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 2022-2023 and into 2024. Even with these successful actions, BHA continues to face high vacancy rates in several critical patient-centered job classes. As of early July 2024, vacancies in these classes now range between 28-44 percent. The ability to maintain current restoration capacity is a challenge, and staffing new facilities' capacity is also very challenging.

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 system for FHARPS in August 2023, crisis housing vouchers in November 2023, and FPATH in May 2024. As expected, there are some data anomalies as providers transition to the new platform. For this reason, FPATH data is reported through May rather than June 2024. HCA and RDA continue to collaborate on how to minimize 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 Dashboard
- Misdemeanor Restoration Orders by Fiscal Year

Power BI dashboards are under development for the crisis housing voucher and FHARPS programs, pending efforts to streamline and verify case data between Excel data trackers and PDAMS. Upon completion, OCRP and FPATH Power BI dashboards 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:

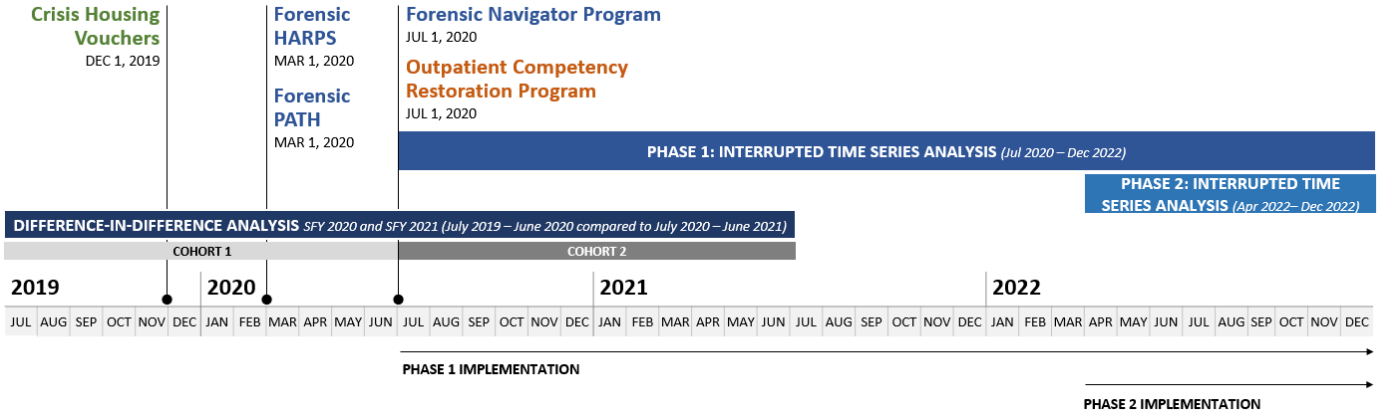
- Use of mental health and substance use disorder treatment services
- Rates of housing instability
- Rates of arrest
- Recidivism in referrals for competency evaluation and restoration

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. Findings will be reviewed with stakeholders at upcoming meetings prior to inclusion in the SAR. 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



Interrupted Time Series Analysis

RDA used an interrupted time series analysis to compare order rates in Trueblood Phase 1 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.

Three iterations of the interrupted time series analysis have been completed, the most recent of which was in Spring 2023. Findings from each analysis are summarized below. The next analysis is complete. It will be presented to stakeholders in Fall 2024 and included in the March 2025 SAR.

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.

- 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.

Overall, this extended analysis of the impact of these programs in the Phase 1 region showed similar impacts to the earlier analysis. The significant decline in Phase 1 competency evaluation orders remained, and there was no significant impact on restoration orders.

Early findings for Phase 2 King region showed no impact on competency orders and a significant decrease in restoration orders.

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.

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.

[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.

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. This analysis is being updated now. It will be presented to stakeholders in Fall 2024 and included in the March 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.

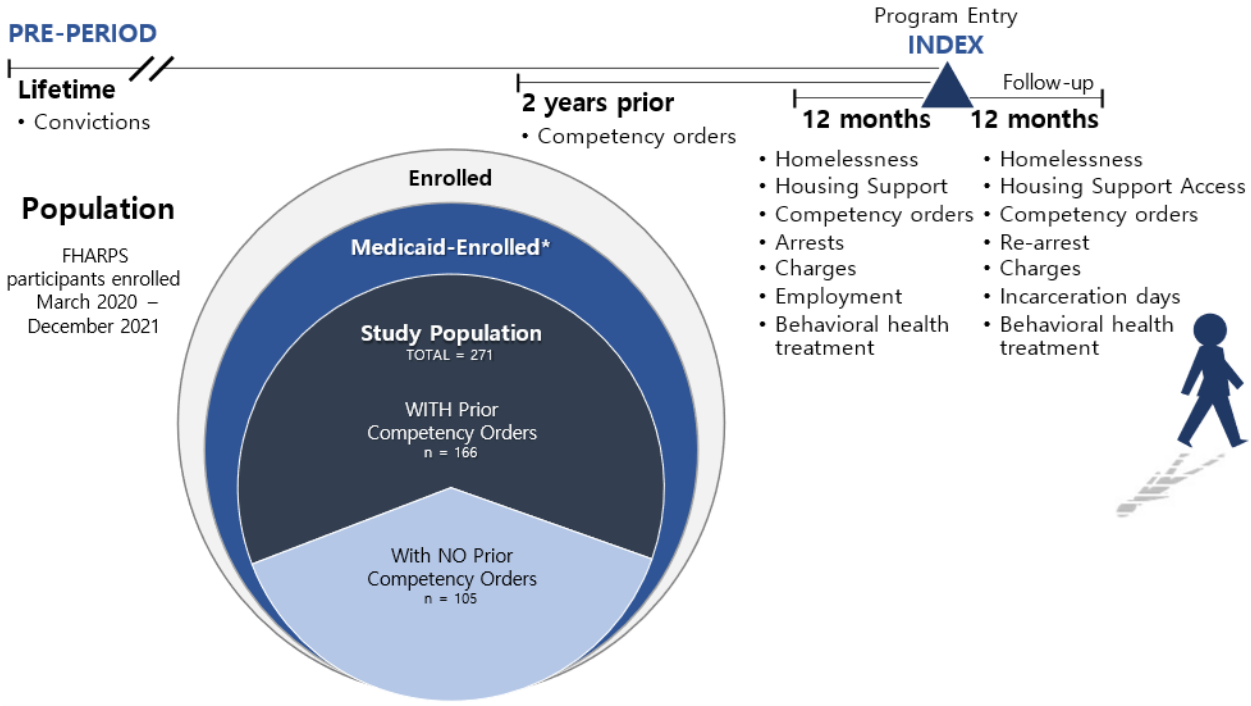
To assess the impact of FHARPS on homelessness and other key measures, the Research and Data Analysis division of DSHS compared outcomes for two groups of Medicaid-enrolled FHARPS program participants enrolled between March 2020 and December 2021, one group with and one group without a competency order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



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 effects 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), and

6. The COVID-19 pandemic (i.e., the 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 will be released by year-end 2024.

FPATH

The FPATH evaluation is underway and will be produced more quickly due to the information gained from the FHARPS evaluation design work and analyses. RDA plans to present high-level findings from the FPATH study in October 2024 and release a detailed report in the first quarter of 2025.

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 June 30, 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 amount of 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 can also be assigned to address the need of completing non-Trueblood forensic assessments (such as specialized forensic risk assessments for the NGRI population in forensic beds, not guilty by reason of insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state. Furthermore, with up-to-date forensic risk assessments, delays for privilege increases are removed, which can directly impact creating more forensic bed capacity.

Current Status and Areas of Positive Impact

For fiscal year 2024 and 2025, OFMHS received funding for an additional 19 positions (11 for fiscal year 2024 and eight for 2025). With staff movement naturally occurring, as of June 3, 2024, 70 of the 93 positions are filled. Recruitment continues to fill the remaining vacancies with an emphasis on filling positions located in the east and north of the state. Several positions are filled with future starts dates out several months into FY25 as well. OFMHS has 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).

During the January-June 2024 reporting period, 59 FRAs were completed at WSH. Now that there is no longer any backlog of forensic risk assessments to complete at WSH, FRAs are being scheduled and distributed evenly throughout the year with the anticipation of completing approximately 12 per month. Additionally, OFMHS is working with ESH to have all forensic risk assessments caught up and on the same evaluation schedule as WSH. ESH completed 21 FRAs during the January-June 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

While competency evaluations have leveled off, at least temporarily, demand for competency services remains near record highs and remains concerning. In Fiscal Year 2024, the number of referrals for all competency evaluations was 6,354, which compares to Fiscal Year 2023's, record number of referrals for all competency evaluations (6,786[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 in the past. It remains to be seen whether the current slowdown and subsequent decline in evaluations orders is due to the post-COVID-19 wave of court orders finally pushing through the system, or if other factors are driving the decrease in services demand.

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 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,

[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 a bridge appropriation for from the state legislature.

and Yakima counties). Currently, jails with telehealth capacity on the west side of the state include the Nisqually Indian Tribe's Nisqually Corrections Center, city jails in Aberdeen, Enumclaw, Forks, Hoquiam, Issaquah, Kirkland, Kent, Marysville, Nisqually, Puyallup, and SCORE in Des Moines (contracted with several cities and towns in King County and elsewhere in the state for local-level inmates), and county jails in Clallam, Cowlitz, Grays Harbor, Island, Jefferson, King (King County Correctional Facility in Seattle, Maleng Regional Justice Center serving south King County in Kent, and SCORE for county-level inmates), Pacific, San Juan (holding facility), Thurston, and Whatcom counties. Jails on the east side with telehealth capacity include the Colville Tribes Corrections Detention Facility, the Yakama Nation Correction & Rehabilitation Facility, city jails in Sunnyside jail, and Yakima, and county jails in Benton, Ferry, Franklin, Grant, Okanogan, Spokane, Stevens, Walla Walla, Whitman, and Yakima counties. In addition, Airway Heights Corrections and Geiger Corrections facility now have telehealth capabilities.

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 3. Overall, compliance rates for jail-based evaluations remain high. As of Sept. 26, 2024, data reflects that in June 2024, a total of 85 percent of evaluation orders were completed within court-ordered time limits, with 81 percent of orders in the WSH catchment area and 98 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.

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 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

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

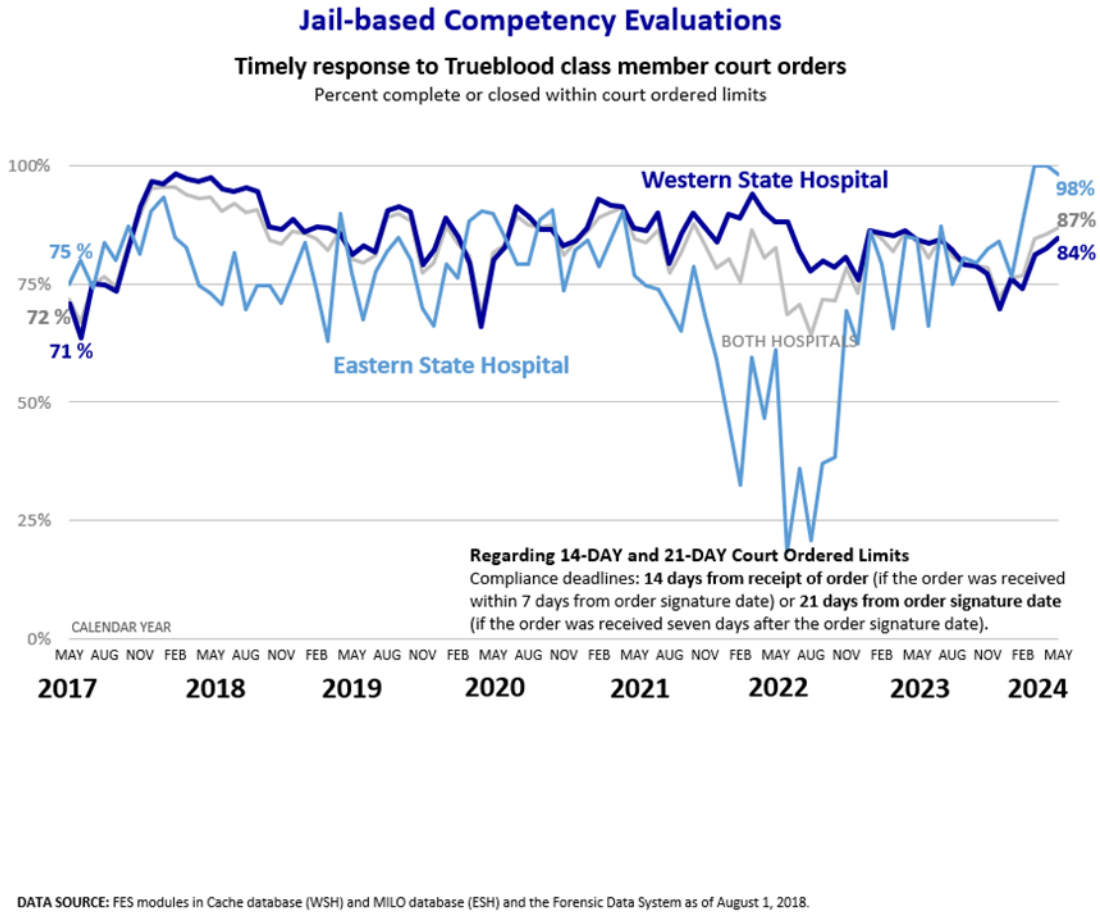
evaluations and annual re-assessments), the increased referrals related to the expansion of outpatient competency restoration, or the 21-day status checks.

FIGURE 3.

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

Percent complete or closed within court-ordered limits

JULY 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 has recently developed a dynamic Power BI report to show the average number of misdemeanor restoration orders made by courts each month, organized by fiscal year. Figure 3 displays the data from July 2017 through June 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 June 2024 shows an average of 20 misdemeanor restoration orders in FY2024 year-to-date. Most recently, in June 2024 there were 19 misdemeanor restoration orders. This chart and data are updated online in Power BI monthly and can be found on the OFMHS' Trueblood website.

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.

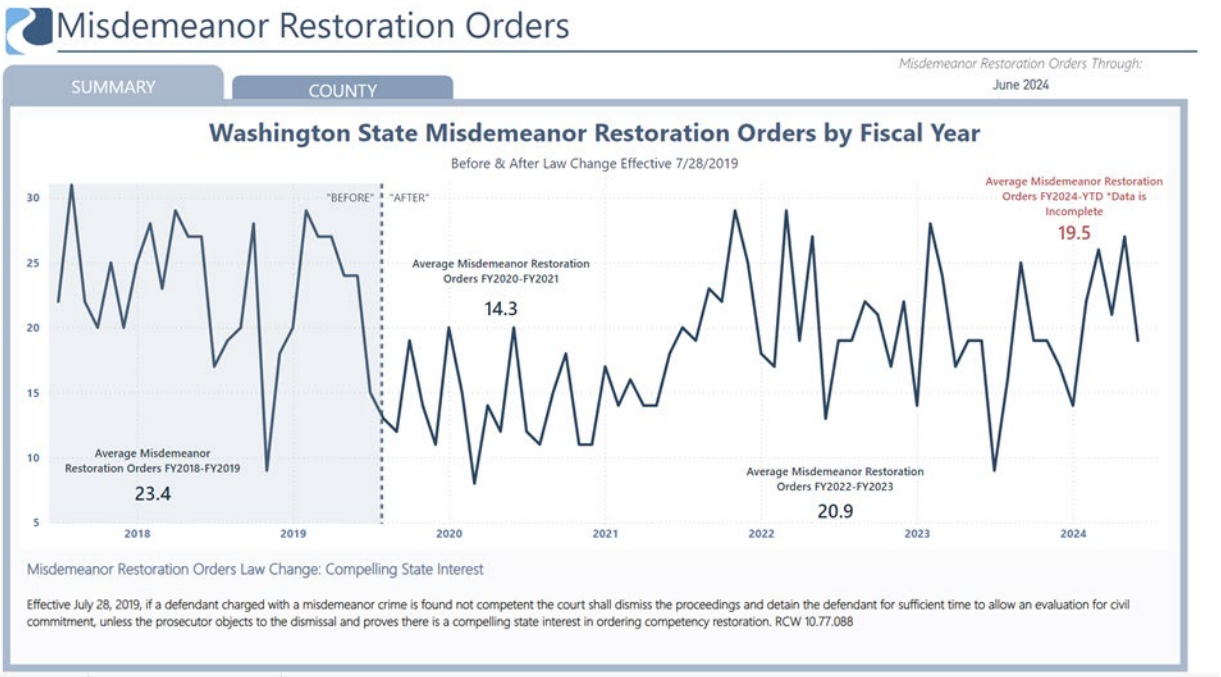
Note that in 2023, RCW 10.77.088 was amended by E2SSB 5440 (signed into law May 15, 2023, and effective July 23, 2023) to require the court to consider "all available and appropriate alternatives to inpatient competency restoration." This includes developing a diversion program for defendants charged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

FIGURE 4.

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

JUNE 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 closer to their home communities. OCRP also offers emergent housing interventions, connects people with housing through Forensic HARPS, and connects people enrolled 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 and 2 regions are continuing to accept outpatient restoration orders from courts in their regions and working with DSHS 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 OCRPs in Pierce, Southwest, and Spokane regions successfully maintained adequate space for every person recommended for OCRP throughout fiscal year 2024. Additionally, since January 2024, Community House successfully maintained adequate space for people recommended to OCRP in King County.

As a part of Phase 3, HCA executed contracts with two additional providers, Olympic Health and Recovery Services and Kitsap Mental Health Services, to provide OCRP services in the Thurston-Mason and Salish regions. During this reporting period, the Phase 3 providers hired staff, wrote policies and procedures for their programs, and attended required trainings to begin delivering OCRP services.

Since 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:

- A transition plan that aids the OCRP, FHARPS, and FPATH teams who may be working with enrolled participants to provide information related to OCRP groups, the element program providers' contact information, and applicable housing plans.
- DSHS and HCA continue to meet to review the findings and identify best practices.
- At a minimum, monthly case staffing events occur between Settlement Agreement elements to ensure communication and program coordination for people enrolled in multiple Trueblood programs.
- OCRP staff complete weekly meetings with forensic navigators and other Settlement Agreement elements, as applicable to review all people enrolled in OCRP services.

- The OCRP administrator, 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, 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. OCRP transitional housing is a newer service delivery model, but Community House reports that participants are benefiting from the stability provided by this type of housing support and the ease of access to services. 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. The Phase 3 contractors are exploring similar models and assessing the possibility of providing OCRP-specific housing in their region.

Areas of Concern

In Phase 1, the Spokane region had several months of no OCRP enrollments for the months of August through December 2023. Additionally, the Pierce region provider, Greater Lakes Mental Health, reported a slight decline of OCRP enrollments during this reporting period.
In Phase 2, one of the initial challenges was meeting the high demand for outpatient restoration in King County. In response, HCA increased the contracted funds with Community House for staffing and OCRP-specific housing. This allowed the program to not only serve all recommended referrals during this reporting period but exceeded the current demand for OCRP in King County.

Recommendations to Address Concerns

HCA, DSHS, and the Spokane OCRP provider, Frontier Behavioral Health, met and created a plan for the OCRP staff and the forensic navigators to outreach Trueblood class members in jail together. The forensic navigators and Frontier are working together to reduce potential barriers to people's suitability for OCRP and increase engagement which has allowed the Spokane region's OCRP to return to historical enrollment numbers.

Additionally in Phase 1, the HCA, DSHS, and the OCR provider in Pierce County, Greater Lakes met with the Pierce County Prosecuting Attorney's Office to discuss how to increase OCRP utilization. We will continue to meet with court personnel to provide education and information about the program and answer their questions.

In Phase 2, HCA is working to continue outreach to court partners to increase the use of OCRP and answer any questions they have about using the program as a resource in their region for people found not competent.

In Phase 3, the providers modified their staff recruitment and regularly met with the HCA to discuss hiring approaches. Significant progress was made toward being fully staffed during this reporting period. Both OCRP providers are on track to have adequate space for people ordered to OCRP soon and are actively working with the forensic navigators to coordinate and plan for OCRP enrollments.

Data-Competency Restoration-Community Outpatient Services

OCRP services began in Phase 1 regions on July 1, 2020, and the Phase 2 King region on Oct. 31, 2022. Phase 3 regions began April 30, 2024, and do not have sufficient cases to report. Between July 1, 2020, and June 30, 2024, 243 clients were enrolled in OCRP Phase 1 and 2 regions: 70 in Pierce, 76 in Southwest, 48 in Spokane, and 49 in King (Appendix B, Table 1). This is an increase of 51 people (27 percent) since Dec. 31, 2023. Across regions, most enrollments were for felony restoration orders (83 percent) and participants were mostly male (67 percent), 30-49 years old (52 percent), non-Hispanic white (60 percent), and unstably housed or homeless (a combined 69 percent).

Of the 202 participants discharged, (Appendix B, Table 2), 39 percent were opined competent, 27 percent had their conditional release revoked, and 12 percent had their charges dismissed. About 6 in 10 (62 percent) were discharged to the community, 17 percent were admitted to inpatient services at either a state hospital or a behavioral health treatment center, and 12 percent were in jail. Among those discharged, the average length of stay in OCRP was 78 days, ranging from 68 days in King region to 85 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 connects 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 interaction remains neutral as courts are beginning to learn of the newer process.

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

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

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. Kirsten Peebles, who was a forensic navigator in another phase, has helped galvanize the team into active engagement with courts and providers. Phase 3 is fully staffed with nine forensic navigators.

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.

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 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 have also faced several barriers with engagement due to court timeliness and court systems hindering staff from engaging Trueblood service members. Additionally with the wide range of clients in King County, two more diversion staff are currently being added.

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.

There were 499 people active in the Forensic Navigator Program at the end of Q2 2024 (Appendix C, Figure 1). Twenty-eight of them were enrolled in OCRP as of the last day of the reporting period (Appendix C, Figure 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 Q2 2024. The Salish and Thurston-Mason regions recently started in April of this year and did not have any people enrolled in OCRP in this most recent quarter. OCRP enrollment data for the Southwest, Spokane, and Pierce 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, a total of 7,226 people were assigned a forensic navigator between July 1, 2020 (program start) and June 30, 2024 (Appendix C, Figure 1). As can be seen in the online Power BI report, this includes 3,343 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 74 people in the Thurston-Mason region and 56 people in the Salish region were assigned a forensic navigator. Statewide, just under half (45percent) 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 to the ramp up of Phase 2 and Phase 3 regions. In the King region about 7 in 10 people served by forensic navigators had a misdemeanor offense. In Thurston-Mason and Salish regions, about 6 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 (64 percent) and were between the ages of 30 to 49 (56 percent). Slightly less than half (47 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 17 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 at or below the program standard of 25 in Q2 2024. (Appendix C, Figure 3). In Q2 2024, the Southwest region had the highest average daily caseload (25), and the Thurston-Mason region had the lowest average caseload (4). 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 44 percent of people assigned a navigator. Forensic navigators provided coordination of care for 38 percent of clients overall, and a higher rate in Southwest (67 percent), Spokane (52 percent) and Pierce (52 percent) regions, compared to Salish (39 percent), Thurston-Mason (32 percent), and King (19 percent) can be seen in the online report. A recommended service plan was completed for 80 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 Q3 2023 (Appendix C, Figure 4), and the full online Power BI report presents changes in time of additional selected services as well. Nearly one in three (33 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: 19 percent received a referral to the FPATH program and 18 percent received a referral to FHARPS (Appendix C, Figure 5).

A total of 6,652 people were discharged during the reporting period, with an average length of stay in the program of 40.3 days, ranging from 19.7 days in the Salish region to 59.6 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. Thirty percent of cases were closed because the person was determined competent, and 21 percent of cases were closed because the person was ordered by the court to receive inpatient restoration (Appendix C, Table 2). Twenty-one 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 (8 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.

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup developed full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for Cascade Unit. As stated above, the timelines were modified due to the DSHS positions being converted to permanent. Significant lessons learned from YCRP's closure were incorporated into the plans for Cascade Unit's closure, and the hard closure plan was implemented spring 2024 at Cascade Unit.

Areas of Concern

The biggest concern is being able to retain staff for continued operations with two other units opening on the same campus during the time of the ramp down of the competency program. As of July 2023, staffing has consistently remained around 75 percent of DSHS positions filled. In order to retain and recruit staff for Cascade all Residential Rehabilitation Counselor positions were converted to Institutional Counselor 3s in March 2024. This made all line staff positions the same across campus.

Recommendations to Address Concerns

DSHS continuously monitors turnover, morale, and other factors, and actively takes steps to neutralize negative affects at Maple Lane's Cascade Unit now that Yakima has closed. Given the

potential variability in closure dates due to agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient discharges. Additionally, our contract oversight of the contractor at the Cascade Unit will focus on the contract requirements to ensure sufficient staffing.

The residential services manager works closely with the director of residential treatment facilities on staffing challenges for the DSHS side of operations at the Cascade Unit. As of late fall 2022, two changes have been made: recruiters have expanded where open positions are advertised, and all DSHS positions have been made permanent. The director of BHTCs worked on reallocating the staff to be consistent with the two other DSHS programs opened on the Maple Lane campus starting in December 2022. In January 2023, Cascade Unit entered a contract with Centralia College to offer a practicum for its students in the college's Behavioral Health program. Staff from Cascade Unit attended a job fair in early January 2023 and received a few applicants from the event.

Data-Competency Restoration-Ramp Down of Maple Lane BHTC

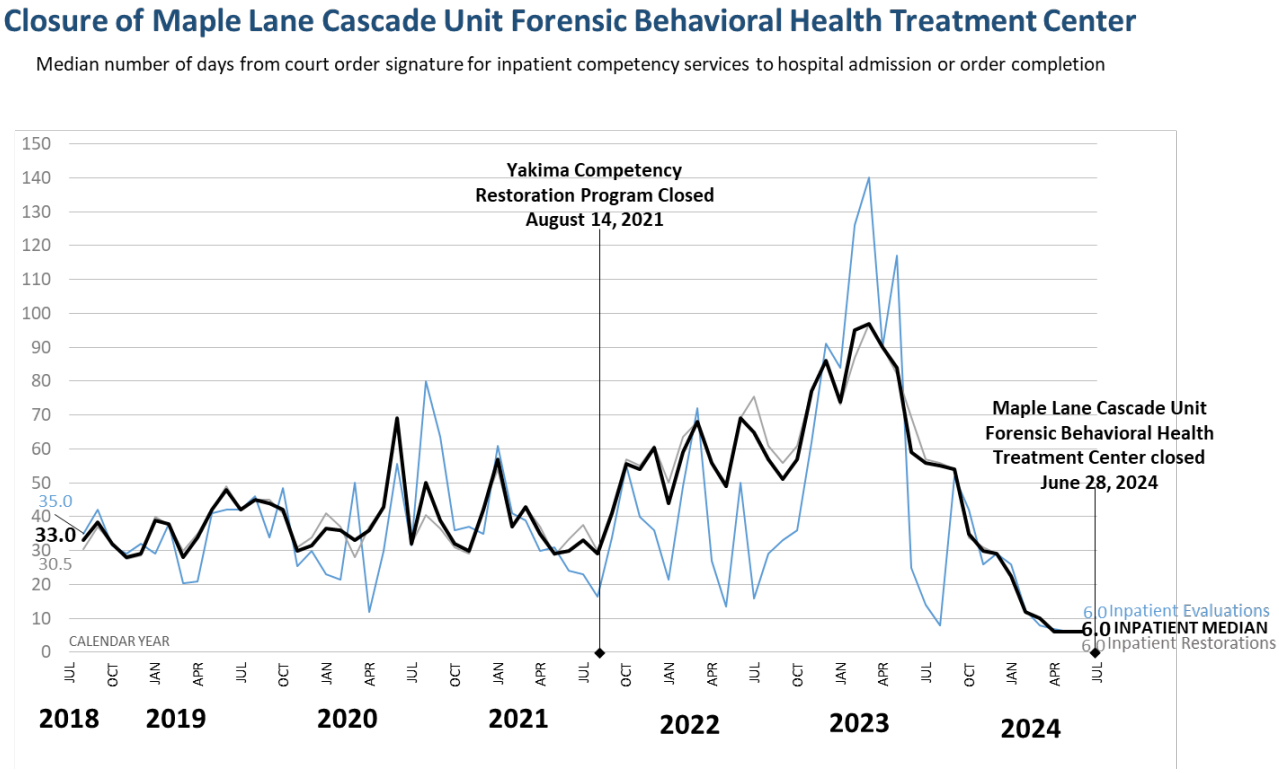
The BHTC ramp down workgroup monitors average wait times for inpatient admission for competency services monthly (Figure 5). As of June 2024, the median wait time for inpatient competency services was 6.0 days. Maple Lane Cascade Unit was closed to competency restoration patients on June 28, 2024, with the last patient discharged on June 11, 2024. The facility was closed by July 1, 2024, as per the Settlement Agreement.

FIGURE 5.

Closure of Maple Lane Behavioral Health Treatment Center

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

AUGUST 2024



DATA SOURCE: BHA Forensic Data System.

MEASURE DEFINITION: The median wait time represents the number of days from the beginning of a period of waiting in jail for competency services to order completion among orders completed in the specified month. This includes all inpatient competency evaluation or restoration orders for individuals waiting for services in jail. The order is completed when the individual is admitted for inpatient services, or when the order is dismissed, withdrawn or when the individual is physically released from jail (e.g., on personal recognizance or work release). Includes admissions to WSH, ESH, Steilacoom Unit Behavioral Health & Treatment Center (BHTC), Maple Lane Cascade Unit Forensic BHTC (until June 11, 2024, when the last patient was discharged, with final facility closure on June 28, 2024), and Yakima Competency Restoration Program (until July 26, 2021, when the last patient was discharged, with final facility closure on Aug. 14, 2021).

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 BHAO 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 is operated by Pioneer Human Services and was designed to provide alternative options for law enforcement and other first responders when interacting with people demonstrating a behavioral health crisis whose behaviors did not meet the threshold of arrest and would benefit from behavioral health support.

SRSC continued its collaboration 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. SRSC maintains regular coordination meetings with a diverse group of community stakeholders, including the Spokane Police Department, Spokane County Sheriff, the Spokane Regional Law and Justice Council, and the Spokane County Regional Interlocal Leadership Structure. The SRCS also provides intensive discharge planning and connects people to housing resources, outpatient behavioral health services, medical care, and medication management. The SRCS received positive feedback from both clients and referring agencies, including law enforcement and first responders.

During this reporting period, the SRSC served 492 people who also had law enforcement contact in the prior 24-month period; 179 people who were referred to the SRSC by police drop-off; and 919 people with co-occurring disorders.

Additional Crisis Beds – King Phase 2
In accordance with the Phase 2 Implementation Plan, the state requested funding from the legislature to support the creation of two additional 16-bed crisis stabilization facilities for the King region. The Department of Commerce entered into a contract with Recovery Innovations International on June 30, 2022, for one of the two King County crisis stabilization facilities. Department of Commerce contracted with ConnectionsWA for the second King County facility.

ConnectionsWA has been under construction since June 2023 and has successfully made progress with meeting the construction deadlines. HCA, DSHS, and Department of Commerce supported ConnectionsWA with navigating the process of obtaining permitting and licensure to meet the construction timeline. As the facility prepared to open, ConnectionsWA began staff recruitment, outreaching with community partners, and collaborating with local law enforcement and first responders. ConnectionsWA opened the Kirkland crisis stabilization facility and campus in July 2024.

Additional Crisis Beds – Thurston-Mason Phase 3
In Phase 3, the legislature allocated enhancement funding for crisis bed capacity in the SFY2025 budget for the Thurston-Mason region. HCA and the Department of Commerce are coordinating to begin the RFP process to add 16 crisis stabilization beds in the Thurston-Mason region. The Salish region has existing sufficient crisis stabilization bed capacity.

<u>Areas of Concern</u>
The 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.

On March 1, 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. RII and Commerce are still working on next steps to resolve the requirements of the cure letter. HCA, DSHS, and Commerce are also 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.
- 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.

As of June 2024, Lifeline Connection's stabilization program served over 2,800 people since the facility opened in August 2020 and averaged about 44 admissions per month. Of the people served during this reporting period, 75 percent completed treatment at Lifeline Connection's crisis stabilization facility and 70 percent of people discharged with community behavioral health support. The Lifeline Connections case management team continues to build strong relationships with community partners to connect people to services upon discharge. Lifeline Connections also uses internal resources to provide onsite coordinated entry assessments and identify housing resources. Lastly, Lifeline Connection's program director is regularly collaborating with the Vancouver Police Department to encourage police drop-offs.

The Spokane BHASO continues to support Pioneer Human Services with maintaining the 24/7 firehouse model of crisis stabilization services. During this reporting period, staff received comprehensive training in trauma-informed de-escalation, person-centered treatment planning, and advanced ethics.

Crisis Enhancements – Phase 2

As of June 2024, Downtown Emergency Services Center's Crisis Solutions Center in King County served over 1,300 people this reporting period, including 378 people who were referred by police or first responders and 264 people who also had law enforcement involvement in the last 24-month period. DESC reports success with partnering with first responders, regional DCRs, the fire department, and local emergency departments. For example, DESC's crisis communication liaison recently started coordinating with referring ERs to gain feedback on how to possibly

improve the referral process to the CSC. DESC also reports success with connecting people to community-based resources including behavioral health treatment, case management, and housing services. Lastly, DESC recently offered several trainings to staff including advanced de-escalation, cultural diversity, and anti-racism seminars.

Crisis Enhancements – Phase 3
As a part of Phase 3 implementation, HCA executed contracts with the Thurston-Mason and Salish BHASOs during this reporting period to add crisis enhancement funds to the regional BHASO contracts to support regional crisis response teams with staff recruitment, retention, and training.

Areas of Concern
The Spokane, King, and Southwest 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.

In March 2024, Recovery Innovation International's Crisis Recovery Center and Recovery Response Center crisis stabilization facilities in Pierce County permanently closed.

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

HCA will continue to support the providers with workforce challenges by encouraging the crisis enhancement funds be used for staff hiring and retention bonuses.

In response to the RII facilities closure, HCA worked with Carelon BHASO to amend the contract to reallocate the enhancement funds to support Pierce County crisis response teams with staff retention and training starting July 2024.

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

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

FHARPS teams must consider all housing interventions in order to be responsive to individual needs and preference of program participants. Phase 1 and 2 FHARPS providers are continuing to use global leasing to expand viable housing options for class members. During this reporting period, Telecare executed two new global leased houses in King County, Columbia River Mental Health executed an additional global leased house in the Southwest region, and Comprehensive Life Resources continues to sustain over 70 global leased units in Pierce County.

Phase 1 and 2 FHARPS providers reported to HCA that the majority of program participants require more time in the program to obtain stability. HCA allowed FHARPS providers to request exceptions to policy when participants are clinically unique, are engaged in the program, and might otherwise re-enter the criminal court or forensic systems if the time in the program is not extended. These extensions provide sustained housing subsidies and housing supports while increasing the likelihood of FHARPS participants obtaining longer-term housing after they are discharged from the program.

Certain FHARPS programs have a higher proportion of participants who were referred by the forensic navigators rather than other referral sources. HCA has observed many benefits to this practice and continues to ensure that the FHARPS teams work closely with the 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 participants.

As a part of Phase 3, HCA is proud to announce that Kitsap Mental Health and Peninsula Behavioral Health have contracted to provide FHARPS programs in the Salish region and Olympic Health and Recovery has contracted to provide FHARPS programs in the Thurston-

Mason region. With technical assistance from HCA, the Phase 3 teams began attending tailored trainings on trauma-informed care, outreach best practices, overcoming implicit bias, housing first principles, and person-centered case management. Olympic Health and Recovery and Peninsula Behavioral Health have fully staffed teams, while Kitsap Mental Health continues to fill open positions. HCA continues to meet with Phase 3 providers on a bi-weekly basis to ensure successful program implementation. Phase 3 ramp up activities include fostering healthy relationships with the forensic and diversion navigators, regionally based court systems, and community partners to facilitate referrals. HCA element leads and Phase 3 providers also attended site visits with Comprehensive Life Resources and Frontier Behavioral Health in order to ask questions and gain historical knowledge on the programs.

In order to respond to the high demand for FHARPS programs, HCA conducted outreach to potential providers and successfully obtained a new provider. Starting in mid-fiscal year 2025, Community House Mental Health Agency will also provide FHARPS programming in King County.

Emergency Housing Subsidies

During this reporting period, there were no licensed crisis stabilization facilities located in the King region. Therefore, HCA and the King County BHASO allocated crisis housing subsidies to programs that provide community-based crisis services. King County BHASO reported that the subsidies are available through Downtown Emergency Services Center's Community Outreach and Advocacy Team program, Navos' Adult Crisis Services, and Valley Cities' Adult Crisis Services and Assisted Outpatient Services team. King County BHASO held support meetings with each provider to identify more ways to support the teams in using this resource. Data shows that through support and technical assistance, utilization of the crisis housing subsides in the King region has almost doubled in 2024 compared to 2023.

In Phase 3, crisis 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, to make crisis housing subsidies available to people needing emergency housing upon discharge from those facilities. The Phase 3 providers began using these subsidies and utilization is anticipated to grow.

With the closure of RII's crisis stabilization facility in the Phase 1 region, HCA added the crisis housing subsidy funds to the Carelon BHASO contract beginning July 1, 2024. Carelon is contracting for the short-term crisis housing subsidies in Pierce County and is interested in increasing utilization and diversifying subsidy distribution.

In meetings between HCA, Frontier Behavioral Health in Spokane, and King County BHASO, reasons for lower levels of utilization by community crisis teams have included the fact that they are often assessing people who are currently experiencing behavioral health crises, whereas

crisis stabilization facilities use crisis housing subsidies after a period of treatment and stabilization within the stabilization facility.

Areas of Concern

HCA is working with the FHARPS programs to identify current gaps in the FHARPS program model and connect participants to housing post-FHARPS. Current gaps include but are not limited to the issues surrounding time-limited, transitional housing for Trueblood class members. As reflected in the data, a portion of the FHARPS program participants discharge from the program with an unknown status. Although the proportion of people who discharge from FHARPS with an unknown status is comparable to other similar programs, this is a common challenge in time-limited, transitional housing programs.

Additionally, FHARPS programs are continuously trying to identify and connect participants to permanent housing options, but these are extremely limited resources that take several years to obtain. Trueblood class members also face unique challenges when it comes to obtaining permanent housing. Some of these challenges may include a lack of positive rental history, behavioral challenges, substance use disorder issues, and eviction history. The FHARPS programs are continuing to extend the length of stay for program participants to prevent discharge to homelessness while working towards connecting participants to permanent housing. However, permanent housing options are not available to the majority of program participants while they are enrolled in FHARPS programs. The pressure on FHARPS programs to provide and sustain immediate, low-barrier housing while working to connect participants to the limited supply of permanent housing has led to unsustainable caseloads and staff burnout. This is not due to a gap in the program model, but rather a reflection of the current housing crisis.

Additionally, several FHARPS programs are continuing to work through challenges such as workforce and staff turnover, implementation barriers such as limited global leasing opportunities in rural areas and responding to the high volume of FHARPS referrals.

Recommendations to Address Concerns

HCA has and will continue to strategize how to increase permanent housing options for Trueblood class members. HCA is working with the FHARPS programs to address the workforce challenges, and the barriers related to time-limited housing interventions without adequate permanent housing options available. In order for Trueblood class members to sustain housing beyond FHARPS, a robust housing continuum that includes indefinite, permanent housing options must exist. Since adequate permanent supportive housing is not readily available to Trueblood class members, HCA is working with the FHARPS providers to provide sustained housing as best as possible within these constraints.

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. The collections continue in Excel tracker workbooks while HCA works to implement the alternative forms-based collection. The FHARPS program was the first to transition to this system in August 2023. Data processes will be updated to report data from both sources in the next semi-annual report.

Vouchers Data

The crisis stabilization and triage facilities and provider teams contracted with HCA to provide housing vouchers distributed 836 vouchers to 657 people between Dec. 1, 2019, and June 30, 2024 (Appendix D, Table 1).[9] The number of people receiving vouchers increased 19 percent between year-end 2023 and June 2024. Vouchers were available in the Phase 2 King region beginning July 2022, and in Phase 3 regions beginning January 2024. Phase 3 regions will be included in reporting when there are sufficient numbers.

Southwest region (accounting for 34 percent of vouchers) distributed the greatest number of vouchers and served the largest portion of people receiving vouchers (226, or 34 percent) across regions. The total amount disbursed across Phase 1 and 2 regions was $767,067 and the average amount per recipient was $1,169. 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 more than half of referrals among those receiving vouchers (32 percent and 23 percent, respectively).

Most voucher recipients were male (67 percent), between 30 and 49 years old (55 percent), and non-Hispanic white (60 percent).

Based on matching crisis housing voucher recipients to those within the FHARPS program data, 19 percent of voucher recipients were referred to FHARPS, 17 percent were contacted and enrolled, and 15 percent were housed or sheltered by FHARPS. Most initial housing placements through FHARPS were shelter/emergency placements (82 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

[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. HCA will continue efforts to obtain this data.

[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.

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 expanded to Phase 3 regions on April 30, 2024, and will be reported when there are sufficient cases. A total of 2,070 people were referred for FHARPS services across Phase 1 and Phase 2 regions from March 1, 2020, to June 30, 2024 (Appendix E, Table 1).[11] Of these referrals, 1,337 (65 percent) were contacted[12] and 1,151 (56 percent) were enrolled.

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 66 percent of recorded referrals. Forensic navigators made the most referrals, 42 percent overall, and comprised 97 percent of referrals in the King region. FPATH referred 14 percent, and crisis stabilization and triage facilities referred 7 percent.

Most initial contacts were made by phone (33 percent), down from 74 percent at year-end 2020 when outreach methods were limited due to COVID-19 protocols. Thirty-three percent of contacts were in jail, largely due to King region conducting 99 percent of their contacts in jail.

Nearly seven in ten people (69 percent) enrolled in FHARPS were male, 55 percent were between 30 and 49 years old, and 47 percent were non-Hispanic white. Nearly one-quarter of participants (24 percent) 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 homeless at the time of enrollment (56 percent).

Of those enrolled, 75 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 June 30, 2024, mainly due to an increase in the use of master leasing options and King region mostly using transitional housing placements (94 percent).

[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.

The King region had a lower rate of people housed or sheltered compared to other regions (47 percent). This is likely due to enrollments in jail and that the King region mostly uses transitional housing rather than emergency placements. Those enrolled could still be incarcerated, may transfer to inpatient treatment, may be released into the community and fail to reconnect with the program, or may be awaiting placement in transitional housing through the program.

Three-quarters (75 percent) of participants enrolled between March 2020 and June 2024 were discharged as of June 30, 2023, with an average length of support of 202 days, ranging from 108 days in the King region to 240 days in the Spokane region (Appendix E, Table 3). The average total subsidy support received by those discharged was $6,587.

It became clear that some providers were not closing cases as requested. HCA worked with providers, particularly King region providers, to close cases since the last report. As a result, the King region went from having 16 percent of their population discharged as of December 2023 to 78 percent by June 2024. Most were discharged due to 'loss of contact' (80 percent) and King reported 81 percent as homeless at time of discharge. Since most of these were loss of contact, it is likely these are actually unknown.

Among people discharged, 36 percent of cases were closed due to loss of contact, 13 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, 29 percent were stably housed, 20 percent were homeless, and 11 percent were in a facility. Housing status at program discharge was unknown for 32 percent of people (slightly lower than the loss of contact rate); this would be higher if King reported loss of contacts as unknown instead of homeless.

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's 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.

FPATH teams are identifying and connecting FPATH participants to available resources to respond to the higher acuity of needs as reported by the FPATH providers. These services include crisis services, outpatient behavioral health treatment, housing, employment, transportation, and public benefits. Many teams are also successfully navigating difficult challenges related to immigration status, outstanding legal or court obligations, and family reconciliation.

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, and the providers are actively hiring for those positions. These positions will not only improve data quality but will allow the direct program staff to focus more service delivery time with FPATH participants. With the addition of HCA's Trueblood data manager, HCA is offering intensive technical assistance and support to the FPATH providers to reduce data-entry challenges and improve data quality.

HCA successfully implemented FPATH in the Phase 3 Thurston-Mason and Salish regions by executing contracts with Olympic Health and Recovery Services, Peninsula Behavioral Health, and Kitsap Mental Health Services. The FPATH teams are attending regular trainings on trauma-informed care, outreach best practices, overcoming implicit bias, housing first principles, and person-centered case management. HCA is also supporting regular coordination and

communication between the Phase 3 providers and regional forensic navigators to facilitate referrals, share resources, outreach to court partners, and improve Phase 3 rollout.

Areas of Concern

In addition to outreaching eligible people on the FPATH list, FPATH teams also receive a high volume of referrals from the forensic and diversion navigators. The teams are struggling with managing the high volume of referrals while maintaining engagement with enrolled participants. This is likely a driving factor for why a higher proportion of FPATH participants are discharged with an unknown status.

Outreach, warm handoffs, and jail release planning is still a challenge for some FPATH programs. Teams are often not informed when a person is released from jail and therefore unable to create an effective release plan. Programs have found ways to intercept participants upon release, but many are still released with no connection to the program. Furthermore, programs have little information about people who are released to the community from jail to complete effective outreach.

Workforce impacts including the Phase 3 providers experiencing challenges with recruiting and hiring certified peer counselors, and frequent turnovers and longstanding vacancies within the Phase 1 and 2 regions are consistently impacting FPATH programs.

Outside of FHARPS, FPATH programs are struggling to identify permanent housing resources for participants.

Recommendations to Address Concerns

HCA is continuing to facilitate coordination between the FPATH programs and the forensic navigators about how to best triage referrals and improve coordination while considering program capacity and maintaining low caseloads. The FPATH referral form was reworked to encompass more information that is relevant to outreach services. HCA is also 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. Additionally, HCA expanded the Community House Mental Health Agency FPATH team to increase program capacity in King County.

In order to better support the peers in the Trueblood programs, HCA resumed the monthly peer meeting to create a space for community-building, brainstorming, and cross-program networking.

HCA also hosts bi-weekly meetings with Phase 3 providers to provide support with program implementation and discuss ongoing housing barriers and possible solutions.

Data-Crisis Triage and Diversion-FPATH

FPATH data in the current report are from the Homeless Management Information System, as well as monthly Excel trackers submitted by FPATH providers in the Phase 1 and 2 regions through May 31, 2024, when the program transitioned to PDAMS for data collection. FPATH data entered into PDAMS are not included in the current report. Data for the current reporting period may change once PDAMS data are added.

The FPATH program began March 1, 2020, in Phase 1 regions, and April 1, 2022, in the Phase 2 region. Program eligibility is based on a referral list of people with two or more competency evaluation referrals in the past 24 months. Between March 1, 2020, and June 30, 2024, 3,823 people were referred to the program across all regions (Appendix F, Table 1). HCA continues to encourage 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 2,465, which was 64 percent of the total referral list.

Of all people on the referral list, FPATH providers attempted to contact 1,291 (34 percent) and successfully contacted 1,204 (31 percent). As of May 31, 2024, a total of 697 people (18 percent of overall referrals) were enrolled in the FPATH program (Appendix F, Table 1). Enrollments among the prioritized population were16 percent of the prioritized list.

Of the Phase 1 regions, Southwest had the smallest referral list and continued to enroll the largest proportion (33 percent, Appendix F, Table 1). The Pierce region had the largest referral list and enrolled 20 percent, while the Spokane region enrolled 17 percent of their referral list. The Phase 2 King region has had 211 enrollees since the program started in April 2022, which was 14 percent of its referral list. Of these, 108 were from the prioritized population.

Among enrolled people, the majority were male (67 percent overall) and between 30 and 49 years old (61 percent). Nearly two-thirds of enrollees (64 percent) were homeless at program enrollment, while 19 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Among the 575 people discharged from the FPATH program through May 31, 2024, the average length of stay in the program was 305 days. People in the Spokane region had the longest length of stay at 476 days, while the King region had the shortest at 144 days. (Appendix F, Table 1). Loss of contact was the most common reason for FPATH discharge throughout all four regions (46 percent overall).

Services

There have been 13,490 service encounters between FPATH providers and participants over the duration of the program, with an average of 1.9 services per participant, per month (Appendix F, Table 2). Averages ranged from 1.6 services per month in the Southwest region to 2.2 in the

Spokane region. Across all FPATH regions, the most common service encounter was case management (1.1 per person, per month, on average), followed by outreach services (0.3 per person, per month) (Appendix F, Table 2).

Referrals

Of the 697 FPATH enrollees, 224 (35 percent) had received at least one referral through May 2024 (Appendix F, Table 2). The Spokane region provided the most referrals, with 64 percent of participants having at least one, followed by 41 percent in the Southwest region and 33 percent in the Pierce region. In the Phase 2 King region, 7 percent of enrollees had received at least one referral.

The most common referral throughout all four regions was to FHARPS housing, with 14 percent of all enrollees receiving at least one referral (Appendix F, Table 2). Approximately 11 percent of enrollees received at least one community mental health referral. Due to low enrollment numbers, and to protect participant confidentiality, detailed referral information for Phase 2 FPATH enrollees is not available as of May 31, 2024.

Education and Training – Crisis Intervention Training

For all the phased regions through June 30, 2024, the Criminal Justice Training Commission has completed 49 of the 40-hour courses for certified peace officers. Within these classes, CJTC has trained law enforcement officers, mental health professionals, dispatchers, co-responders, military police, and corrections officers. As of June 30, 2024, 3,037 law enforcement officers have completed this training. As of June 30, 2024, 35 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. Nine 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, 1,091 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. New regional classes were developed and deployed in Phase 3 areas in Port Angeles and Lacey.

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. To date, 1,014 dispatchers have received the full eight hours of training.

For Phase 2, the King region continues running a robust 40-hour CIT program. Because of this, of the 3,222 certified peace officers in the King region, 1,557 have completed the training (48 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 first half of 2024.

The King region has six correctional agencies encompassing 574 correctional officers. To date, 548 officers (95 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 166 telecom/911 dispatchers. Of these, 122 (73 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

The current training environment is continuing to improve. The CJTC has more than doubled the number of basic law enforcement academies it is offering to meet demand. As these newly trained officers come on board, they are replacing senior, experienced officers who are much more likely to have completed the 40-hour training. This natural attrition creates a demand for continually offering courses in the Phase 1 and 2 regions to remain compliant.

Recommendations to Address Concerns

CJTC continues to increase communication and marketing efforts, working with individual agencies to increase student enrollment in classes. The CIT for Corrections eight-hour course can be offered on swing shift and weekends to accommodate all schedules. CJTC has hired a dedicated program specialist 3 and several additional instructors, creating a robust team. This has allowed us to create new regional classes in the Trueblood Phased areas and other regions in the state that don't presently have programs.

Data-Education and Training-CIT

Phase 1

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

Appendix G, Figure 1 displays training completion rates for each individual law enforcement agency in Phase 1. As of June 30, 2024, 32 (59 percent) law enforcement agencies are meeting or exceeding the 25 percent benchmark. Large agencies continued to achieve higher training completion rates (42 percent overall) than small agencies (29 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 38 percent as of June 30, 2024. In the Pierce region, 24 percent of officers were trained, compared to 51 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 24 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 June 30, 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, 92 percent of correctional officers in the Phase 1 regions completed CIT training, ranging from 52 percent in the Southwest region to 96 percent in the Pierce 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 June 30, 2024, 26 (93 percent) law enforcement agencies exceeded the 25 percent benchmark, with an overall training completion rate of 48 percent (Appendix G, Table 1). Washington State Patrol units in Phase 2 had a training completion rate of 29 percent. Unlike Phase 1, small law enforcement agencies in King County had the highest overall training rate (55 percent) while medium-sized agencies had a lower overall rate of 36 percent.

Most (96 percent) correctional officers in King County had completed the eight-hour CIT course by June 30, 2024 (Appendix G, Table 2), as well as 95 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 June 30, 2024, 12 (55 percent) law enforcement agencies had met or exceeded the 25 percent training requirement, with an overall training rate of 36 percent. Large law enforcement agencies had higher training rates than small agencies (40 percent and 16 percent, respectively), and Washington State Patrol units had a training completion rate of 40 percent (Appendix G, Table 1).

Among correctional officers in the Phase 3 regions, 31 percent had completed the eight-hour CIT course by June 30, 2024 (Appendix G, Table 2), as well as 74 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 June 30, 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 61 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 16 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 December 2024.

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 as of June 2024, JTA provided 11 statewide training events toward the minimum of twenty required during this phase.

The learning events presented from January 1, 2024, through June 30, 2024, were:

- January: An Overview of the Recovery Navigator Program
- February: Crisis De-escalation: Using Validation and Why it is Essential
- March: Collaborative Enhanced Behavioral Health Services at SCORE jail
- April: Continuity of Care: What Yakima County Jail is Doing to Promote Reentry
- May: An Overview of the Outpatient Competency Restoration Program
- June: Let's Talk About Recruitment and Retention

Through outreach and relationship-building efforts, staff have extended the reach of JTA training. Staff has also worked toward improving audience engagement by inviting all interested stakeholders to participate in various presentation events and through increasing opportunities for discussion. Staff has 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. JTA staff attended the task force meeting as an observer but was added to a task force subgroup responsible for developing recommendations based on jail survey data. 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. Updates to the *Best Practices for Behavioral Health Services in Jail Settings* guidebook are currently

underway. 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, the average number of participants was 16 people per event. For calendar year 2023, the average number of participants per event was 16. The average number of attendees from January 2024 to June 2024 was 25. The first half of the year typically has higher attendance rates, but overall, the number of attendees has increased since 2021 and reflects JTA's outreach and engagement efforts.

Enhanced Peer Support

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

Current Status and Areas of Positive Impact

Because HCA has an entire section of staff dedicated to the licensure, training, and support of certified peer specialists across the state, the HCA Trueblood team reevaluated the needs of our team. In conjunction with the plaintiffs' counsel, the decision was made to repurpose this position to a Trueblood data program manager. This position will work with all our Trueblood element leads to interpret, analyze, and make data-informed programmatic decisions about OCRP, FPATH, and FHARPS.

HCA will continue to support peers working in the Trueblood programs through monthly peer meetings, on-going access to training opportunities, and community-building. Moving forward, the Trueblood team will approach the peer-based model as a foundational part of all the elements rather than a stand-alone element. This will allow the Trueblood team to refocus the priorities on supporting and enhancing FHARPS and FPATH data. This concludes HCA's reporting on the Enhanced Peer Support element.

HCA continues to require all newly hired staff working in Trueblood element programs to attend both the *Intersection of Behavioral Health and the Law* and the *Enhancing Your Cultural Intelligence* trainings within 30 days of onboarding. The contracted providers continue to utilize these trainings for their program staff and report positive feedback to HCA about the training curriculum.

In response to stakeholder feedback in 2023, HCA contracted with a curriculum development group of certified peer counselors to create a complimentary curriculum titled, *Cultural Inclusion in Peer Support: Compassion in Action.* During this reporting period, this work was being managed and supported by an HCA subject matter expert, the senior manager of the Office of Community Voices and Empowerment. After consideration, they determined that this training need is best supported by existing DEIB resources and future technical assistance by experts in this field.

The Trueblood data manager position was filled during this reporting period and began providing intensive technical assistance to the contractors and improving data quality and oversight for the HCA team.

First, the new data manager, in close collaboration with RDA, began creating logic models for the element programs to guide data collection and programmatic assessment. These models will

outline key activities and identify meaningful data outputs for collection. Consequently, we foresee making necessary adjustments to PDAMS data collection practices.

Additionally, HCA plans to introduce new metrics that will help to better capture the time spent and services provided to program participants. HCA is working to capture data that can answer both how the programs are doing at adhering to the logic model activities adhere and the goals of the program.

Lastly, the data manager began regular meetings with providers to address data entry issues, review the information entered into the system, and correct any errors. On a monthly basis, the data manager plans to share concise reports with each program, highlighting demographic data and providing an overview of team performance.

Data-Enhanced Peer Support

Beginning February 2022, data collection around completion of the online trainings offered by the Enhanced Peer Support program has been captured by a learning management system that registers individual users and tracks each user's completion of trainings.

Between July 1 and Dec. 31, 2023, 183 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions, have completed *The Intersection of Behavioral Health and the Law* online training. Between July and December 2023, 265 learners, including certified peer counselors from FPATH, FHARPS, OCRP, mobile crisis response and co-responder programs in Phase 1 and Phase 2 regions have completed *Enhancing Your Cultural Intelligence* online training.

Workforce Development

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

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 January 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.

Also in 2022, workforce development staff created a survey to learn more about the perspectives of prosecutors, defense counsel, and judges regarding the continuing increase in demand for pretrial competency services. Expanding on the information gathered during the survey of legal partners, the workforce development team procured a contract with Groundswell Services Inc.

to conduct follow-up focus groups and interviews with attorneys and judges to collect information regarding the forensic mental health system from their perspective, to discover potential strategies, and to disseminate information about current and future OFMHS initiatives to improve the competency system.

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. It issued a report on its 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 continues to meet regularly to move these recommendations forward. In March 2024, workforce development presented information on the survey and focus groups as part of a larger presentation, *Trueblood v. Washington State: The Continued Impact of the Competency Crisis on State Psychiatric Services and Program Development,* at the American Psychology Law Society conference. While in California, workforce development staff also toured an outpatient restoration home in the community for people who are felony incompetent to stand trial. The tour of the home was hosted by a resident, and it culminated in a discussion session with leadership and direct staff. This visit provided OFMHS with information for discussion pertaining to the Groundswell legal system partners focus group report recommendations. It also provided opportunities and connections for further engagement.

In early 2024, workforce development staff continued to lead the Behavioral Health Administration's trauma-informed care workforce development subcommittee, in an intensive effort to embed trauma-informed principles into all DSHS forensic mental health facilities, starting with a pilot project at Western State Hospital. In December 2023, this subcommittee submitted its deliverables to leadership for their review. The deliverables included identifying TIC core competencies, developing a master list of trainings in support of TIC implementation, building out a training schedule, developing evaluation and coaching tools, audit tools, and developing recommendations for employee wellness and recognition. In March 2024, the workforce development workgroup deliverables were successfully approved by leadership, requiring no further revisions by the workforce development team. This allowed the initial training phase of the pilot to begin.

Also in March 2024, a workforce development staff member applied and was accepted to SAMHSA GAINS Center's Behavioral Health and Justice Transformation Train-the-Trainer event

for individual trainers, "How Being Trauma-Informed Improves Criminal Justice System Responses." This opportunity instructs participants on the training delivery as well as provides them with the skills and resources necessary to deliver effective trainings. The TTT event's objectives include presenting the curriculum to participants, and discussing the design, purpose, objectives, and goals of the training; additional objectives include introducing, developing, and enhancing training, co-training, facilitation, and public speaking skills with participants to help familiarize them with the available tools and resources. Available tools include those available on the trainer website, noteworthy publications in the trauma field, and connecting participants with peers for ongoing support, collaboration, and dialogue regarding trauma-informed responses and community-based training opportunities.

Workforce development staff also continue to be centrally involved in providing guidance and technical assistance statewide in a leadership role with the BHA telehealth 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 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.

In 2023, the telehealth committee was working with the King and Snohomish County jails to establish a robust telehealth setup. Evaluations via telehealth are now being completed at the King County jail and equipment installation is underway at the Snohomish County jail. In 2024, the committee also visited Chelan County jail to assess their capability and is working with their staff to get equipment installed. Workforce development staff also worked with Kittitas County to successfully enable telehealth. 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.

Workforce development staff also facilitate the BHA Telehealth Governance Committee enabling discussions around prioritization, goals, and future planning. WFD staff is also 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. The group 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. More than 30 locations statewide are now using videoconferencing to regularly complete telehealth evaluations.

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.

The workforce development team updated the *Hiring and Onboarding Manual* and companion checklist in early 2024 to assist hiring managers in implementing a standardized set of protocols following policy and procedure established by DSHS human resources. This manual serves as OFMHS policy for the hiring and onboarding process. OFMHS workforce development staff are continuing 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. Staff continue to work on completing an online version of this training to be used as new OCRP staff onboard. Workforce development staff also are working on 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 February 2024, the team participated in two career fair events at Seattle University and Pierce County. Staff engaged with students and answered questions about jobs in behavioral health. Staff also connected with career center staff at Edmonds College and Shoreline Community College. In March 2024, the team hosted a career fair booth and engaged with students at FUSE in Spokane, which is the largest career event in the region with attendance of more than 700 students. Participating schools included Gonzaga, Whitworth, Washington State, and Eastern Washington Universities and the University of Idaho. In April 2024, the team engaged with students at Eastern Washington University's criminal justice fair and hosted a career fair booth at WorkSource in Vancouver, WA. In May 2024, the team hosted a career fair booth at the Shoreline Community College Career Fair and delivered two interactive presentations for Eastern Washington University students. The information presented to the EWU criminal justice students covered career opportunities in forensic mental health and described the functions within the Office of Forensic Mental Health. The presentation to the EWU social work students provided information about OFMHS and also the Trueblood lawsuit with a targeted focus on social work career fields within behavioral health. Staff gathered informative materials and developed an in-depth presentation for this event. It is recommended that staff continue to participate in educational outreach.

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. Breaking Barriers has ten modules, and staff are continuing to work on updating and converting each to a more interactive online version.

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.

In June 2024, workforce development completed five trainings for the not guilty by reason of insanity program and uploaded them to the state Learning Center. It is recommended that staff continue developing trainings in process and assess future training needs such as opportunities

to provide training related to *How Being Trauma-Informed Improves Criminal Justice System Responses*.

Develop Current Staff (supporting retention)
During the last reporting period, staff were in the process of creating an online introduction to mentorship in preparation for a staff mentorship program. This program is designed to support staff with professional development and leadership opportunities. The program training materials have been completed and uploaded to the state Learning Center. The program started accepting applications in early 2024 and has been met with positive feedback. It is recommended that staff continue to assess staff development programs such as the mentorship 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 June 2024, for the 30-day survey, four of nine staff responding to survey question one replied *excellent,* another four replied *good* and one reported *fair.* For question number two five of nine staff responding to the survey replied *excellent,* another four replied *good.* For the 90-day survey, four of eleven staff responding to survey question one replied *excellent*, six replied *good* and one reported *fair*. For question number two five of eleven staff responding to the survey replied *excellent*, and six replied *good*. Upon 30 days almost 89 percent of new staff responding to the survey felt that they had received *good* or *excellent* job-related training and communication so far, and 100-percent had *good* or *excellent* satisfaction with their job. Upon 90 days about 91 percent of new staff responding to the survey felt that they had received *good* or *excellent* job-related training and communication so far, and 100 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 May 31, 2024, 31 of the 73 Phase 3 implementation tasks were completed on time or early, including 30 that were completed early. Forty-two implementation tasks remain to complete.

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[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.

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 Healthcare Authority, 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 in Phase 1 Regions began July 1, 2020, and became available in the Phase 2 Region (King County) in October 2022. From July 2020 to June 2024, OCRP enrolled 243 individuals.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2024

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

CONTACTS

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Contents

TABLE 1.

OCRP Participant Characteristics

CUMULATIVE: July 1, 2020 - June 30, 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	243	100%	70	100%	76	100%	48	100%	49	100%
Among Enrolled Individuals…										
RESTORATION ORDER TYPE (unduplicated)										
Felony	201	83%	56	80%	55	72%	--	--	--	--
Misdemeanor	42	17%	14	20%	21	28%	--	--	--	--
GENDER										
Female	50	21%	--	--	--	--	11	23%	--	--
Male	163	67%	47	67%	52	68%	37	77%	27	55%
Other/Unknown	30	12%	--	--	--	--	0	0%	--	--
AGE GROUP										
18-29 yrs	63	26%	20	29%	25	33%	--	--	--	--
30-49 yrs	127	52%	30	43%	36	47%	27	56%	34	69%
50+ yrs	53	22%	20	29%	15	20%	--	--	--	--
RACE/ETHNICITY*										
Non-Hispanic White	145	60%	37	53%	52	68%	40	83%	16	33%
Black, Indigenous, and People of Color	68	28%	--	--	--	--	--	--	22	45%
Unknown	30	12%	--	--	--	--	--	--	11	22%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	65	27%	29	41%	--	--	15	31%	--	--
Unstably Housed	130	53%	26	37%	56	74%	15	31%	33	67%
Homeless	38	16%	--	--	11	14%	17	35%	--	--
In a Facility	9	4%	--	--	0	0%	--	--	--	--
Unknown	1	0%	0	0%	--	--	--	--	0	0%

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

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

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

TABLE 2.

OCRP Discharges

CUMULATIVE: July 1, 2020 - June 30, 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	243	100%	70	100%	76	100%	48	100%	49	100%
Active	41	17%	--	--	--	--	--	--	18	37%
Discharged	202	83%	--	--	--	--	--	--	31	63%
Among Discharged Individuals…										
DISCHARGE REASON										
Charges Dismissed	24	12%	--	--	--	--	--	--	--	--
Opined Competent	78	39%	16	26%	32	46%	16	40%	14	45%
Opined Not Competent	6	3%	--	--	--	--	--	--	0	0%
Opined Not Restorable	5	2%	--	--	0	0%	0	0%	--	--
Returned to Jail	10	5%	--	--	--	--	0	0%	0	0%
Inpatient Medical Care	2	1%	--	--	0	0%	0	0%	--	--
Inpatient Civil Psychiatric Care	12	6%	--	--	0	0%	--	--	--	--
Revoked Conditional Release	55	27%	--	--	23	33%	13	33%	--	--
Legal Authority Ended	5	2%	--	--	0	0%	0	0%	--	--
Death	2	1%	0	0%	0	0%	--	--	--	--
Other	3	1%	--	--	0	0%	0	0%	--	--
DISCHARGE LOCATION										
Community	126	62%	45	74%	41	59%	22	55%	18	58%
Behavioral Health Treatment Center*	3	1%	--	--	0	0%	0	0%	--	--
State Hospital	33	16%	--	--	12	17%	13	33%	--	--
Jail	24	12%	--	--	--	--	--	--	--	--
Unknown	16	8%	--	--	--	--	--	--	--	--
LENGTH OF STAY										
Average Length of Stay in Program (days)	78	N/A	84	N/A	73	N/A	85	N/A	68	N/A
HOUSING STATUS AT PROGRAM DISCHARGE										
Stably Housed	77	38%	26	43%	21	30%	--	--	--	--
Unstably Housed	61	30%	24	39%	--	--	--	--	18	58%
Homeless	25	12%	--	--	18	26%	--	--	--	--
In a Facility	20	10%	--	--	--	--	11	28%	0	0%
Unknown/Missing	19	9%	--	--	--	--	--	--	--	--

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 residential treatment facility. See definitions.

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, and 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.

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	Refers to DSHS facilities licensed as residential treatment facilities that serve both forensic and civil patients.
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.
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, and 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 June 2024, the Forensic Navigator program served 7,226 individuals.

As began last year, an online Power BI report provides both quarterly and cumulative data that can be broken down by region to track program data and illustrate trends. The data presented here represents selected figures and tables from this Power BI report. The full report, including all data and definitions, can be accessed online here*.

REPORTING PERIOD

Cumulative: July 1, 2020 to June 30, 2024

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

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Contents

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

Figure 1.

Forensic Navigator Program Measures

Enrollment Summary

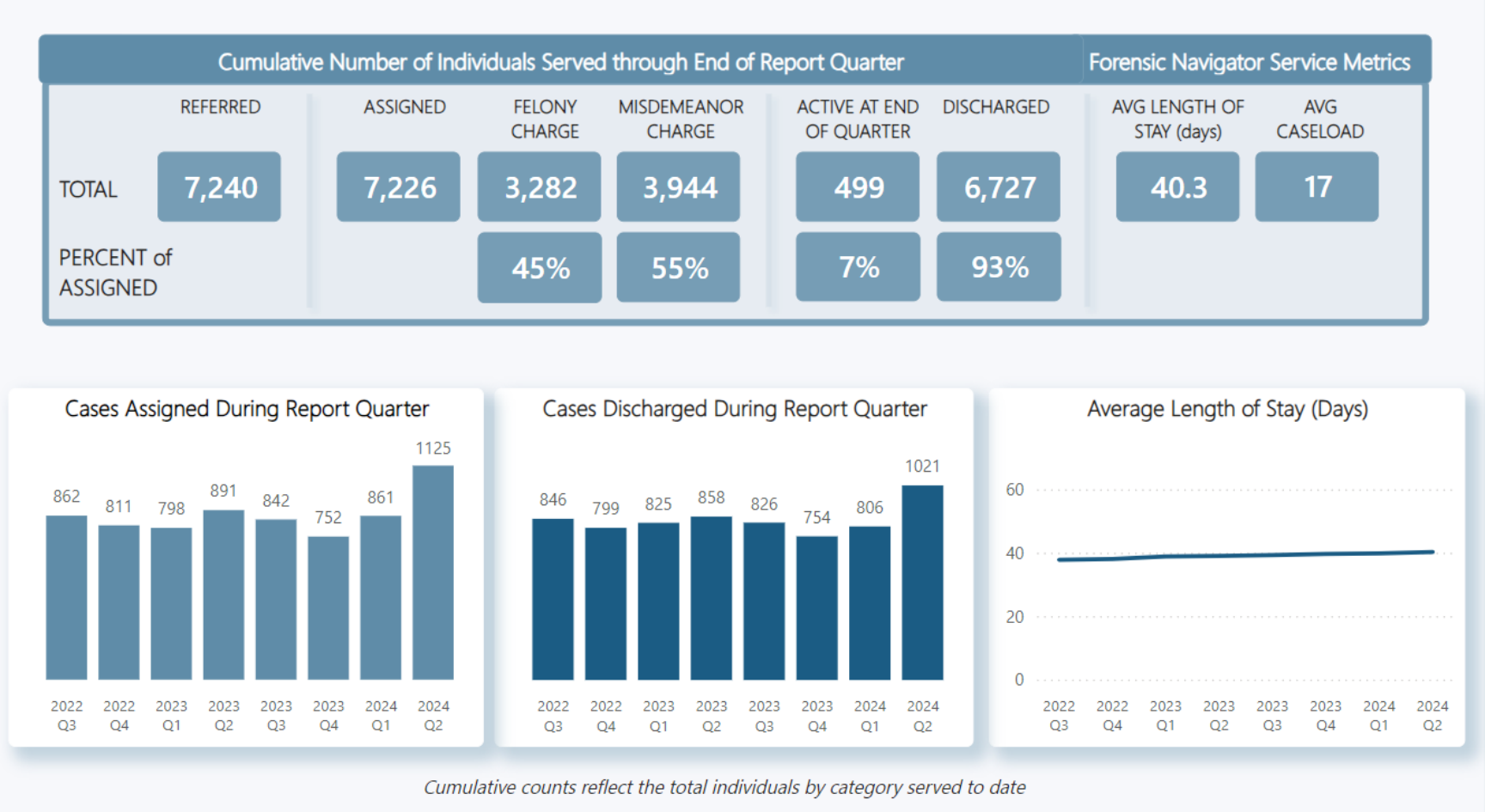

Figure 2.

Forensic Navigator Program Measures
Case Status

Active Case Status at End of Quarter (last day of report period)

Case Status	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2
Active	139	173	151	338	387	379	384	337	382	392	375	418	499
Pre-Competency Hearing	125	155	135	318	368	344	340	290	325	335	326	364	442
OCRP Enrolled	10	14	13	15	15	22	28	26	33	34	22	30	28
Post OCRP	4	4	3	5	3	5	6	9	3	2	10	7	7
Reassess for OCRP	0	0	0	0	1	8	9	8	10	17	8	11	11
In Process of OCRP Removal	0	0	0	0	0	0	1	4	11	4	9	6	11

Figure 3.

Forensic Navigator Program Measures
Caseload by Region

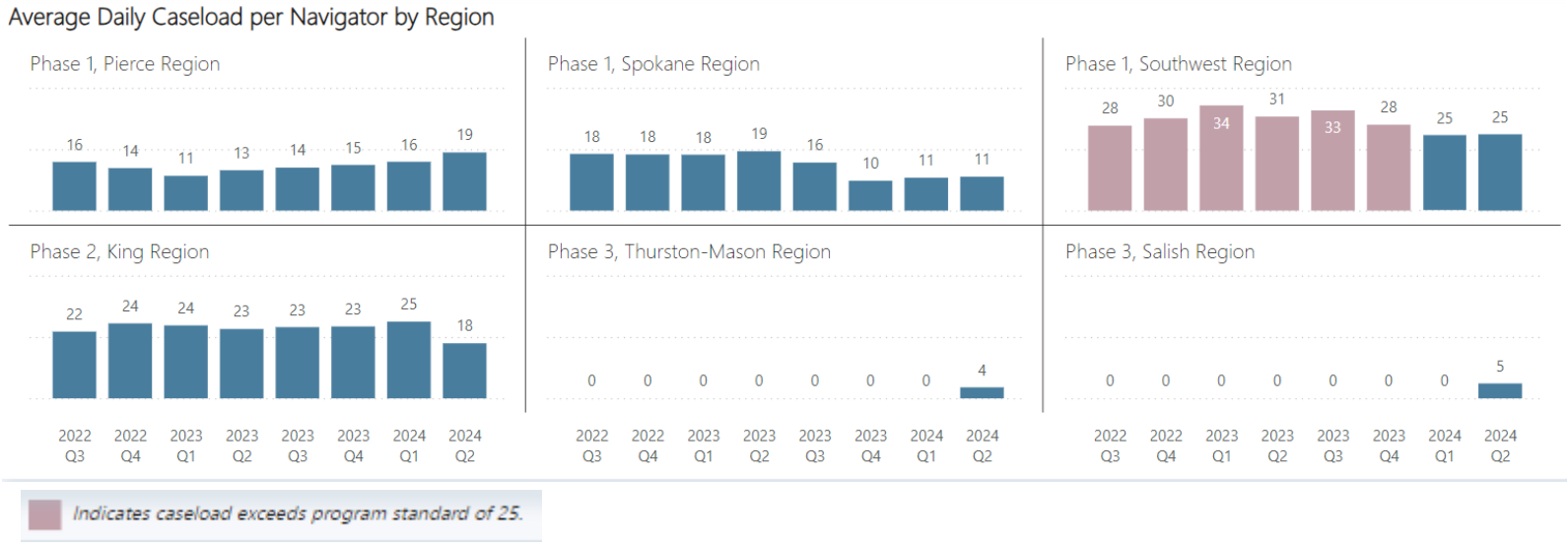

Table 1.

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	410	25%	278	23%	244	27%	731	22%	*		*		**1,690**	**23%**
30-49	879	54%	680	56%	502	55%	1,884	56%	40	54%	35	63%	**4,020**	**56%**
50 +	335	21%	260	21%	165	18%	728	22%	16	22%	12	21%	**1,516**	**21%**
Gender														
Female	342	21%	311	26%	186	20%	644	19%	17	23%	16	29%	**1,516**	**21%**
Male	1,034	64%	888	73%	618	68%	1,975	59%	43	58%	34	61%	**4,592**	**64%**
Other/Unknown	248	15%	19	2%	107	12%	724	22%	*		*		**1,118**	**15%**
Race-Ethnicity														
American Indian or Alaska Native	37	2%	31	3%	*		48	1%	*		*		**121**	**2%**
Asian	53	3%	*		27	3%	155	5%	*		*		**248**	**3%**
Black or African American	393	24%	97	8%	112	12%	890	27%	*		*		**1,506**	**21%**
Hispanic or Latino	29	2%	11	1%	36	4%	149	4%	*		*		**230**	**3%**
Native Hawaiian or Other Pacific Islander	51	3%	*		17	2%	32	1%	*		0	0%	**107**	**1%**
White Only, Non-Hispanic	753	46%	910	75%	531	58%	1,157	35%	41	55%	36	64%	**3,428**	**47%**
Other Race	14	1%	*		11	1%	106	3%	*		*		**135**	**2%**
Unknown	313	19%	156	13%	184	20%	898	27%	*		*		**1,578**	**22%**

Figure 4.

Forensic Navigator Program Measures
Services

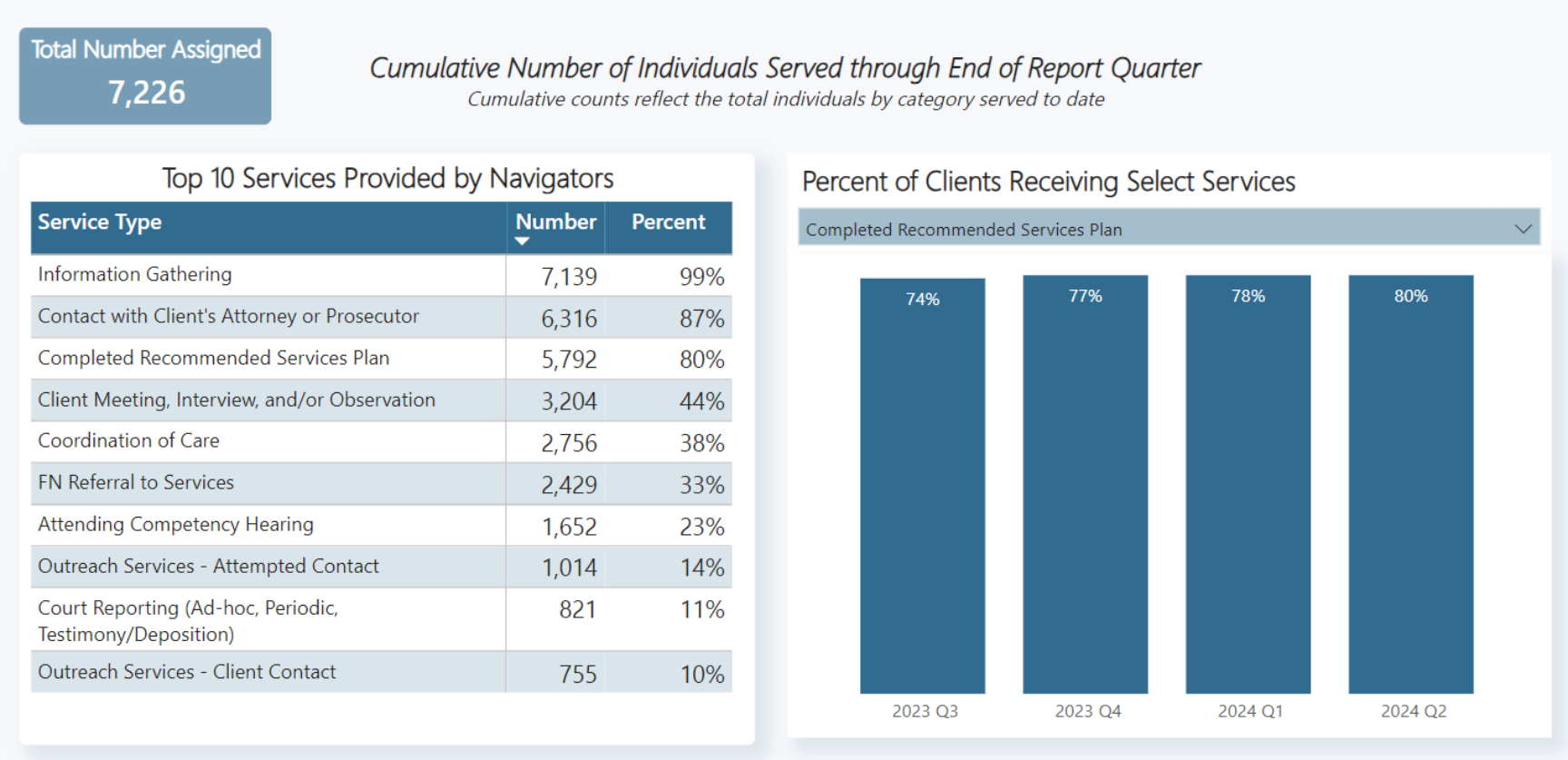

Figure 5.

Forensic Navigator Program Measures

Referrals

Total Number Assigned
7,226

Cumulative Number of Individuals Served through End of Report Quarter

Cumulative counts reflect the total individuals by category served to date

Top 10 Service Referrals Made by Navigators

Referral Type	Number	Percent
Forensic PATH	1,413	19%
Forensic HARPS	1,271	18%
Community Outpatient Mental Health Services	770	11%
Other Community Based Resource	591	8%
Substance Use Disorder Treatment	517	7%
EBT/ABD (Food/Cash Benefits)	328	4%
Housing Services (Non-HARPS)	326	4%
Home and Community Services	315	4%
SSI/SSDI	252	3%
Medical Insurance Services	244	3%

Percent of Clients Referred to Select Services

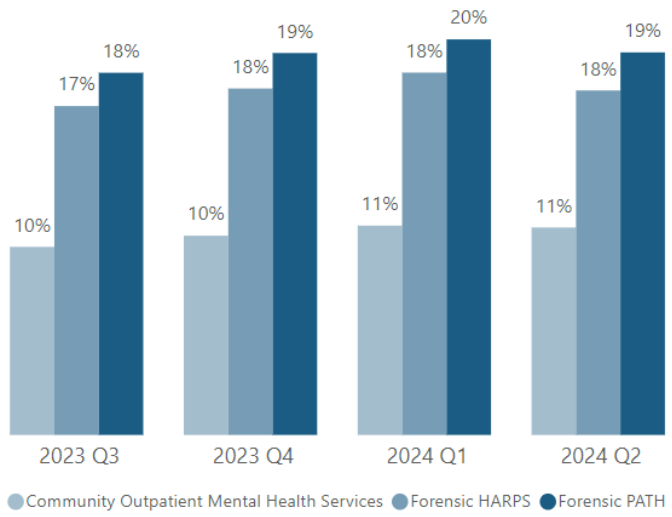

Table 2.

Forensic Navigator Program Measures

Discharges

Cumulative Number of Individuals Served through End of Report Quarter

Cumulative counts reflect the total individuals by category served to date

Number of Clients Discharged	Number with Warm Hand-Off	Percent with Warm Hand-Off	Average Length of Stay (days)
6,652	2,005	30%	40.3

Discharge Reason	Number	% Discharged
Client Determined Competent	2,003	30%
Inpatient Restoration	1,403	21%
Released From Jail on Personal Recognizance (PR)	1,393	21%
Charges Dismissed	1,078	16%
Dismiss & Refer (to Designated Crisis Responder)	331	5%
Order Cancelled or Withdrawn	184	3%
Refused Forensic Navigator Program Services	106	2%
Successful OCRP Completion - Coordinated Transition Completed	49	1%
Violation of OCRP Conditions of Participation/Court Ordered CR	35	1%
Felony (Up to 120 Hours) Civil Conversion	31	0%
Felony (Up to 120 Hours) Civil Conversion - FN Completed Warm Hand Off	23	0%
Not Restorable - Pre-Hearing/OCRP	21	0%
Client Death	13	0%
Successful OCRP Completion - Summary of Treatment Completed	13	0%
Not Restorable - Developmental Disability	10	0%
Diversion Program(s)	6	0%
Civil Conversion - Removal from OCRP	5	0%
Diversion: DN Completed Warm Hand-Off	5	0%
Re-arrest	4	0%
Disability- Transferred to DDA/ALTSA	2	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 were available in the Phase 1 Regions of the Trueblood settlement agreement including Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties) regions on December 1, 2019. Vouchers were available in Phase 2 Region (King County) in July 2022. From December 2019 to June 2024 vouchers were disbursed to 657 individuals.

REPORTING PERIOD

Cumulative: December 1, 2019 to June 30, 2024

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

CONTACTS

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TABLE 1.

Crisis Housing Vouchers

CUMULATIVE: December 1, 2019 to June 30, 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	836	100%	130	16%	281	34%	229	27%	196	23%
Recipients (unduplicated)	657	100%	129	20%	226	34%	150	23%	152	23%
Total Amount Disbursed	$767,067	N/A	$166,063	N/A	$299,815	N/A	$193,287	N/A	$107,902	N/A
Average Amount Per Recipient	$1,169	N/A	$1,293	N/A	$1,327	N/A	$1,289	N/A	$710	N/A
FACILITY REFERRAL SOURCE										
Crisis Call Center	3	0%	0	0%	--	--	--	--	0	0%
Family/Friend	7	1%	--	--	--	--	0	0%	0	0%
Hospital	152	23%	51	40%	--	--	64	43%	--	--
Community Behavioral Health Agency	46	7%	--	--	24	11%	--	--	15	10%
Mobile Crisis Response	32	5%	--	--	--	--	29	19%	0	0%
Designated Crisis Responder	40	6%	0	0%	0	0%	40	27%	0	0%
Tribe or Indian Healthcare Provider	0	0%	0	0%	0	0%	0	0%	0	0%
Emergency Responder	6	1%	--	--	--	--	0	0%	--	--
Law Enforcement (Police, Co-Responders)	88	13%	14	11%	--	--	--	--	67	44%
Court/Criminal Justice Referred	24	4%	0	0%	--	--	--	--	22	14%
Self	211	32%	31	24%	158	70%	--	--	--	--
Other Healthcare Provider	5	1%	--	--	--	--	0	0%	--	--
Other	43	7%	21	16%	--	--	--	--	18	12%
GENDER										
Female	211	32%	31	24%	74	33%	50	33%	56	37%
Male	438	67%	98	76%	150	66%	95	63%	95	63%
Other/Unknown	8	1%	--	--	--	--	--	--	--	--
AGE GROUP										
18-29	142	22%	29	22%	47	21%	29	19%	37	24%
30-49	361	55%	65	50%	128	57%	83	55%	85	56%
50+	154	23%	35	27%	51	23%	38	25%	30	20%
RACE/ETHNICITY**										
Non-Hispanic White	393	60%	70	54%	173	77%	95	63%	--	--
Black, Indigenous, and People of Color	239	36%	--	--	--	--	42	28%	88	58%
Unknown	25	4%	--	--	--	--	13	9%	--	--

	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
Among Voucher Recipients…										
FORENSIC HARPS (FHARPS) STATUS* **										
Referred to FHARPS	124	19%	--	--	31	14%	62	41%	--	--
Contacted by FHARPS staff	111	17%	--	--	25	11%	59	39%	--	--
Enrolled in FHARPS	110	17%	--	--	24	11%	50	33%	--	--
Housed or sheltered by FHARPS	98	15%	--	--	24	11%	50	33%	--	--
Among Individuals Housed or Sheltered by FHARPS…										
FIRST FHARPS HOUSING TYPE*										
Permanent	3	3%	--	--	0	0%	--	--	0	0%
Transitional	15	15%	--	--	--	--	--	--	--	--
Shelter/emergency	80	82%	18	82%	--	--	43	86%	--	--
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. Counts and percentages may not sum due to unreported data and/or rounding.

*Pierce Region data are missing up approximately three weeks of due to RI International not submitting the 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.
Community Behavioral Health Agency	Organization that provides behavioral health services within a specified locality.
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).

Law Enforcement (Police, Co-Responders)	Federal, state, or local law enforcement officers. Includes Co-Responder teams made up of law enforcement and mental health staff to professionally, humanely, and safely respond to crises involving persons with behavioral health issues.
Court/Criminal Justice Referred	Court or other criminal justice related resource (e.g., reentry program, attorney).
Self	Self-referral.
Other Healthcare Provider	A healthcare provider not included in the other category options (e.g., outpatient behavioral health, primary care physician).
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 Healthcare Authority, is designed to provide residential support to unstably housed individuals with former or current involvement with the forensic mental health system, or individuals at risk of becoming involved in the system due to mental health needs. The program began March 1, 2020 in Phase 1 Regions of the Trueblood settlement agreement: Pierce, Southwest (Clark, Klickitat, and Skamania Counties), and Spokane (Spokane, Adams, Ferry, Lincoln, Pend Oreille, and Stevens Counties) regions. FHARPS services began in the Phase 2 Region (King County) in April 2022. From March 2020 to June 2024, FHARPS enrolled 1,151 individuals.

REPORTING PERIOD
Cumulative: March 1, 2020 to June 30, 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.

FHARPS Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - June 30, 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	2,070	100%	828	100%	418	100%	466	100%	358	100%
Contacted	1,337	65%	571	69%	349	83%	231	50%	186	52%
Enrolled	1,151	56%	467	56%	318	76%	225	48%	141	39%
Among Referred Individuals…										
REFERRAL SOURCE										
Trueblood partner programs	1,357	66%	378	46%	289	68%	342	73%	348	97%
Forensic Navigator	869	*42%*	*186*	*22%*	*216*	*52%*	*119*	*26%*	*348*	*97%*
Forensic PATH	283	*14%*	*120*	*14%*	*37*	*9%*	*126*	*27%*	*0*	*0%*
OCRP	35	*2%*	--	--	--	--	*17*	*4%*	*0*	*0%*
Crisis Stabilization Center	150	*7%*	*48*	*6%*	*33*	*8%*	*69*	*15%*	*0*	*0%*
Co-Response Team	20	*1%*	--	--	--	--	*11*	*2%*	*0*	*0%*
Mobile Crisis Response	2	0%	--	--	0	0%	--	--	0	0%
Diversion Navigator	1	0%	--	--	0	0%	--	--	--	--
Behavioral Health Facility - Outpatient	274	13%	132	16%	91	22%	51	11%	0	0%
Inpatient Facility	62	3%	43	5%	--	--	12	3%	--	--
Family/Self	51	2%	34	4%	--	--	16	3%	--	--
Other	323	16%	240	29%	--	--	44	9%	--	--
Among Contacted Individuals…										
LOCATION OF INITIAL CONTACT										
Phone	435	33%	240	42%	164	47%	31	13%	0	0%
Court	1	0%	--	--	0	0%	0	0%	--	--
Hotel/Motel	38	3%	31	5%	--	--	--	--	0	0%
Jail	438	33%	71	12%	149	43%	34	15%	184	99%
Crisis Stabilization Center	64	5%	--	--	--	--	49	21%	0	0%
Behavioral Health Facility - Outpatient	155	12%	63	11%	21	6%	71	31%	0	0%
Inpatient Facility	34	3%	20	4%	--	--	13	6%	--	--
Shelter	13	1%	11	2%	0	0%	--	--	--	--
Street/encampment	12	1%	11	2%	0	0%	--	--	--	--
Temporary Residence	9	1%	--	--	--	--	--	--	0	0%
Other	138	10%	104	18%	--	--	26	11%	--	--
Among Enrolled Individuals…										
PARTICIPANT STATUS (on last day of reporting period)										
Active	282	25%	121	26%	64	20%	66	29%	31	22%

	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
Discharged	869	75%	346	74%	254	80%	159	71%	110	78%
GENDER										
Female	332	29%	--	--	--	--	--	--	--	--
Male	799	69%	299	64%	233	73%	166	74%	101	72%
Other/Unknown	20	2%	--	--	--	--	--	--	--	--
AGE GROUP										
18-29	260	23%	118	25%	75	24%	36	16%	31	22%
30-49	629	55%	226	48%	173	54%	146	65%	84	60%
50+	207	18%	112	24%	38	12%	41	18%	16	11%
Unknown	55	5%	11	2%	32	10%	--	--	--	--
RACE/ETHNICITY*										
American Indian or Alaska Native	76	7%	32	7%	26	8%	--	--	--	--
Asian	23	2%	11	2%	--	--	--	--	--	--
Black or African American	276	24%	169	36%	36	11%	36	16%	35	25%
Hispanic or Latino	116	10%	48	10%	39	12%	--	--	--	--
Native Hawaiian or Pacific Islander	17	1%	--	--	--	--	--	--	--	--
White Only, Non-Hispanic	544	47%	203	43%	155	49%	155	69%	31	22%
Other Race	69	6%	18	4%	41	13%	--	--	--	--
Unknown	141	12%	--	--	55	17%	--	--	56	40%
HOUSING STATUS AT PROGRAM ENROLLMENT										
Unstably Housed	508	44%	128	27%	206	65%	53	24%	121	86%
Homeless	643	56%	339	73%	112	35%	172	76%	20	14%

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 race/ethnicity.

TABLE 2.

FHARPS Housing Support

CUMULATIVE: March 1, 2020 - June 30, 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	1,151	100%	467	100%	318	100%	225	100%	141	100%
Housed or Sheltered	866	75%	413	88%	207	65%	180	80%	66	47%
Among Enrolled Individuals…										
SERVICES PARTICIPANT AGREED TO										
Subsidies only	29	3%	--	--	0	0%	18	8%	--	--
Support Services and Subsidies	1,122	97%	457	98%	318	100%	207	92%	140	99%
Among Housed/Sheltered Individuals…										
FIRST HOUSING TYPE										
Permanent	69	8%	46	11%	--	--	12	7%	--	--
Transitional	377	44%	185	45%	71	34%	59	33%	62	94%
Shelter/emergency	418	48%	182	44%	126	61%	--	--	--	--
Other	2	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 - June 30, 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	1,151	100%	467	100%	318	100%	225	100%	141	100%
Active (on last day of reporting period)	282	25%	121	26%	64	20%	66	29%	31	22%
Discharged (during reporting period)	869	75%	346	74%	254	80%	159	71%	110	78%
Among Individuals Discharged…										
SUBSIDY										
Average total subsidy since enrollment	$6,587	N/A	$7,658	N/A	$6,913	N/A	$4,785	N/A	$1,803	N/A
DISCHARGE REASON										
Transitioned to other housing support	116	13%	95	27%	--	--	--	--	0	0%
Received maximum subsidy	*22*	*19%*	*12*	*13%*	--	--	--	--	*0*	*0%*
Did not receive maximum subsidy	*94*	*81%*	*83*	*87%*	--	--	--	--	*0*	*0%*
Transitioned to self-support	97	11%	48	14%	29	11%	20	13%	0	0%
Admitted to a facility	55	6%	--	--	--	--	23	14%	--	--
Received maximum assistance (no transition)	69	8%	29	8%	27	11%	13	8%	0	0%
Withdrew	103	12%	32	9%	45	18%	--	--	--	--
Loss of contact	310	36%	70	20%	101	40%	51	32%	88	80%
Served by another FHARPS team	7	1%	--	--	--	--	--	--	0	0%
Other	112	13%	53	15%	31	12%	13	8%	15	14%
LENGTH OF SUPPORT										
Average Length of Stay in Program (days)	202	N/A	234	N/A	176	N/A	240	N/A	108	N/A
HOUSING STATUS AT DISCHARGE										
Stably Housed	255	29%	153	44%	54	21%	--	--	--	--
Unstably Housed	61	7%	--	--	29	11%	--	--	--	--
Homeless	178	20%	54	16%	22	9%	13	8%	89	81%
In a Facility	97	11%	--	--	28	11%	47	30%	--	--
Unknown	278	32%	96	28%	121	48%	50	31%	11	10%

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.
Diversion Navigator	Staff from a Diversion Navigator team who work to identify incarcerated people who may be eligible and willing to engage in diversion programs pursuant to RCW 10.77.
Co-Response Team	Staff from a Co-Responder or Co-Deployment team, made up of law enforcement and mental health staff to professionally, humanely, and safely respond to crises involving persons with behavioral health issues.
Behavioral Health Facility - Outpatient	Staff from a Community behavioral health agency that provides outpatient mental health or substance use services (outside of others listed here, e.g., FPATH and OCRP); excludes Crisis Stabilization Center.
Inpatient Facility	Staff from an Inpatient facility providing treatment for mental health, substance use, or medical needs; exclude crisis stabilization centers and outpatient services.
Family/Self	Family member or guardian of participant referral, or participant initiated contact. May include cases in which family or participant contacted FHARPS after receiving referral information from another source.

Other	Other referral sources not listed as a referral source option, including non-government organizations offering support and recovery services.
Location of Initial Contact	Point of initial contact between participant and FHARPS staff.
Phone	Telephone conversation not including voicemail messages.
Court	Superior, District, or Municipal Court within the region.
Hotel/Motel	Establishment for lodging on a short-term basis.
Jail	County, city, or tribal correctional facility.
Crisis Stabilization Center	A short-term residential stabilization service for individuals with mental health and/or substance use disorders.
Behavioral Health Facility - Outpatient	A community behavioral health agency that provides outpatient mental health or substance use services; excludes Crisis Stabilization Center.
Inpatient 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.
Support Services and Subsidies	Participant agreed to support services (e.g., transportation, seeking housing, assisting with lease and landlord relations, referrals to additional services, etc.) from an FHARPS peer or housing specialist and subsidy support.

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

Appendix F-FPATH Dashboard

FPATH Dashboard

Forensic Projects for Assistance in Transition from Homelessness

CUMULATIVE UPDATE

Led by the Washington State Health Care Authority (HCA), the Forensic PATH program offers enhanced engagement and connection to services for individuals identified as most at risk of being referred for a competency evaluation within the next six months. Teams within behavioral health agencies will connect program participants with services and supports, including behavioral health treatment, housing, transportation, and health care services. The Forensic PATH program began on March 1, 2020 in the Phase 1 regions and April 1, 2022 in the Phase 2 region. Between March 2020 and May 2024, the Forensic PATH program enrolled 697 individuals.

March 1, 2020 to May 31, 2024*

Prepared by Washington State Department of Social and Health Services
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*FPATH enrollment, services, and referral data are presented through May 31, 2024, when FPATH transitioned to PDAMS for data collection. PDAMS data are not included in the current report. Data for the current reporting period may change once PDAMS data are added.

TABLE 1.

Forensic PATH Enrollment and Participant Characteristics

CUMULATIVE: March 1, 2020 - May 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 Referral List	3,823	100%	1,163	100%	401	100%	720	100%	1,539	100%
Attempted Contacts	1,291	34%	607	52%	123	31%	374	52%	187	12%
Contacted	1,204	31%	296	25%	173	43%	296	41%	439	29%
Enrolled	697	18%	230	20%	131	33%	125	17%	211	14%
PRIORITIZED POPULATION										
Prioritized Referral List	2,465	64%	778	67%	213	53%	547	76%	918	60%
Attempted Contacts	796	32%	411	53%	55	26%	239	44%	91	10%
Contacted	730	30%	192	25%	106	50%	200	37%	232	25%
Enrolled	389	16%	129	17%	72	34%	80	15%	108	12%
Among Enrolled Individuals…										
PARTICIPANT STATUS										
Active (on last day of reporting period)	122	18%	51	22%	--	--	--	--	40	19%
Discharged*	575	82%	179	78%	--	--	--	--	171	81%
Average Length of Stay in Program (days)	304.7	N/A	368.0	N/A	294.7	N/A	476.3	N/A	144.1	N/A
DISCHARGE REASON										
Successful exit	85	15%	41	23%	20	16%	--	--	--	--
Loss of contact	262	46%	72	40%	36	29%	51	50%	103	60%
Needs could not be met by program	20	3%	--	--	--	--	--	--	--	--
Withdrew	28	5%	--	--	--	--	--	--	--	--
Incarceration	48	8%	--	--	27	22%	--	--	--	--
Admitted to hospital	12	2%	--	--	--	--	--	--	--	--
Transferred to another FPATH program	3	1%	--	--	--	--	--	--	--	--
Death	13	2%	--	--	--	--	--	--	--	--
Other	45	8%	--	--	22	18%	15	15%	--	--
Missing	59	10%	23	13%	--	--	--	--	36	21%
GENDER										
Female	151	22%	49	21%	--	--	--	--	39	18%
Male	466	67%	157	68%	98	75%	88	70%	123	58%
Other/Unknown	80	11%	24	10%	--	--	--	--	49	23%
AGE GROUP										
18-29	167	24%	58	25%	32	24%	31	25%	46	22%
30-49	425	61%	127	55%	82	63%	80	64%	136	64%
50+	105	15%	45	20%	17	13%	14	11%	29	14%

RACE/ETHNICITY**										
American Indian or Alaskan Native	25	4%	--	--	--	--	--	--	--	--
Asian	24	3%	--	--	--	--	--	--	11	5%
Black or African American	172	25%	61	27%	24	18%	13	10%	74	35%
Hispanic or Latino	47	7%	--	--	13	10%	--	--	13	6%
Native Hawaiian and Other Pacific Islander	10	1%	--	--	--	--	0	0%	--	--
White Only, Non-Hispanic	304	44%	82	36%	82	63%	66	53%	74	35%
Other Race	40	6%	--	--	--	--	--	--	22	10%
Unknown	115	16%	65	28%	--	--	27	22%	--	--
HOUSING STATUS AT PROGRAM ENROLLMENT										
Stably Housed	44	6%	13	6%	--	--	--	--	--	--
Unstably Housed	131	19%	51	22%	--	--	32	26%	--	--
Homeless	445	64%	145	63%	96	73%	70	56%	134	64%
Unknown	77	11%	21	9%	--	--	--	--	47	22%
HOUSING STATUS AT PROGRAM EXIT										
Stably Housed	93	16%	48	27%	20	16%	--	--	--	--
Unstably Housed	31	5%	--	--	--	--	--	--	--	--
Homeless	64	11%	18	10%	31	25%	--	--	--	--
In a Facility	68	12%	--	--	36	29%	13	13%	--	--
Unknown	319	55%	87	49%	22	18%	66	65%	144	84%

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

*FPATH enrollment, services, and referral data are presented through May 31, 2024, when FPATH transitioned to PDAMS for data collection. PDAMS data are not included in the current report. Data for the current reporting period may change once PDAMS data are added.

**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 - May 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	13,490		4,786		2,093		4,018		2,593	
Average Service Encounters (per participant, per month)	1.9		2.0		1.6		2.2		1.9	
Among Enrolled Individuals…										
FORENSIC PATH SERVICES - *Average number of services per participant, per month*										
Outreach services	0.3		0.1		0.2		0.7		0.2	
Re-engagement	0.0		0.0		0.0		0.1		0.0	
Screening	0.2		0.2		0.0		0.1		0.2	
Clinical assessment	0.0		0.0		0.0		0.0		0.0	
Habilitation/rehabilitation	0.0		0.0		0.1		0.0		0.0	
Community mental health	0.0		0.0		0.1		0.0		0.0	
Substance use treatment	0.0		0.0		0.0		0.0		0.0	
Case management	1.1		1.4		0.7		1.0		0.9	
Residential supportive services	0.1		0.0		0.3		0.0		0.0	
Peer services	0.1		0.0		0.0		0.0		0.3	
Service coordination	0.2		0.1		0.2		0.2		0.2	
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	224	32.1%	75	32.6%	54	41.2%	80	64.0%	15	7.1%
Referral Type										
Community mental health	73	10.5%	23	10.0%	--	--	29	23.2%	--	--
Substance use treatment	42	6.0%	--	--	--	--	23	18.4%	--	--
Primary health/dental care	34	4.9%	--	--	--	--	26	20.8%	--	--
Job training	1	0.1%	--	--	0	0.0%	0	0.0%	--	--
Educational services	3	0.4%	--	--	0	0.0%	--	--	0	0.0%
FHARPS housing	99	14.2%	40	17.4%	--	--	29	23.2%	--	--
Permanent housing (non-FHARPS)	20	2.9%	--	--	--	--	--	--	--	--
Temporary housing (non-FHARPS)	33	4.7%	13	5.7%	--	--	--	--	--	--
Other Housing Services (non-FHARPS)	50	7.2%	16	7.0%	27	20.6%	--	--	--	--
Housing services (pre-August 2021)	28	4.0%	12	5.2%	--	--	12	9.6%	--	--
Income assistance	10	1.4%	--	--	--	--	--	--	0	0.0%
Employment assistance	11	1.6%	--	--	--	--	--	--	0	0.0%
Medical insurance	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	43	6.2%	--	--	--	--	33	26.4%	0	0.0%

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

*FPATH enrollment, services, and referral data are presented through May 31, 2024, when FPATH transitioned to PDAMS for data collection. PDAMS data are not included in the current report. Data for the current reporting period may change once PDAMS data are added.

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, and 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 Referral List	Number of individuals who appeared on the Forensic PATH eligibility list during the reporting period. Eligibility criteria include having two or more competency evaluation referrals in the past 24 months.
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 Referral List	Number of individuals who appeared on the prioritized Forensic PATH eligibility list during the reporting period. Eligibility is prioritized based on the number of referrals for competency evaluation, county of residence, and housing status.
Attempted Contacts	Individuals on the prioritized referral list with an attempted (unsuccessful) contact during the reporting period.
Contacted	Individuals on the prioritized referral list who were successfully contacted by the program during the reporting period.
Enrolled	Individuals on the prioritized referral 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.
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.
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.
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.
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 trainings (CIT) are being offered to law enforcement, 911 dispatch, and corrections officers throughout Washington State. At a minimum, 25% of patrol officers in the Phase 1 and 2 regions are required to complete 40 hours of enhanced CIT, while 100% 911 dispatchers and correctional officers are required to complete an eight-hour course. Contempt settlement-mandated crisis intervention trainings began on July 1, 2019 for Phase 1; 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: June 2024

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Contents

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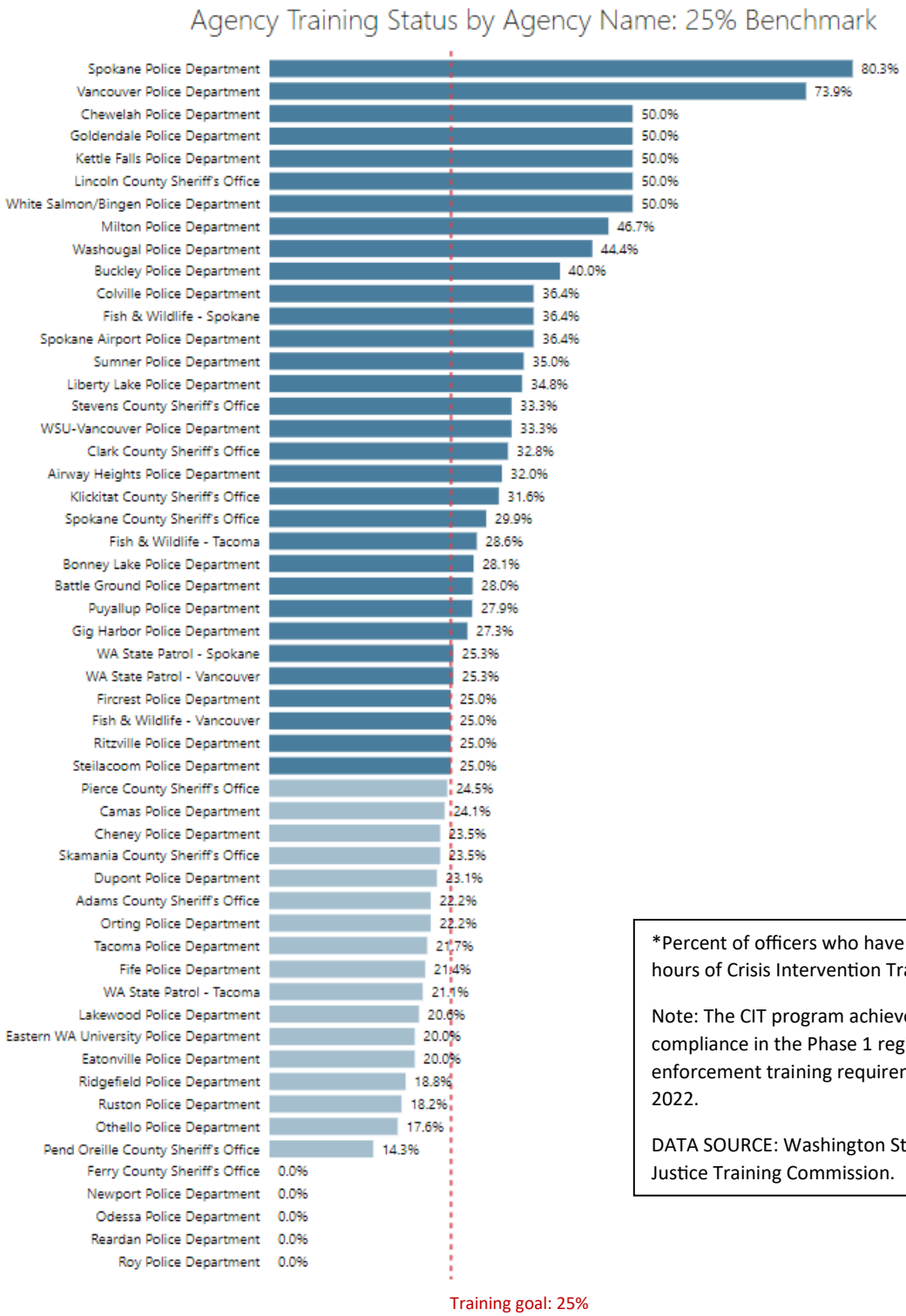
Figure 1.

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

JUNE 30, 2024



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

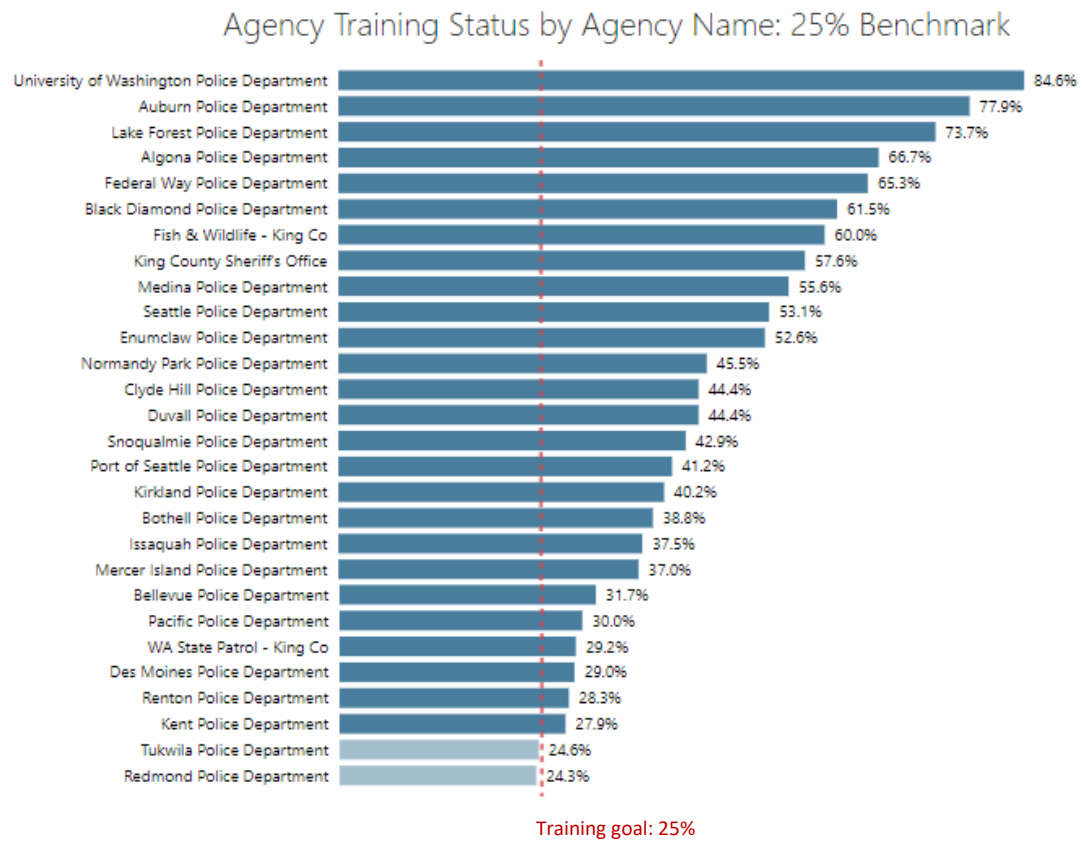
Note: The CIT program achieved 100 percent compliance in the Phase 1 regions for the law enforcement training requirement in June 2022.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 2.

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

JUNE 30, 2024



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

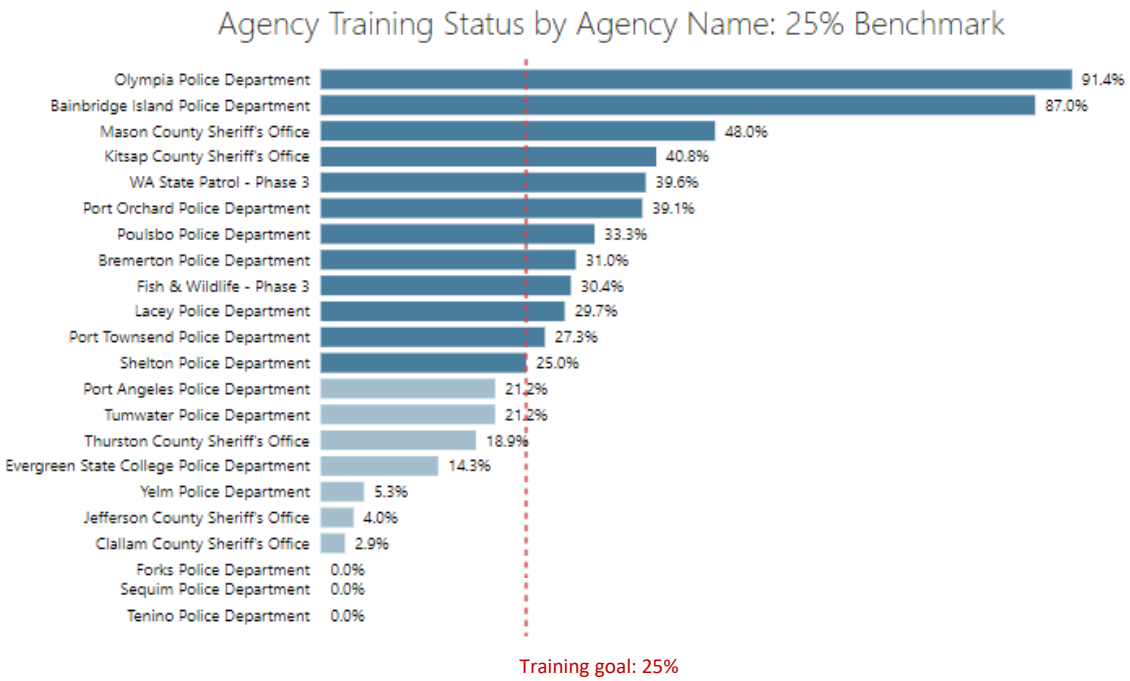
Note: The CIT program achieved 100 percent compliance in the Phase 2 region for the law enforcement training requirement in June 2023.

DATA SOURCE: Washington State Criminal Justice Training Commission.

Figure 3.

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

JUNE 30, 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

JUNE 30, 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	**1,761**	**740**	**42.0%**	**439**	**120**	**27.3%**	**360**	**105**	**29.2%**	**2,560**	**965**	**37.7%**
Fish & Wildlife - Phase 1							30	9	30.0%	**30**	**9**	**30.0%**
Pierce Region	730	166	22.7%	150	40	26.7%	105	31	29.5%	**985**	**237**	**24.1%**
Southwest Region	356	208	58.4%	54	14	25.9%	87	29	33.3%	**497**	**251**	**50.5%**
Spokane Region	566	343	60.6%	81	27	33.3%	138	36	26.1%	**785**	**406**	**51.7%**
WA State Patrol - Phase 1	109	23	21.1%	154	39	25.3%				**263**	**62**	**23.6%**
Phase 2	**2,761**	**1,370**	**49.6%**	**343**	**122**	**35.6%**	**118**	**65**	**55.1%**	**3,222**	**1,557**	**48.3%**
Fish & Wildlife - Phase 2							10	6	60.0%	**10**	**6**	**60.0%**
King Region	2,600	1,323	50.9%	343	122	35.6%	108	59	54.6%	**3,051**	**1,504**	**49.3%**
WA State Patrol - Phase 2	161	47	29.2%							**161**	**47**	**29.2%**
Phase 3	**254**	**102**	**40.2%**	**526**	**194**	**36.9%**	**97**	**15**	**15.5%**	**877**	**311**	**35.5%**
Fish & Wildlife - Phase 3				23	7	30.4%				**23**	**7**	**30.4%**
Salish Region	120	49	40.8%	196	56	28.6%	51	9	17.6%	**367**	**114**	**31.1%**
Thurston-Mason Region				307	131	42.7%	46	6	13.0%	**353**	**137**	**38.8%**
WA State Patrol - Phase 3	134	53	39.6%							**134**	**53**	**39.6%**
Total	**4,776**	**2,212**	**46.3%**	**1,308**	**436**	**33.3%**	**575**	**185**	**32.2%**	**6,659**	**2,833**	**42.5%**

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

JUNE 30, 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	**446**	**429**	**96.2%**				**76**	**51**	**67.1%**	**522**	**480**	**92.0%**
Pierce Region	238	232	97.5%				13	8	61.5%	**251**	**240**	**95.6%**
Southwest Region							23	12	52.2%	**23**	**12**	**52.2%**
Spokane Region	208	197	94.7%				40	31	77.5%	**248**	**228**	**91.9%**
Phase 2	**526**	**504**	**95.8%**				**48**	**44**	**91.7%**	**574**	**548**	**95.5%**
King Region	526	504	95.8%				48	44	91.7%	**574**	**548**	**95.5%**
Phase 3				**97**	**44**	**45.4%**	**49**	**1**	**2.0%**	**146**	**45**	**30.8%**
Salish Region				97	44	45.4%	31	1	3.2%	**128**	**45**	**35.2%**
Thurston-Mason Region							18	0	0.0%	**18**	**0**	**0.0%**
Total	**972**	**933**	**96.0%**	**97**	**44**	**45.4%**	**173**	**96**	**55.5%**	**1,242**	**1,073**	**86.4%**

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Table 3.

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

JUNE 30, 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	**247**	**247**	**100.0%**	**106**	**106**	**100.0%**	**120**	**111**	**92.5%**	**473**	**464**	**98.1%**
Spokane Region	101	101	100.0%	26	26	100.0%	58	50	86.2%	**185**	**177**	**95.7%**
Pierce Region	146	146	100.0%							**146**	**146**	**100.0%**
Southwest Region				57	57	100.0%	23	22	95.7%	**80**	**79**	**98.8%**
WA State Patrol - Phase 1				23	23	100.0%	39	39	100.0%	**62**	**62**	**100.0%**
Phase 2	**238**	**232**	**97.5%**	**133**	**119**	**89.5%**	**78**	**77**	**98.7%**	**449**	**428**	**95.3%**
King Region	238	232	97.5%	133	119	89.5%	59	58	98.3%	**430**	**409**	**95.1%**
WA State Patrol - Phase 2							19	19	100.0%	**19**	**19**	**100.0%**
Phase 3				**108**	**91**	**84.3%**	**58**	**31**	**53.4%**	**166**	**122**	**73.5%**
Salish Region				51	51	100.0%	27	16	59.3%	**78**	**67**	**85.9%**
Thurston-Mason Region				57	40	70.2%	17	3	17.6%	**74**	**43**	**58.1%**
WA State Patrol - Phase 3							14	12	85.7%	**14**	**12**	**85.7%**
Total	**485**	**479**	**98.8%**	**347**	**316**	**91.1%**	**256**	**219**	**85.5%**	**1,088**	**1,014**	**93.2%**

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.