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

Semi-Annual Report

September 30, 2020

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

ASO – administrative service organization

BHA – Behavioral Health Administration, part of DSHS

BHASO – Behavioral Health Administrative Service Organization

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

FDS – Forensic Data System

HARPS – Housing and Recovery through Peer Services

HCA – Health Care Authority

MCR – Mobile Crisis Response

OCRP – Outpatient Competency Restoration Program

OFMHS – Office of Forensic Mental Health Services (part of DSHS)

PATH – Projects for Assistance in Transition from Homelessness

RDA – Research and Data Analysis (part of DSHS)

RTF – Residential Treatment Facility

SAR – semi-annual report

SUD – substance use disorder

VTC – video conferencing technology

WASPC – Washington Association of Sheriffs and Police Chiefs

WSH – Western State Hospital

Preamble

Welcome to the September 2020 semi-annual report (SAR); these reports are published in March and September each year through the duration of implementation of the Trueblood contempt settlement agreement.

The report provides updates on each of the element areas and related programs being designed and implemented as part of the contempt settlement agreement. Many of the programs have been in pre-launch and service roll-out phases throughout spring and summer 2020.

Ultimately, a major focus of this report is to provide relevant programmatic data that demonstrates program use and outcomes where possible. For this second SAR, a growing number of elements contain programs with data available to view. Most of the elements have aggregate or program-level data to display a high-level picture of initial program engagement and indicate how future reports might appear. As with the launch of any major new program, it will take time to receive usable and reliable data for reporting. As programs' begin operations and mature, this report will expand over time to include more data and reporting elements. With few exceptions data is current through June 30, 2020. Exceptions are clearly noted.

Accordingly, the data templates shown will also be modified as programs develop. Data on program participation will typically be included in the SAR after programs have been operational for at least two calendar quarters.

Impacts of the COVID-19 Pandemic

In March 2020, the COVID-19 pandemic began impacting Trueblood implementation efforts. The state of Washington has experienced an ongoing state of emergency since mid-March, and this has affected aspects of operations and preparations for service enhancements. From supply procurement challenges, to ward construction being impacted, to competency evaluation interviews being delayed when there is no safe way to interview a defendant, rapid changes in the early spring and summer required significant adaptation, and additional changes could be required at any time in response to changing COVID-19 conditions. As permitted by evolving employee, client, and contractor safety considerations, the state is continuously undertaking efforts to minimize impacts to settlement activities, but impacts are ongoing and inevitable. Specific impacts, as well as the state's efforts to overcome those impacts, are discussed in more detail below.

Background

All criminal defendants have the 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, and if the court finds the evaluation shows the person is not competent, the court will order the defendant to receive mental health treatment to restore competency.

In April 2015, a federal court found that the Department of Social and Health Services (DSHS) was taking too long to provide these competency evaluation and restoration services.

As a result of this case, the state has been ordered to provide court-ordered in-jail competency evaluations within 14-days and inpatient competency evaluation and restoration services within 7-days of receipt of a court order. Trueblood applies to people 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 evaluations can be prevented if fewer people with mental illness enter the criminal court system and receive community-based treatment instead. People who get the treatment they need when they need it are more likely to avoid becoming involved with the criminal system. A major goal of many of the programs covered in this report include 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 December 11, 2018, the court approved the contempt 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 includes a plan for phasing in programs and services. In each phase, the state will focus its efforts within specifically identified geographic regions. The contempt settlement agreement includes three phases of two years each and can be expanded to include additional phases.

Phases run parallel to the Legislative biennia beginning with the 2019-2021 biennium.

- Phase 1: July 1, 2019 – June 30, 2021 Pierce County, Southwest, and Spokane regions
- Phase 2: July 1, 2021 – June 30, 2023 King County region
- Phase 3: July 1, 2023 – June 30, 2025 Region(s) to be determined

The goals envisioned as part of this contempt settlement agreement are beginning to take shape within the behavioral health transformation underway in the state of Washington. 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 a number of names and titles are referred to frequently. The definitions below provide common usage and understanding throughout the report.

Authority, the Authority, or HCA: Washington State Health Care Authority

Certified Peer Counselor (CPC): Is 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 the state exam. CPCs use their personal lived experience of recovery from behavioral health challenges to build rapport, promote recovery, empower, and inspire hope to the individuals they serve. CPCs who have lived experience with criminal court involvement are especially valuable to individuals who are served on Trueblood service teams.

CJTC or the Commission: Washington State Criminal Justice Training Commission

Crisis housing vouchers: Allows unhoused or unstably housed persons in behavioral health crisis to obtain short-term housing assistance for up to 14-days post discharge from crisis triage/stabilization facilities and who have criminal justice involvement or referred by law enforcement.

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

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

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

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

Forensic Data System or FDS: Beginning August 1, 2018, the data entry and reporting system of record for Office of Forensic Mental Health Services (OFMHS) and Trueblood related data.

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

Mobile Crisis Response: Enhancements to the current crisis delivery system ensure that services quickly intervene in behavioral health crisis situations to prevent arrests, and incarceration, and to quickly connect clients to needed treatment.

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

Residential Treatment Facilities or RTFs: (1) DSHS usage refers to an inpatient facility that treats forensic clients without indication of acute violent behavior to self or others, or otherwise complex treatment needs, which require a level of care provided in the state hospitals; and

(2) HCA usage refers to facilities that serve their communities by providing least restrictive alternatives to care for the purpose of diverting individuals from arrest, detention, and lengthy hospitalizations. Services within these facilities are short term and focus on stabilizing and returning the individual back to their community.

Evaluation and Monitoring Overview

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

Project Monitoring

The department will provide ongoing project monitoring analyses through monthly and quarterly reporting. Monthly monitoring reports will provide rapid-cycle information to assess progress in achieving required competency evaluation and restoration timeliness metrics, and slowing the rate of growth in competency evaluation referral volume. Most commonly, this information is available as part of the monthly reports to the court-appointed monitor and can be found on DSHS' Trueblood website[1]. Quarterly reporting on implementation elements (e.g., Forensic PATH and the Forensic Navigator Program) will provide timely information on client engagement in implementation programs. Monitoring measures to be tracked will include:

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

A Trueblood quarterly dashboard will be produced containing client enrollment and demographic characteristics (age, gender, race/ethnicity, and region) for the elements listed below. Data will come from a range of sources, and largely from tools or system adaptations still under development. Additional program measures may be added as feasible. HCA is working to identify and implement long-term data collection tools for programs, as well as strategies to optimize data quality, and efficient sharing, to support timely reporting. Programs designated for this quarterly dashboard include:

- FPATH (Forensic PATH)
- FHARPS (Forensic HARPS)
- Forensic Navigator Program
- OCRP
- Mobile Crisis Response

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

- Crisis housing vouchers.

Compliance with Crisis Intervention Training (CIT) targets will also be monitored through the quarterly dashboard. Preliminary examples of quarterly dashboards are displayed in the applicable implementation plan Element - Data sections of this report.

RDA is working with the various teams to establish a reliable and efficient data processing system for the Trueblood-related data. This requires significant work to determine how to receive and store data securely from various sources/providers, conduct initial error checks, follow-up quickly with individual providers on suspected errors, merge data into existing systems, create a central repository, establish consistent definitions and counting rules, perform reliable analyses, and generate accurate reports.

Data maturity — the point at which data are consistently entered and submitted — also takes time, particularly for new programs, most of which are using interim data collection methods until more efficient ones can be deployed. For these reasons, early program data will take a bit longer to curate. Once data collection and data processes are stabilized, the time from submission to Trueblood dashboard reporting will decrease, assuming that data providers submit required data in a timely manner.

All client-level data is aggregated to protect client confidentiality and suppression guidelines are being followed. Data tables included in this report reflect what was possible to produce from early data received by the report deadline. Draft tables reflect what is anticipated to be ready for the next report. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served increase.

Following a new program's implementation, program data will be reported by RDA through the Trueblood dashboard in the first quarter for which information is determined to be consistent and reliable for each program. RDA anticipates most program's data will be ready to report two quarters after program implementation. Prior to a program's program-level data release and dashboard development, circumstances occasionally exist where early higher-level program data can be released with proper precautions taken to ensure client confidentiality and compliance with appropriate state and federal statutes.

Longer-term Impact Analyses

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

- Use of mental health and substance use disorder treatment services

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

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

Timeline

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

1. Impacts on measures derived directly from FDS data (substantial compliance timeliness metrics, number of competency evaluation referrals, and number of competency restoration referrals) will be tested on a semi-annual basis beginning two quarters after the implementation of all major contempt settlement agreement components in July 2020. Initial tests of statistical significance of impacts in the first six months of full implementation are expected to be produced no earlier than the end of January 2021.

2. Impacts on behavioral health access and social outcome metrics will require significantly more time to measure. These measures are produced on a global scale for all Medicaid beneficiaries and require a 12-month measurement window, seven months of data maturity[2], one month of global measure production and testing, and one month for analysis of results for the Trueblood population. Analysis of first-year impacts (through the period ending June 30, 2021) on these measures will be available in March 2022.

3. Preliminary estimates of the impact of specific contempt settlement agreement components based on propensity-score matching methods will be available no earlier than March 2022. This assumes that the initial study populations will include persons entering services during the first six months of program operations, with a minimum six-month follow-up period, seven months for data maturity, and at least two months for data integration, analysis, and reporting.

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

Implementation Plan Elements

The sections that follow detail the 14 elements that serve as a services enhancement framework to implement Phases 1 and 2 of the Trueblood contempt settlement agreement.

Each element's report considers the following five items as they relate to the element specifically and to the Trueblood contempt settlement agreement and to the implementation plan more holistically: (1) background on each element's inclusion in Trueblood; (2) overview of current status and areas of positive impact within an element's programmatic area; (3) areas of concern; (4) recommendations to address concerns; and (5) data pertaining to the element. As previously described, data for new programs takes time to mature. Data tables included in this report reflect what was possible to produce from early data received by the report's deadline. Draft tables anticipate available data for the next report, which is due by March 31, 2021. Additional data (e.g., expanded racial and ethnicity categories, program services) will be provided over time as both data quality and the numbers served increase.

Competency Evaluation – Additional Evaluators

The contempt settlement agreement requires hiring 18 additional forensic evaluators over two years. While the primary purpose of the hiring is to achieve full compliance with the 14-day timelines, evaluators can also be assigned to address the need of completing non-Trueblood forensic assessments (such as civil petitions, Not Guilty by Reason of Insanity evaluations, out-of-custody competency evaluations, and diminished capacity assessments). This creates the capacity to meet the need of in-jail evaluations, while also creating workforce capacity that can respond to shifts in referrals, from an increase in one county to large increases in total referrals across the state.

Current Status and Areas of Positive Impact

From July 1, 2019 to June 30, 2020, OFMHS hired 13 evaluators meeting the contempt settlement agreement requirements for fiscal year 2020. In the current fiscal year, OFMHS has hired 10 more forensic evaluators with start dates ranging from July 1, 2020 to December 1, 2020. Five of these positions were elements of the settlement agreement while the additional five evaluators filled pre-existing vacancies. On-going recruitment is focused on filling the remaining three evaluator vacancies. The new hires have allowed OFMHS to complete jail-based competency evaluations within 14-days nearly 90 percent[3] of clients even though referrals have hit new record numbers in the last quarter of 2019. Furthermore, the new evaluators have allowed a record number of civil commitment petitions to be completed and an approximately 39 percent increase in forensic risk assessments (FRA) completed in 2020 on top of an approximately 50 percent increase in completed FRA's in 2019.

Areas of Concern

In Fiscal Year 2020, Washington state had its highest number of referrals for competency evaluations (4,710[4]) to date. This continued increase (3.4%) in referrals occurred even though 12 fine-funded contempt programs and three state-funded prosecutorial diversion programs were in full operation. Without these programs, demand for evaluations would have increased even more in the past and current fiscal year. Additionally, the arrival of COVID-19 in late winter, its initial effects on society at large by mid-to-late March, the state's ongoing pandemic response, and the resultant slowing of court procedures and reduced arrests that were implemented in response to the COVID-19 pandemic, all resulted in suppressed demand for competency services as well as an inability to safely conduct many in-person services for several months throughout spring 2020.

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[3] *Table 8. Class member status at WSH and ESH (totals) – Jail-based competency evaluations.* Aug.-Nov. 2019, Mature Data. In Cassie Cordell *Trueblood*, et al., v. Washington State Department of Social and Health Services, et al. Case No. C14-1178 MJP, Final Monthly Report to the Court Appointed Monitor. January 31, 2020, p. 15.

[4] Source: Aug. 2018 and forward: BHA Forensic Data System (FDS): Last updated Summer 2020.

Recommendations to Address Concerns

The department continues its efforts to resolve ongoing issues with defense attorney scheduling because that continues to be the primary reason for evaluations being completed after 14 days. Furthermore, the department has been working with various jails to establish a telehealth presence to complete evaluations remotely. Video conferencing technology (VTC) for competency evaluations is seeing more interest from jails and other entities seeking to continue evaluations while minimizing physical contact/proximity of clients and staff due to the COVID-19 pandemic.

OFMHS has reached out to 20 jails on the west side of the state and 16 jails on the east side to expand the use of telehealth beyond the original pilot sites (Snohomish, Island, Grays Harbor, and Yakima counties). The west side jails include city and county jails in Skagit, Issaquah, King (King County Correctional Facility [KCCF] in Seattle, Maleng Regional Justice Center [MRJC] serving south King County in Kent, and South Correctional Entity [SCORE] in Des Moines), Klickitat, Skamania, Kitsap, Kent, Pierce, Thurston, Mason, Lewis, Aberdeen, Whatcom, Clallam, Pacific, and Clark. The ability to conduct evaluations remotely using VTC has now been established at SCORE, Kent jail, Thurston County, Klickitat County, and the Issaquah and Aberdeen jails.

The jails on the east side include county jails in: Spokane, Stevens, Ferry, Okanogan, Pend Oreille, Chelan, Kittitas, Grant, Benton, Douglas, Walla Walla, Franklin, Adams, Whitman, Lincoln, and the Airway Heights Correctional Center. The ability to conduct evaluations remotely has been established in the Ferry, Benton, Franklin, Grant, Okanogan, Whitman, and Stevens county jails.

OFMHS continues to work with and educate jails, VTC users, and IT staff to address issues and provide ongoing support for video evaluations. Additionally, support is being provided for video evaluations conducted at Western State Hospital, and all evaluations at RTFs (Maple Lane, Fort Steilacoom Competency Restoration Program and Yakima). OFMHS has also added the capability to use Zoom for Healthcare in addition to the DSHS VTC Cisco application, to provide an alternative application to enable expanded use.

A VTC/telehealth workgroup has been established with representation from evaluators, evaluator supervisors, and OFMHS staff regarding the technology side of implementation. This workgroup acts as a discussion forum to present ideas and issues pertaining to VTC, tracks progress with jail implementation, and is working to develop work instructions for evaluators. A shared mailbox has also been established to more expediently route issues to staff working on VTC issues.

Establishing this technology in multiple locations around the state (especially in rural areas) allows OFMHS to conduct more evaluations, thereby helping to meet Court-ordered

requirements, makes it easier for attorneys to be present for their clients' interviews, and minimizes risks for all those involved during this pandemic.

A multi-partner meeting with King County to address scheduling of evaluations occurred in May and a smaller workgroup was formed including membership from defense, prosecution, OFMHS, Disability Rights Washington, the jail, the Attorney General's Office, and the King County Superior court. The Honorable Patrick Oishi serves as the moderator for the group. This group is focused on how to best use technology to complete evaluations and the most recent meeting occurred on September 14, 2020. In some counties, evaluator supervisors have been able to cultivate relationships with defense counsel leadership to elevate individual scheduling issues. Evaluator supervisors will continue to develop these relationships as a means to encourage timely scheduling.

Data – Competency Evaluation – Additional Evaluators

DSHS continues to utilize data from the Forensic Data System (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 1.

The department examined the number of orders filed by the courts between January 2017 and December 2019, and projected the number of evaluation orders through June 2023 using an exponential smoothing forecast model[5]. Based on recent trends, statistical modeling projects that the number of orders will continue to grow, although the Trueblood settlement and Engrossed Substitute Senate Bill (ESSB) 5444 direct multiple policy changes that may impact future demand for competency evaluation services.

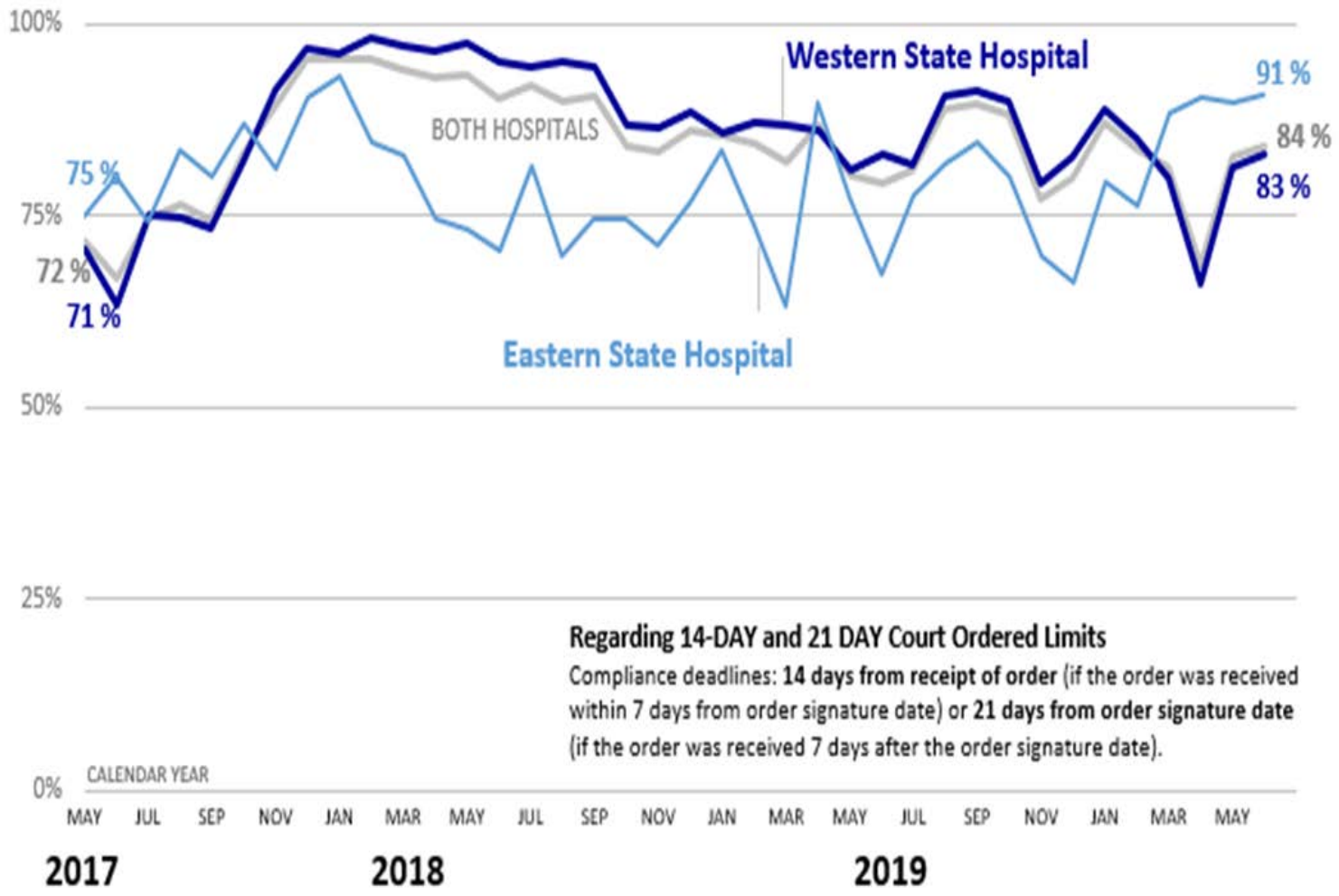
Projections indicate that the number of evaluation orders will not exceed evaluator capacity, if all funded positions are filled (including all 74 full time equivalent in the FY2021 budget), and all evaluators work at the expected rate of productivity. Note that the number of orders per month shows seasonal 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.

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

FIGURE 1.

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

Percent complete or closed within court ordered limits



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

NOTE: Refer to page 15 and footnote 2 for additional details on jail-based competency evaluation completion rates.

Competency Restoration – Legislative Changes

As part of the contempt 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 supported legislation towards this goal. One eventual bill came to be known as ESSB 5444, and included changes to RCW 10.31.110, RCW 10.77.086, and RCW 10.77.088. ESSB 5444 passed unanimously in both the House and Senate, and was signed into law by the governor on May 9, 2019.

Current Status and Areas of Positive Impact

ESSB 5444 went into effect on July 28, 2019. At a high level, this bill changed the standard under which non-felony restoration may be ordered and made a number of other changes necessary to support new programs, like outpatient competency restoration. RCW 10.77.088(1)(a)-(b) (including changes made by ESSB 5444).

ESSB 5444 also modified the length of time that a defendant charged with a non-felony can be ordered for restoration. Since the change in the law went into effect, there has been a decrease in orders for misdemeanor competency restoration, although it is too early to derive any clear trend.

Areas of Concern

The courts continue to issue a small number of misdemeanor restoration orders, signaling the potential need for continued outreach to the judicial community. The codification of the changes to RCW 10.77.088 was confusing because of multiple changes made to that statutory section during the 2019 legislative session. There was concern that confusion was leading to potential misapplication of the new standards.

Recommendations to Address Concerns

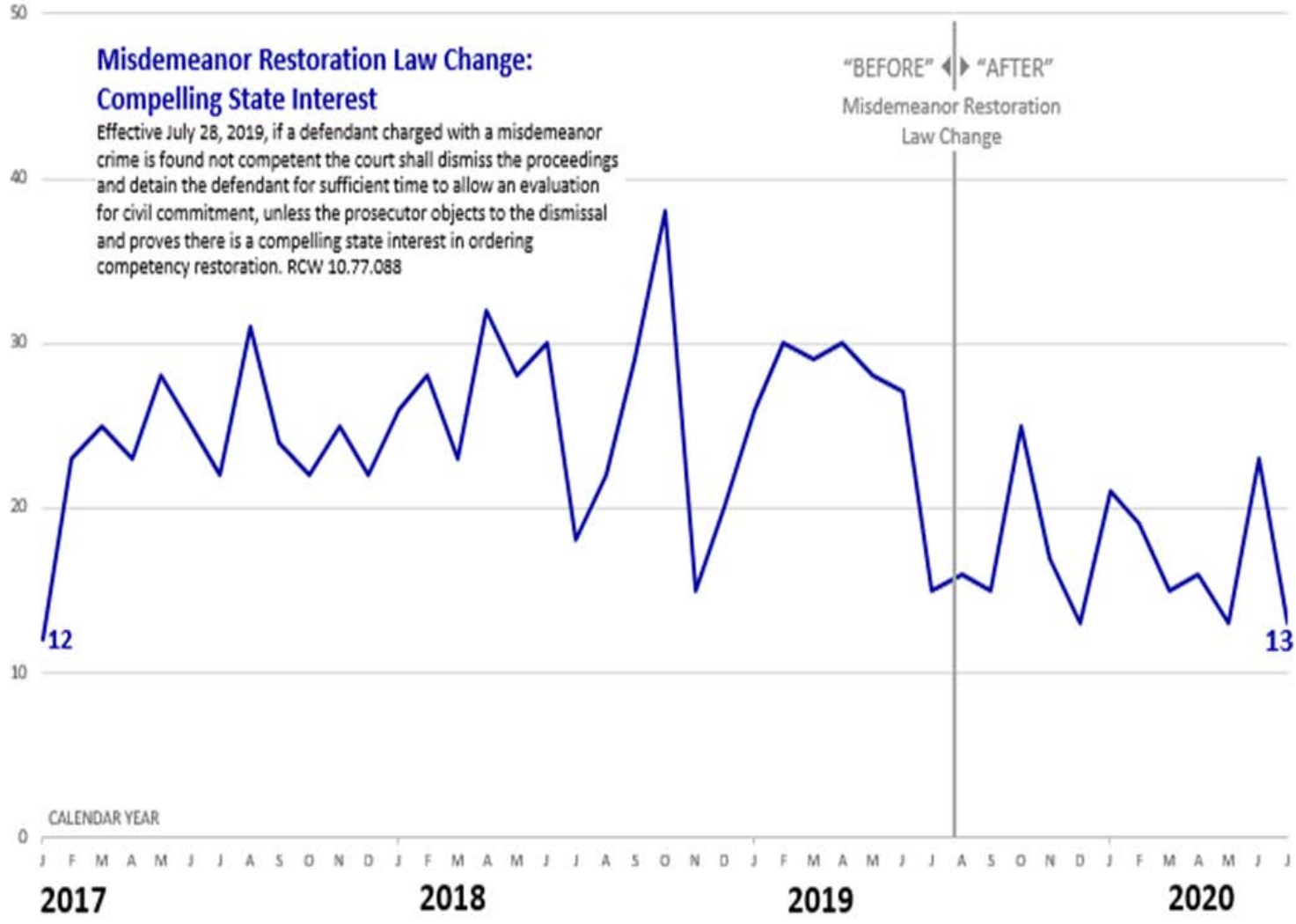
Additional communications and trainings about these changes will continue to enhance awareness, understanding, and application of the statutory changes. A technical correction bill was pursued during the 2020 legislative session to clarify the changes made to RCW 10.77.088 in 2019. The governor signed the bill, and the corrections went into effect on June 11, 2020. This will hopefully address any remaining confusion regarding the statute. The website that hosts the official code reviser's version of statutes was slow to be updated with these changes, but as of the publication of this report, the clarified version of RCW 10.77.088 now appears on that website. Because this is one of the primary resources used by courts and attorneys, the state is hopeful this change will help to resolve any persisting confusion. Additionally, ongoing data analysis will allow targeted outreach to any jurisdictions that show temporary or ongoing data patterns that are higher than expected under RCW 10.77.088.

Data – Competency Restoration – Legislative Changes

DSHS is monitoring the number of misdemeanor restoration orders before and after the 2019 law change that required "compelling state interest" (RCW 10.77.088). In July 2020, there were 13 misdemeanor restoration orders issued statewide, down slightly from 15 in July of the year prior (Figure 2).

FIGURE 2.

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



DATA SOURCE: Forensic Data System (FDS).

Competency Restoration – Community Outpatient Services

The Outpatient Competency Restoration Program (OCRP) element of the Trueblood settlement is managed by the Health Care Authority (HCA) in collaboration with the department. DSHS will continue providing court-ordered inpatient competency restoration services; however, OCRP will provide an additional option for courts to order community-based restoration services in a less restrictive environment for defendants with appropriate acuity levels. The intent of OCRP is to provide the most appropriate level of care to the individual, ideally closer to their home community. Providing restoration services in a safe and cost-effective environment, while utilizing the newly available community treatment program, should hopefully reduce the number of people wait-listed to receive competency restoration in an inpatient setting.

Current Status and Areas of Positive Impact

In consultation with key partners and stakeholders, a program model has been developed. A consulting firm, Groundswell Services, Inc., also conducted a review, which assisted in this model's development by providing evidence-based critique and analysis of other states' OCRP models.

As of April 2020, OCRP contractors were identified and contracted to provide this new service in each of the three Phase 1 regions, with contractors in the Pierce and Spokane regions actively providing services since July 1, 2020. Due to impacts from COVID-19 and workforce hiring challenges, the contractor in the Southwest region has been delayed in their ability to accept clients into the program. The program began operations on September 1, 2020.

During the start-up time between contracting and July 1, 2020, all contractors were trained in how to utilize and administer the Breaking Barriers Competency Restoration Program structure, and have received specialized training on working with individuals living with intellectual and developmental disabilities.

Areas of Concern

A single provider has been identified in each implementation region. This could be problematic for the more rural regions, although the provider contracts require services to be available to the entire region. If problems arise with the contractor, a new procurement would be required. Individuals within multiple county regions may find transportation to the OCRP services challenging. Providers are aware of this challenge and are working to identify strategies to resolve it.

Another continued concern is consistent support for this program by system partners. DSHS and HCA have partnered to meet directly with all municipal, district and superior courts in the implementation regions during the first quarter of 2020 to engage court staff in process collaboration, and to generate support for utilization of this program for qualified individuals.

These system partners will control the flow of patients into the outpatient programs, and their reluctance could frustrate the success of the programs.

Workforce hiring challenges and COVID-19 continue to be an area for concern, especially in the Southwest region; however, HCA is working closely with the providers in the regions to address these challenges.

Recommendations to Address Concerns

DSHS and HCA will continue to engage court partners in discussions of this new program. Currently, contractor agencies are included in collaboration and engagement activities in all of the Phase 1 regions and relationships are being developed among the programs. Additionally, continuity of care plan development is an important contingency to address the potentiality that a region's contracted provider could discontinue services or be terminated.

Data – Competency Restoration – Community Outpatient Services

OCRP services began on July 1, 2020, and one client was enrolled in the month of July. Phase 1 region OCRP referrals, enrollment, and participant characteristics will be included in future reports as data become available (Table 2). As of August, there is one individual being served in each of these regions. Navigators continue to work with criminal courts to facilitate referrals to outpatient restoration, and participation in the program is expected to increase in the months ahead. Program data is from pilot Microsoft Excel data trackers. Additional data will be provided from the FDS and the Navigator Case Management System (NCM).

TABLE 1. **PRELIMINARY EXAMPLE**

Outpatient Competency Restoration Program Enrollment and Participant Characteristics

QUARTER III 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION	888	88percent	888	88percent	888	88percent	888	88percent
Referrals	888	88percent	888	88percent	888	88percent	888	88percent
Clients Referred (unduplicated)	888	88percent	888	88percent	888	88percent	888	88percent
Clients Enrolled (unduplicated)	888	88percent	888	88percent	888	88percent	888	88percent
Among Enrolled Clients…								
GENDER								
Female	888	88percent	888	88percent	888	88percent	888	88percent
Male	888	88percent	888	88percent	888	88percent	888	88percent
AGE GROUP								
18-29	888	88percent	888	88percent	888	88percent	888	88percent
30-49	888	88percent	888	88percent	888	88percent	888	88percent
50+	888	88percent	888	88percent	888	88percent	888	88percent
RACE/ETHNICITY								
Non-Hispanic White	888	88percent	888	88percent	888	88percent	888	88percent
Minority	888	88percent	888	88percent	888	88percent	888	88percent

DATA SOURCE: Forensic Data System, Navigator Case Management System, and interim OCRP Microsoft Excel trackers submitted by providers to the Washington Health Care Authority (HCA).

Forensic Navigators

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

Navigators work closely with the courts and the jails in the pre-hearing phase, meeting with, interviewing, and observing program participants, and assessing their willingness to participate in outpatient restoration services, if found not competent to stand trial. Navigators utilize client-reported information and gather records from OFMHS, jails, behavioral health agencies, and other agencies, as well as from registries and databases in order to assist in fully informing the court in its determination of clinical appropriateness for outpatient restoration.

If a client is determined clinically appropriate for outpatient restoration and the court agrees to order the client to outpatient restoration, forensic navigators continue to work with these participants, to assist those participants in maintaining compliance with any conditions of release, assisting clients to attend their outpatient competency restoration classes, and encouraging their adherence to prescribed medications. If the client is not ordered into outpatient restoration, navigators complete warm hand-offs to inpatient facilities, jail mental health professionals, designated crisis responders, and other forensic services in order to retain for their clients as many services as possible.

Current Status and Areas of Positive Impact

As of August 20, 2020, the Forensic Navigator program has served a total of 157 clients, averaging about 20 new cases per week. Forensic navigators have made contact with the family members of Trueblood class members in all three Phase 1 regions. Forensic navigators have also been in close contact with attorneys, outpatient competency restoration programs, and have referred program participants to outpatient forensic service providers in the three Phase 1 regions. Filling a wide array of gaps in services that existed prior to July 1, 2020, forensic navigators have continued to facilitate connections for eligible clients to housing and recovery programs as well as to forensic peer services and case management supports, even when class members are not ordered into outpatient restoration, and even when the forensic navigator has been discharged and is no longer actively assigned to the client.

Areas of Concern

While some jurisdictions have accepted the role of the navigator as one which primarily serves Trueblood class members, others have expressed dissatisfaction that the navigator role does not

extend to a larger group of individuals for whom competency to stand trial has been raised, particularly those individuals for whom a competency evaluation is ordered at or after their release from jail.

Outreach and education that occurred prior to go-live does not seem to have resulted in the desired level of understanding of the program by court partners. Program staff continue to engage and inform prosecution, defense and bench to develop a shared understanding of this new program.

As with any new program, there have been lessons learned in what works for these programs to interface smoothly. DSHS and its service partners are working well together in order to iron out these programmatic alignments.

Recommendations to Address Concerns

Continue to focus forensic navigator time and resources primarily on Trueblood class members who are awaiting forensic evaluation or restoration services in jail, while simultaneously messaging to the courts in each region the willingness of the program to continue to provide warm hand-offs to applicable agencies and entities, in any circumstance even when the forensic navigator is discharged and no longer actively assigned to the client.

Data – Forensic Navigators

The Forensic Navigator program began July 1, 2020. Preliminary data from the new Navigator Case Management System (NCM) for July 1 to July 31, 2020 are included in Table 2. There were 99 individuals referred to the program in the first month of operation; about half (50) were in the Pierce region. Across Phase 1 regions, over two-thirds (68%) of individuals enrolled were active on July 31 and were in the pre-competency hearing stage. Additional information will become available as data matures.

TABLE 2.

Forensic Navigator Enrollment and Participant Characteristics

JULY 1 – 31, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Individuals Referred (unduplicated)	99	100%	50	100%	15	100%	34	100%
Individuals Assigned a Navigator (unduplicated)	87	88%	42	84%	11	73%	34	100%
Among Enrolled Individuals…								
CLIENT STATUS								
Active (on last day of reporting period)	59	68%	29	69%	--	--	22	65%
Pre-Competency Hearing	58	67%	28	67%	--	--	22	65%
Enrolled in OCRP	1	1%	--	--	--	--	--	--
Coordinated Transition	0	0%	0	0%	0	0%	0	0%
Discharged	28	32%	13	31%	--	--	12	35%

DATA SOURCE: Navigator Case Management System (NCM)

Note: Twelve individuals referred to the Forensic Navigator Program were not assigned a navigator because they had outpatient evaluation orders that were converted to inpatient evaluations.

-- Cells suppressed due to small n's.

Competency Restoration – Additional Forensic Beds

The vision of the parties in creating the contempt settlement agreement was to both reduce the number of people who become or remain class members and to more timely serve those who become class members.

The addition of beds at Eastern and Western State Hospitals is intended to provide timelier competency evaluation and restoration services to class members.

The contempt settlement agreement requires that Eastern State Hospital (ESH) convert two previously administrative staff floors into forensic wards. These wards are 1North 3 (1N3) and 3North 3 (3N3). This project requires not just construction but also staffing increases and adjustments to the ESH admissions process and will result in 50 additional beds.

The contempt settlement agreement requires that Western State Hospital (WSH) convert two civil wards into forensic wards. These wards are E3 and E4. This project also requires construction and some staffing work to convert civil staffing models to the forensic model. This will result in the addition of 40 forensic beds.

In the 2019-2021 biennium, funding was allocated for additional forensic bed capacity. Over $27 million was allocated to the department for the addition of forensic bed capacity across the state. This includes two new competency restoration units at ESH. In the 2017-19 budget, the Legislature allotted funding for the conversion of two civil wards to forensic wards at WSH.

Both Eastern and Western State Hospitals experienced construction delays and supply chain impacts as a result of the COVID-19 pandemic. Because of the ever-evolving impacts and necessary staffing adjustments on site to preserve health and safety, the department was unable to determine the exact time delay expected. As a result, the department was granted additional time to complete the construction from the Court with the understanding that the department will provide updates on the status of both projects to the Court two times per month until they are completed.

Current Status and Areas of Positive Impact – ESH

As of the date of this report, Eastern State Hospital has completed construction of the two new wards which includes 50 beds plus four total seclusion rooms and two total quiet rooms. 1N3 began accepting patients June 1st and 3N3 began accepting patients August 3.

Current Status and Areas of Positive Impact – WSH

The state requires additional time to complete the renovations of E3 and E4 at WSH. When completed, these wards will contain 40 beds plus two full seclusion rooms. Despite the impacts

of COVID-19, the contractor and the state have been able to work together to overcome the many unexpected construction challenges.

- The contractor conducts daily screenings of all onsite personnel for COVID-19 and personal protective equipment is required on site.
- Construction work is proceeding with social distancing requirements in place to ensure the health and safety of workers.
- DSHS staff presence is limited to only those coordinating with the contractor and sub-contractor to ensure social distancing guidelines.
- Major furniture, fixtures, and equipment are on site and ready for installation when construction is complete.

Areas of Concern

Construction delays and supply chain impacts continue. These impacts are universal in the construction world, which means that alternatives previously employed pre-COVID-19 such as seeking out new suppliers or sub-contractors are not viable. When WSH staff and patients test positive for COVID-19, some high-risk workers have been reluctant to work on site even with precautions in place. Practices meant to stop, slow or minimize the spread of the virus are essential but time consuming.

Even with the addition of 50 forensic beds at ESH, the increased bed capacity may not be enough to handle the increased volume of patients. Completion of the new additional wards at WSH is important to creating sufficient capacity for class members.

Recommendations to Address Concerns

The state has and will continue to implement strategies to minimize delays created by the COVID-19 pandemic and continues to explore other efficiencies that might help. The state has built a strong partnership and communication with the contractor so that any new impacts are quickly known and the parties can strategize on how to overcome them. The Court continues to receive detailed status reports from the state two times per month and this will continue until the new WSH wards are able to accept patients.

Data – Competency Restoration – Additional Forensic Beds

DSHS will continue to monitor average wait times for admission to inpatient evaluation and restoration as additional inpatient forensic beds become available (see Figure 3, page 31 – Closure of Maple Lane and Yakima Residential Treatment Facilities).

Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

DSHS opened two competency Residential Treatment Facilities (RTF) to provide additional in-patient competency restoration services in 2016. The goal of the increased beds was to decrease the waitlist and have class members admitted within seven days of a court order. Maple Lane Competency Restoration Program is staffed with a combination of state and contract employees. Yakima Competency Restoration Program is staffed by contract employees.

Both of these facilities will close as part of the overall integrated system changes contemplated in the Trueblood contempt settlement agreement. Both facilities have planned, hard closure dates – Yakima on December 31, 2021, and Maple Lane on July 1, 2024. As part of the contempt settlement agreement, low median wait times for inpatient competency services can trigger an earlier closure. For Yakima, that level is four consecutive months of a median of 13-days or fewer wait time for admission, and for Maple Lane, it is four consecutive months of a median wait time for admission of nine days or fewer.

The waitlist median times may be impacted by several projects associated with the contempt settlement agreement. This includes statutory changes for misdemeanor restoration effective July 28, 2019; the net addition of four total forensic wards coming online at Eastern and Western state hospitals during summer and fall 2020 (adding 90 beds); and new outpatient competency restoration programs coming online as part of the agreed on new services stemming from the contempt settlement agreement's Phase 1 regions: Pierce and Spokane began OCRP on July 1, 2020 and in the Southwest region on September 1, 2020.

Current Status and Areas of Positive Impact

Because ramp down dates are potentially variable, the ramp down workgroup is developing full closure plans that can be initiated at the appropriate time for either a hard or triggered closure date for each facility. Plans are similar for both Yakima and Maple Lane but have different components because of the staffing differences at the two facilities. As news of the eventual closure of these facilities reached residents, families, and communities, many shared their positive experiences at these two facilities. This strong community commitment has helped build stronger communication and partnership bridges between OFMHS and those impacted, which has improved planning for the eventual closure.

Areas of Concern

The biggest concern is being able to retain staff for continued operations during ramp down after the official closure notification is given. At this time, staffing remains at stable levels and within typical turnover margins.

Recommendations to Address Concerns

DSHS is continuously monitoring turnover, morale, and other factors, and actively taking steps to neutralize their effects as the hard closure dates, especially for Yakima, draw closer. Given the potential variability in closure dates due to contempt settlement agreement triggering events, DSHS is mindful to maintain staffing levels for appropriate care and treatment until the last patient is discharged. Additionally, our contract oversight between the two main contractors will focus on the contract requirements to ensure sufficient staffing.

Data – Competency Restoration – Ramp Down of Maple Lane and Yakima RTFs

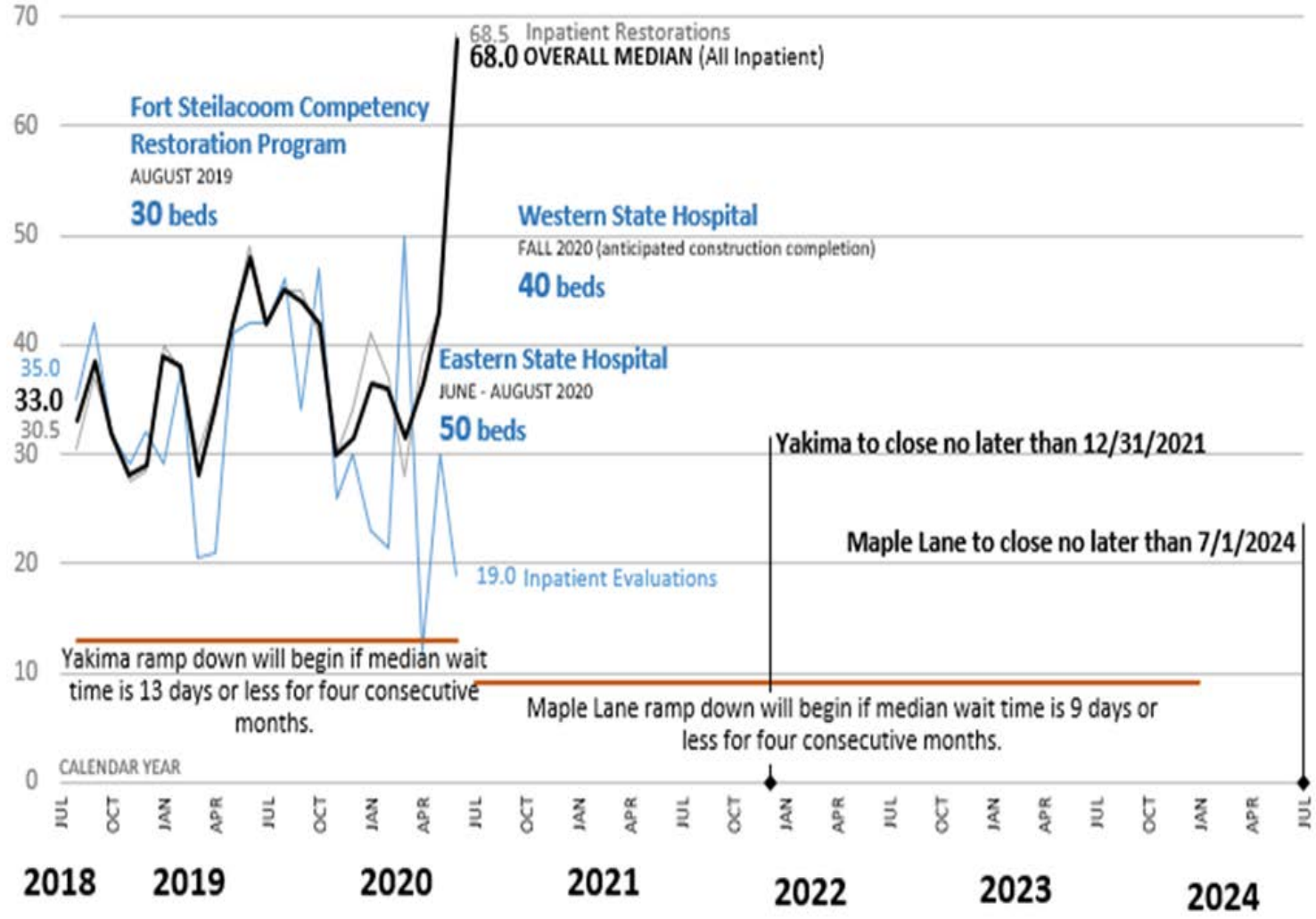
The RTF ramp down workgroup monitors average wait times for inpatient admission for competency services on a monthly basis (Figure 3). Wait times have not yet decreased to a level that would trigger early ramp down of the Maple Lane or Yakima facilities. In June 2020, the median wait time for inpatient competency services was 68 days. The Yakima ramp down will begin if median wait times reach 13 days or fewer for four consecutive months, with a hard closure date of December 31, 2021 regardless of wait times. The ramp down of Maple Lane will begin if median wait times reach nine days or fewer for four consecutive months. Per the contempt settlement agreement, the facility will close by July 1, 2024 regardless of wait times.

FIGURE 3.

Closure of Maple Lane and Yakima Residential Treatment Facilities

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

SEPTEMBER 3, 2020



DATA SOURCE: BHA Forensic Data System.

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

Crisis Triage and Diversion – Additional Beds, Enhancements, and Gap Recommendations

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

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

Current Status and Areas of Positive Impact

HCA supported the Department of Commerce in issuing a request for proposals for the expansion of 16 new beds for crisis stabilization in the Spokane region. The closing date for this RFP was December 31, 2019 with the successful bidder identified as a joint partnership from the Spokane County and the City of Spokane. After their own thorough and competitive bidding process for a social service provider, this joint partnership selected Pioneer Human Services to be the operational agency for the Mental Health Crisis Stabilization Facility (MHCSF). This site continues to be on schedule for becoming operational on or before the July 1, 2021 go live date pending no construction delays.

HCA successfully negotiated with four CS/CT facilities to provide residential crisis services in each of the three regions for enhancing their ability to provide crisis stabilization services and to accept police drop-offs and referrals and holds. Examples of facility-identified enhancements include:

- Addition of peer bridger services in CS/CT or other RTFs to provide support for potential class members and class members by working with an individual with lived experience for behavioral health needs and/or the criminal court system.

- One-time purchases of equipment and facility upgrades that will increase the acuity level a facility can accommodate.

- Additional staffing that will increase the acuity level a facility can accommodate.

- Training and technical assistance to support facilities in adapting practices to enable successful service for individuals referred via contact with law enforcement.

Another significant accomplishment for the CS/CT element includes the development and presentation of the CS/CT gap analysis along with recommendations for the three Phase 1 regions. This report was presented to the General Advisory Council and was completed by the March 30, 2020, deadline. The analysis utilized the Public Consulting Group report, the House Bill 1109 Legislative Report on Crisis Stabilization and Crisis Triage Services, and information gleaned from the implementation process for project elements. In response to a request for additional information, an addendum was added to the report with specific information received from each of the regions.

Areas of Concern

With the exception of the Pierce region, HCA found hesitancy on the part of CS/CT providers in accepting police referrals, drop-offs, and holds. Most providers did not design their facilities or staffing patterns with this referral source in mind. Without intentional planning for this need, staffing may be insufficient to meet the needs of this population and law enforcement personnel are unlikely to utilize this option if referrals are infrequently accepted.

In the operation of a CS/CT facility designated to provide services 24/7/365, which has the purpose of providing assessments, evaluating, and stabilizing rapidly, it is important that facility standards be reevaluated and redesigned to provide services as a crisis drop-off facility supported with recliners for individuals requiring only a short-term stay rather than standard beds. The CS/CT facility can then utilize the beds for individuals requiring longer respite and stabilization.

Similarly, another concern revolves around the ability to break individual cycles of perpetual crisis by introducing immediate housing and follow-up supports. An aspect of these supports includes funding emergency hotel/motel vouchers that were designed to aid in supporting individuals who would have historically recycled through the crisis system.

It is noteworthy that the current crisis service delivery landscape in Washington state is very dynamic. In the past year, some providers have closed facilities, an example of which is Telecare, which closed its evaluation and treatment facility in Vancouver in August 2019. However, other facilities are being developed and plan to come online in the coming year. This presents a challenge in planning as new construction often comes with delays.

Recommendations to Address Concerns

HCA will continue to work with CS/CT providers to enhance their ability to serve individuals with mental illness being diverted from arrest and jail. The planned enhancements are intended to increase the expertise and infrastructure to support this population and improve coordination with law enforcement. Despite the reluctance initially expressed by providers, they have been open to learning more about how to serve this population and are accepting of the enhancement opportunity offered through the Trueblood implementation plan.

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

Emergency hotel/motel vouchers provide an important opportunity to decrease a client's contact with law enforcement and to lessen their likelihood of either being arrested or hospitalized. Voucher use, along with the opportunity to partner with the Forensic HARPS teams, has allowed for a warm handoff while providing needed support and housing. Funding for this service may require adjustment to address a larger geographic population and to ensure adequate ability to serve clients.

Data – Crisis Triage and Diversion – Additional Beds and Enhancements

Additional crisis triage and stabilization beds and enhancement to services (e.g., accepting police drop-offs to serve persons in mental health crisis) may divert some individuals from arrest and incarceration. HCA will provide information on the date, location, and number of beds added. The department will assess the feasibility of detecting the impact of additional beds and services from other Trueblood efforts. Refer to Table 3, in the following section on Crisis Triage and Diversion – Residential Supports, for data on crisis housing vouchers distributed by crisis triage and stabilization facilities.

Crisis Triage and Diversion – Residential Supports

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

Current Status and Areas of Positive Impact

HCA has issued contracts to four Forensic HARPS teams — one in Spokane, one in Southwest Washington and two in Pierce County. The teams have been staffed and accepting referrals since services began in early March. All four teams have been successful in housing eligible individuals.

Several strategies have been used to assist those enrolled into temporary, transitional and permanent housing options including motel/hotels, shared living, their own apartment or even purchasing a reasonably priced RV within a mobile home park. Some of the living options have structured support and some do not.

All four teams were trained in the philosophies of Permanent Supportive Housing, Housing First, and Harm Reduction. Trainings were provided virtually by Advocates for Human Potential, a national technical assistance organization well versed in the PSH model over the course of three months.

Beginning July 1, Forensic HARPS teams began receiving referrals from the forensic navigators and OCRP teams. The Forensic HARPS teams have received direction and training on how to prioritize these referrals. Forensic HARPS teams continue to receive referrals from Forensic PATH, crisis stabilization facilities and other community partners.

Areas of Concern

Long-term permanent housing vouchers are needed to achieve permanent supportive housing for people at risk of homelessness and who have touched the legal system. The participants served by the Forensic HARPS teams will only have short-term housing subsidies. Ongoing supportive services can and should be provided by the Foundational Community Supports (FCS) programs in each region, but the concern is how these individuals will financially sustain their housing due to the extremely limited number of permanent supportive housing vouchers/subsidies across our state. Another concern is the fact that individuals eligible and enrolled in Forensic HARPS may not meet the U.S. Department of Housing and Urban Development (HUD) eligibility guidelines for housing opportunities available through the local continuum of care projects.

Some individuals choose not to pursue more permanent housing options. In some instances these participants have opted to stay in motels, even when their behaviors do not align with motel policies resulting in regular requests to leave. Those individuals continue to receive support in order to be placed in different motels while the behaviors are addressed. In a testament of the ongoing support that the FHARPS team provides, one individual has been placed in seven different motels, and the team continues to support this person. The team observes that the biggest challenge is overcoming the barrier of co-occurring disorders and active substance usage. There are a few individuals who have been re-incarcerated or detained to involuntary treatment. On release from jail or hospitalization, Forensic HARPS teams have continued to support those individuals.

Another challenge vocalized by the FHARPS teams are landlords who appear reluctant to fill their vacancies due to the statewide eviction moratorium related to COVID-19. The landlords state they would rather leave their units empty than "risk" occupying them and having difficulty with the tenant.

Substance use appears to be the overarching barrier for many individuals who are not doing well in the program. The teams have been encouraged to use their motivational interviewing skills to work with those individuals in hopes that they will want to access treatment. The teams all know that if someone goes into a treatment setting, they will have the support and financial resources offered by the Forensic HARPS team after graduation.

Recommendations to Address Concerns

The Forensic HARPS program administrator has and will continue to provide ongoing technical assistance. The teams have been encouraged to use motivational interviewing and other evidenced-based techniques to help participants overcome their barriers to successful placements in housing. HCA has worked with teams on developing a robust housing portfolio for the individuals served. Forensic HARPS teams will be strongly encouraged to refer individuals to community resources for supported employment. HCA believes that everyone can work with the appropriate supports.

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 Forensic HARPS program. A data tracker was created for each program as an interim data collection tool until a long-term solution is identified and implemented by HCA. Facilities and FHARPS providers submit the data as required by their HCA provider contracts. Tables 3 and 4 below represent the first data available for both program types.

A total of 51 vouchers were distributed to 37 individuals from December 1, 2019 to June 30, 2020 (Table 3). The average amount per recipient across regions was $1,213. Spokane disbursed

about three-quarters of the vouchers (75%) and accounted for nearly two-thirds of recipients (65%). Overall, most recipients were male (76%), between 30 and 39 years old (51%), and non-Hispanic White (59%). Voucher recipients are referred to the FHARPS program, where they may be eligible for additional housing support. . This referral to FHARPS will create an additional data reporting opportunity to provide additional detail about persons who receive these vouchers, and what happens once the FHARPS referral is made. Additional information, such as expanded racial and ethnicity categories and counts by region will become available as data mature.

TABLE 3.

Crisis Triage and Stabilization Facility Housing Voucher Disbursals

DECEMBER 1, 2019 to JUNE 30, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
VOUCHER SUMMARY								
Total Vouchers Disbursed	51	100%	--	--	--	--	38	75%
Recipients (unduplicated)	37	100%	--	--	--	--	24	65%
Total Amount Disbursed	$44,903	100%	$11,445	25%	$2,994	7%	$30,465	68%
Average Amount Per Recipient…	$1,214	N/A	$1,040	N/A	$1,497	N/A	$1,269	N/A
GENDER								
Female	8	22%						
Male	28	76%						
AGE GROUP								
18-29	8	22%						
30-49	19	51%						
50+	10	27%						
RACE/ETHNICITY								
Non-Hispanic White	22	59%						
Minority	15	41%						

DATA SOURCE: Crisis housing excel trackers submitted by each provider to the Washington Health Care Authority (HCA).
-- Cells suppressed due to small n's (includes greyed out cells).
N/A: Not applicable.
Gender does not total to 100 percent because Gender X and unknown are not shown.
* Contractors reconcile payments with motels upon participant check-out. The voucher amounts will vary based on contractual relationships with motels and unforeseen incidentals that may be owed to the motel. This data may change in future reports based on this reconciliation process.

A total of 349 individuals were referred for FHARPS services from March 1 to June 30 (Table 4). Of these referrals, 225 (nearly 65%) were contacted and 193 (55%) were enrolled. Spokane received the largest number of referrals, of which many were ineligible. These are expected to decline as the community partners learn more about eligibility criteria. The Pierce region accounted for over half of the individuals enrolled in FHARPS across Phase 1 regions.

About six in 10 people enrolled in FHARPS were male, 55 percent were between 30 and 49 years old, and 55 percent were non-Hispanic White. FHARPS and RDA are working with providers to

ensure accurate data entry on a number of data elements. Future reports should have lower rates of unknown race/ethnicity as well as additional information, such as expanded racial and ethnicity categories and referral source.

TABLE 4.

Forensic HARPS Enrollment and Participant Characteristics

MARCH 1 to JUNE 30, 2020

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Referrals (unduplicated)	349	100%	167	100%	79	100%	103	100%
Individuals Contacted (unduplicated)	225	65%	115	69%	72	91%	38	37%
Individuals Enrolled (unduplicated)	193	55%	103	62%	50	63%	40	39%
Among Enrolled Individuals…								
CLIENT STATUS								
Active on last day of reporting period	167	87%	91	88%	47	94%	29	73%
Discharged during reporting period	26	13%	--	--	--	--	--	--
GENDER								
Female	76	39%	39	38%	22	44%	15	38%
Male	114	59%	62	60%	28	56%	24	60%
AGE GROUP								
18-29	45	23%	28	27%	--	--	--	--
30-49	106	55%	46	45%	34	68%	26	65%
50+	42	22%	29	28%	--	--	--	--
RACE/ETHNICITY								
Non-Hispanic White	106	55%	44	43%	35	70%	27	68%
Minority	73	38%	46	45%	15	30%	12	30%
Unknown	14	7%	13	13%	0	0%	1	2%

DATA SOURCE: FHARPS Microsoft Excel trackers submitted by each provider to the Washington Health Care Authority (HCA).
-- Cells suppressed due to small n's.
Gender does not total to 100 percent because Gender X and unknown are not shown. Sums may not total to 100 percent due to rounding.

Crisis Triage and Diversion – Mobile Crisis and Co-Responders

Currently in Washington State, Mobile Crisis Response (MCR) services are provided 24 hours per day, 365 days per year throughout the state, under HCA's contracts with regional Behavioral Health Administrative Service Organizations (BHASOs). MCR is an intricate part of the regional behavioral health crisis system and is designed to provide community based services to individuals experiencing, or at imminent risk of experiencing, a behavioral health crisis. MCR offers law enforcement and first responders an option for diverting people from the legal system while providing community-based interventions supporting people through least restrictive community-based behavioral health options intended to support and stabilize acute symptomology. The goals of these services are engagement, symptom reduction, and stabilization. In some large rural communities, MCR services are provided by designated crisis responders (DCR) while other communities are served by dedicated crisis interventionists. According to contract, MCR teams are required to meet a response time of two hours or less. Based on community discussions with the three Phase 1 implementation regions, the majority of MCR teams report that they are responding within 90 minutes or less.

Under the Trueblood implementation plan, HCA sought to enhance the regional MCR service provision by working with the BHASO to identify what enhancements would be needed in their region to support the goals of the implementation plan. These enhancements will support and provide supplemental assistance to traditional MCR services. The three Phase 1 regions are designing their enhanced services to provide a more timely response to community crisis calls and to ensure acceptance of referrals from law enforcement as well as from co-responder teams. Overall enhancements have included:

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

Additionally, each region developed and implemented specific enhancements to include:

Spokane Region:

- Frontier Behavioral Health (FBH) is developing and implementing a Trueblood-centered segment of its mobile crisis service designed and trained to work with individuals who are identified as either class members or potential class members. FBH reports a long

history of providing crisis intervention services, operation of the Regional Crisis Line (RCL), and is currently piloting a co-deployment team with the Washington Association of Sheriffs and Police Chiefs (WASPC) to respond to individuals presenting with mental health distress.

- Frontier Behavioral Health is expanding its MCR services outside of Spokane County to assist with and to address the needs of neighboring rural counties.

- Adams County is creating a linkage to requested/necessary resources in the community for family and individuals while shouldering up its frontline assessment services.

Pierce Region:

- Providing a more rapid response time for interaction with law enforcement and co-responders by expanding coverage area and creating two service bases to cover the region.

- Coordinated communication with tribal and law enforcement partners.

Southwest Region:

- Expansion of community-based crisis hours in order to provide 24/7 services.

- Creation of a behavioral health / certified peer response pilot program.

Areas of Concern

Acquiring signatures for the initial MCR contracts was an arduous task as the BHASO contracts required multilevel ratification from Boards of County Commissioners or corporate legal departments. These authorizations were necessary before the BHASO could enter into negotiation with their regional agencies or develop contract language for their services.

In consultation between HCA and DSHS staff, regional representatives from the crisis response systems, and local rural law enforcement representatives, the law enforcement representatives stated that they struggled with managing the need for providing secure transportation for people who needed to be brought to metropolitan areas for treatment. These trips take the already limited number of officers' offline during transport, which can take hours depending on the distance traveled. Another concern was that in the most rural areas, despite having funding to hire staff, qualified candidates simply do not apply to work in these remote regions. Additionally, some regions possess very limited healthcare or behavioral healthcare treatment settings.

Recommendations to Address Concerns

The review and assessment of the MCR enhancement plans from the three regions must take into consideration the local needs and challenges the BHASOs encounter when improving MCR services. The review cannot take a one-size-fits-all approach and should be flexible in considering settings where crisis intervention can occur, the methods utilized, and the ways in which to address staffing shortages by employing a variety of service providers. The timeline for contracting future services must be established within the region's ratification system and take into account the processes for which they operate. These steps must be done before establishing any final date of signature.

Data – Crisis Triage and Diversion – Mobile Crisis and Co-Responders

The number of interventions, client characteristics, and average response time will be reported by each Phase 1 region through the Trueblood Quarterly Dashboard (see Table 5). Data will be collected through HCA's Behavioral Health Data System (BHDS). HCA posted an update to the Behavioral Health Data Guide (BHDG) in July 2020 that lists the data required for MCR interventions, and providers are currently adapting their systems. Data are anticipated to be submitted by January 2021, as required by the implementation plan, and will be included in the subsequent semi-annual report. The Washington Association of Sheriffs and Police Chiefs (WASPC) is independently collecting data on co-responders.

TABLE 5. **PRELIMINARY EXAMPLE**

Mobile Crisis Response Interventions and Client Characteristics

QUARTER

	TOTAL - ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Individuals Served (unduplicated)	888	88%	888	88%	888	88%	888	88%
Among Served Individuals…								
GENDER								
Female	888	88%	888	88%	888	88%	888	88%
Male	888	88%	888	88%	888	88%	888	88%
AGE GROUP								
18-29	888	88%	888	88%	888	88%	888	88%
30-49	888	88%	888	88%	888	88%	888	88%
50+	888	88%	888	88%	888	88%	888	88%
RACE/ETHNICITY								
Non-Hispanic White	888	88%	888	88%	888	88%	888	88%
Minority	888	88%	888	88%	888	88%	888	88%
RESPONSE TIME/DURATION								
Average Response Time (hours)	888	88%	888	88%	888	88%	888	88%
Average Duration (minutes)	888	88%	888	88%	888	88%	888	88%

DATA SOURCE: Washington State Health Care Authority (HCA) Behavioral Health Data System (BHDS)[6].

[6] Table 5 above does not include data from WASPC. Per the *Trueblood* implementation plan, WASPC independently collects data on co-responders.

Crisis Triage and Diversion – Forensic PATH

As part of the Trueblood contempt settlement agreement, the state is funding enhanced outreach and engagement to connect identified individuals with behavioral health services using a federal model called Projects for Assistance in Transitions from Homelessness (PATH). In the contempt settlement agreement, this program is identified as Intensive Case Management for High Utilizers. HCA, in partnership with DSHS' RDA, has been tasked with creating a referral list to identify individuals who are at risk of repeat court orders for competency evaluations. .RDA identified individuals with two or more competency evaluations orders in the last two years are at higher risk of future intersection with the criminal justice system. FPATH is focusing outreach and engagement efforts to individuals on that list that are predominately homeless or have had multiple competency evaluations.

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

Current Status and Areas of Positive Impact

Forensic PATH teams have been providing targeted outreach and engagement to people identified on the referral list since early March. Using a model similar to the federal PATH program, teams have been outreaching eligible individuals with an emphasis on homeless or unstably housed individuals. The goal is to connect people with community resources and services by building relationships and rapport. While most of the eligible individuals are homeless or unstably housed, some are not. In all instances, teams seek out the individual "where they are at."

All Forensic PATH Teams are located within a community behavioral health agency, which allows for warm handoffs to other needed services to include certified peer counselors who have experience working with individuals who may be experiencing homelessness or housing instability combined with multiple competency evaluation orders within the last two years.

Eligible people court ordered for forensic navigator/outpatient competency restoration may also utilize Forensic PATH for case management services.

HCA has provided all teams with 10 technical assistance webinars, national TA coaching calls, and two in-person trainings to train them on how to provide assertive outreach and engagement services to individuals who are on a by-name list.

HCA's Forensic PATH program administrator has built effective relationships with service providers to provide needed support and technical assistance during the COVID-19 pandemic to meet the needs of the eligible individuals and connect them to services. Support included best practices on outreach and engagement during a public health crisis. Even with the COVID-19 social distancing requirements, all teams have been able to provide outreach services and engage with clients.

Areas of Concern

In July, a new implementation challenge arose regarding the referral list. When Forensic Navigators were referring individuals that were not showing up on the referral list held by the providers. This specific issue was due to the lag time between client referral and list creation and distribution and forensic navigators identifying individuals who are receiving their second competency evaluation order. Because of strong communication between the Forensic PATH Program Administrator, Forensic Navigators and service providers this issue was identified quickly and an interim policy has been put into place. HCA and DSHS are working closely to identify a more permanent solution.

Recommendations to Address Concerns

The HCA Forensic PATH program in collaboration with RDA, DSHS, and HCA IT, are working to come up with a permanent solution to address the issue of the referral list that would eliminate the inaccuracies that are causing concern. Until this permanent solution is identified the interim solution is making sure that the appropriate referrals are being made.

Data – Crisis Triage and Diversion – Forensic PATH

Forensic PATH data included here is submitted by Forensic PATH providers monthly. Program eligibility is based on the HCA referral list (formerly the "high utilizer list") of individuals with two or more competency evaluation referrals in the past 24 months. This list is produced monthly by RDA and sent to providers.

The Forensic PATH program began March 1, 2020. Between March 1 and June 30, 2020, 561 individuals were on the HCA referral lists sent to providers (Table 6). Initial data indicate 49 (9percent) of these individuals were enrolled in Forensic PATH. It is anticipated this percentage will increase as providers streamline processes and the impacts of COVID-19 subside. All individuals enrolled were active as of July 30, 2020. The majority of clients were male (69percent) and between 30 and 49 years old (55percent). Forensic PATH operations and data

collection methods are complex and practices continue to evolve. Additional information will be available as data mature.

TABLE 6.

Forensic PATH Enrollment and Participant Characteristics

MARCH 1, 2020 to JUNE 30, 2020

	TOTAL – ALL REGIONS		PHASE 1 REGIONS					
			PIERCE		SOUTHWEST		SPOKANE	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
TOTAL POPULATION								
Individuals on Referral List	561	100%	351	100%	91	100%	119	100%
Individuals Enrolled in Forensic PATH	49	8%	20	6%	25	23%	--	--
CLIENT STATUS								
Active (on last day of reporting period)	49	100%	20	100%	25	100%	--	--
Discharged	0	0%	0	0%	0	0%	0	0%
GENDER								
Female	15	31%						
Male	34	69%						
AGE GROUP								
18-29	15	36%						
30-49	27	49%						
50+	7	15%						
RACE/ETHNICITY								
Non-Hispanic White	22	49%						
Minority	22	44%						
Unknown	5	7%						

DATA SOURCE: Forensic PATH Microsoft Excel trackers submitted by each provider to the Washington Health Care Authority (HCA).
-- Cells suppressed due to small n's (includes greyed out cells).

Education and Training – Crisis Intervention Training (CIT)

Crisis Intervention Training is designed to provide tools and resources to certified peace officers, corrections officers, and telecom/911 operators in order to respond effectively to individuals who may be experiencing an emotional, mental, physical, behavioral, or chemical dependency crisis, distress, or problem. The training provides skills that are designed to increase the safety of both the criminal justice personnel and individuals in crisis. Law enforcement agencies are already familiar with CIT training and corrections agencies in a few locations have come on board the last couple years.

Current Status and Areas of Positive Impact

To date, the Criminal Justice Training Commission (CJTC) has completed seven 40-hour courses for law enforcement and trained 143 certified peace officers. Within these classes we have trained a total of 230 attendees that consisted of law enforcement officers, mental health professionals, dispatchers, emergency responders, security officers, and corrections officers. There are 207 officers left to train to reach the 25 percent goal in the Phase 1 areas. Please note, this does not account for State Patrol and the Washington State Department of Fish and Wildlife (Fish and Wildlife) as we are determining the exact numbers in those districts. CJTC's database tracks WSP and Fish and Wildlife as a whole, not by each district. CJTC will need to schedule two classes in the Spokane region, one in the Southwest region and four in the Pierce region to be completed June 30, 2021.

Six of the 24 funded 8-hour corrections courses are complete with 155 corrections officers receiving training. In addition, Clark County Corrections hosted a 40-hour CIT for corrections, exceeding the mandate. Clark County trained 110 corrections officers in this program, for a total of 342 corrections officers trained by attending the 8-hour corrections course or the 40-hour course, which exceeds the requirement. There are an estimated 397 correctional officers left to train in the Phase 1 areas.

In addition to the 16 hours of backfill costs already provided in Washington state, agencies in the Phase 1 regions are eligible to receive an additional 16 hours of cost coverage as a result of the Trueblood funding provided by the legislature. Not all agencies are availing themselves of this benefit. The CJTC team is continuing to provide significant outreach and education to Phase 1 regions to encourage them to use this available resource to remove barriers to participation.

The telecom/911 training has not yet been deployed. CJTC is working on an interagency agreement with the state's 911 office. This agreement is in the process of being filed with the contracts department. Once complete, they will coordinate scheduling and providing the 8-hour telecommunications class to all dispatchers in the Trueblood regions. After each completed training, CJTC will receive the course rosters for completed trainings that count toward the training and numbers will be updated then.

Areas of Concern

Currently, the largest area for concern regarding implementation are the effects that COVID-19 has on developing and implementing the training either in person or online. Another area of concern that has been discussed is low staffing levels in most county jails. Even with backfill and overtime provided, there are not sufficient personnel to cover the shifts to allow officers to attend training. One commander stated they are already mandating corrections officers work 16 hours of mandatory overtime every two weeks, which is the maximum permitted by the relevant labor agreement. The second area of concern primarily impacts smaller law enforcement agencies: allowing an officer to leave the jurisdiction for a week of training. While smaller agencies have only a few officers to train, one officer represents a significant percentage of the overall police force. The loss of one officer to a 40-hour training course is extremely difficult to absorb within existing resources, even with the available backfill funding.

Recommendations to Address Concerns

CJTC is developing an 8-hour corrections course that can be offered in an online platform and classes should be available mid-fall. With this training being available online, we may be able to train more officers per class rather than being limited to the number of seats offered in person. For the 40-hour course, CJTC is looking at options to deliver the training around the state as a blended hybrid online course depending on the agency's accommodations and resources in the area.

Data – Education and Training – CIT

The Criminal Justice Training Commission monitors law enforcement training completion rates through a Learning Management System. Per the contempt settlement agreement, 25 percent of patrol officers in each law enforcement agency are required to complete 40 hours of enhanced CIT by June 30, 2021. Trainings began July 1, 2019. Since then, 30 percent of law enforcement officers from the Phase 1 regions have completed CIT (Table 7). Large agencies had higher training completion rates than small agencies in all three regions.

Training rates decreased across Phase 1 regions since December 2019. As of June 28, 2020, 14 percent of officers were trained in the Pierce region, compared to 48 percent in the Southwest region, and 40 percent in the Spokane region. These rates are down from 16 percent, 50 percent, and 51 percent, respectively (see March 2020 semi-annual report). This is largely due to the impact of COVID-19 on in-person trainings throughout the state.

The contempt settlement agreement also states the 25 percent training target should prioritize agencies that serve areas with higher population densities. As of July 31, 2020, larger agencies, serving the areas of greater population density within the Southwest and Spokane regions (Southwest 56%) and (Spokane 51%) have higher rates of training completion than the Pierce region (14%).

The Trueblood contempt settlement agreement also requires all 911 dispatchers and correctional officers complete an eight-hour CIT course by June 30, 2021. As of June 28, 2020, 46 percent of correctional officers in Phase 1 regions completed training, ranging from 13 percent in the Spokane region to 86 percent in the Southwest region. Data are not yet available for 911/Dispatch agencies.

TABLE 7.

Crisis Intervention Training (CIT) Program Measures

June 28, 2020

	TOTAL - ALL REGIONS			PHASE 1 REGIONS								
				PIERCE			SOUTHWEST			SPOKANE		
	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED	NUMBER OF OFFICERS	OFFICERS TRAINED	PERCENT TRAINED
AGENCY												
Law Enforcement/Patrol	**2,293**	**689**	**30%**	1,018	139	14%	504	242	48%	771	308	40%
Small Agencies (1-20 Officers)	**377**	**51**	**14%**	124	7	6%	92	27	29%	161	17	11%
Medium Agencies (21-100 Officers)	**333**	**59**	**18%**	225	40	18%	51	12	24%	57	7	12%
Large Agencies (101+ Officers)	**1,583**	**579**	**37%**	669	92	14%	361	203	56%	553	284	51%
911/Dispatch	-	-										
Correctional Officers	**740**	**339**	**46%**	310	163	53%	166	142	86%	264	34	13%

DATA SOURCE: Washington State Criminal Justice Training Commission.
NOTES: As part of the Trueblood contempt settlement agreement, Crisis Intervention Training (CIT) is being offered to law enforcement and corrections officers throughout Washington state. Twenty-five percent of patrol officers in each law enforcement agency in the Phase 1 regions are required to complete 40 hours of enhanced CIT. All 911 dispatchers and correctional officers are required to complete an eight-hour course.

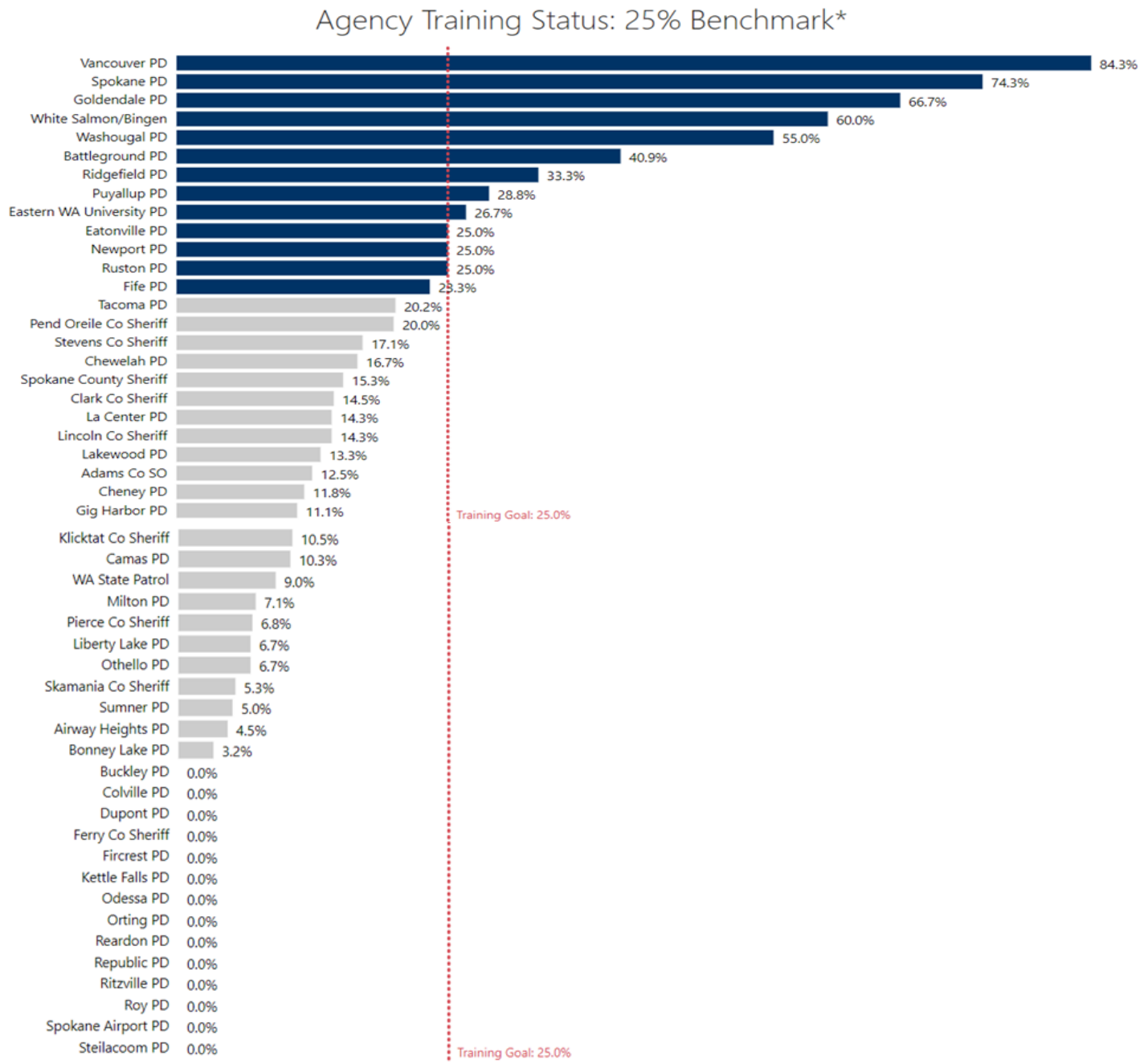
Figure 4 displays training completion rates for each law enforcement agency in Phase 1 regions. Twelve law enforcement agencies in the Phase 1 regions are meeting or exceeding the 25 percent benchmark.

FIGURE 4.

Crisis Intervention Training (CIT)

Individual Agency Compliance Metrics: Phase 1 Regions

JULY 31, 2020



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

FIGURE 4 clarifying details continue below:

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

DATA SOURCE: Washington State Criminal Justice Training Commission.

Education and Training – Technical Assistance for Jails

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

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

Current Status and Areas of Positive Impact

All training topics designated by the Trueblood contempt settlement agreement and the implementation plan have been delivered. Webinar based trainings continue on a monthly basis, and the schedule for these trainings has been established through February 2021. Several of the topics scheduled for delivery were identified by input from the field, including those attending prior trainings and providing feedback on additional trainings that would be useful. Other topics are extensions of prior trainings, in order to provide greater depth of coverage than was possible in the initial training session.

Efforts are underway to extend the reach of JTA trainings and improve audience engagement. As part of this effort, the team collaborates with a BHA communications consultant to improve content and user interface of our public-facing website. JTA recently purchased licenses for a suite of authoring tools intended to create more engaging and interactive online learning experiences.

There has been a significant increase in the use of videoconferencing software to conduct forensic evaluations remotely as an adaptation to the limitations imposed by COVID-19 on in-person evaluations. Members of the JTA team have been centrally involved in providing guidance and technical assistance statewide in support of this transition to increased online forensic evaluations at jails throughout the state.

Areas of Concern

The primary area of concern is regional awareness of the JTA program. Although the foundation of the program has been established and a communication plan created, program awareness, as well as attendance (by jail staff, etc.) at trainings offered by the JTA Team, could be enhanced.

Another area of concern is determining how the JTA program can be most effective in the delivery of training and other forms of assistance. One of the primary challenges is that jails have several common obstacles to receiving training (e.g., budget, staffing, technology), which may be a factor in the modest training attendance numbers.

Recommendations to Address Concerns

JTA had arranged to staff a booth at the spring 2020 WASPC conference and planned to deliver an awareness campaign as well as to solicit additional information regarding JTA needs. Unfortunately, this important outreach opportunity was canceled due to the COVID-19 pandemic. WASPC currently indicates that their fall conference is tentatively scheduled for the week before Thanksgiving, and if it is held, it will be held virtually. Opportunities to present at this and other relevant conferences will be pursued.

As noted above, work is underway to improve the effectiveness of our public-facing website, and to improve engagement with online trainings through the use of updated software tools. Efforts are also underway to collaborate with WASPC in the posting of training opportunities and the best practices manual.

Data – Jail Technical Assistance

The Technical Assistance for Jails team needs to develop and implement a method to accurately track data for online training participation that does not present an obstacle to participants and thereby reduce attendance. Consultation with communications and RDA will continue.

Enhanced Peer Support

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

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

Current Status and Areas of Positive Impact

The curriculum was created and the training developed. Peers will learn about the components of the legal system and how they intersect with the behavioral health system. Members of the legal and forensic mental health systems professionals will learn about the successful impacts and effectiveness of peer services.

The in-person continuing education training that was scheduled for April 29-30 was postponed due to COVID-19 and the continued need for physical distancing. HCA and OFMHS created pre-recorded overviews of the training modules to meet the May 1, 2020 deadline. These overview modules were made available to all CPCs employed on Trueblood-related service teams across the Phase 1 regions. The HCA is in the process of posting the overview modules of the training onto the HCA's Peer Support webpage, making them available to all CPCs in the state and other professionals who support individuals who are involved in the criminal court system.

Due to COVID-19 and the continued need for physical distancing for the foreseeable future, the Enhanced Peer Services program administrator will work on transitioning the interactive in-person training to a virtual format.

Traditionally, people with criminal court involvement have been reluctant to move forward to become certified peer counselors because of the possibility they would not be employable. However, changes to RCW 43.43.842 decreased restrictions for certified peer counselors to access the Agency Affiliated Counselor Credential through the Department of Health. These changes are projected to expand the workforce opportunities for individuals with lived criminal court and behavioral health experiences to work in the field. The reluctance to become a CPC has created a shortage of peers with the desired lived experience to fill the Trueblood-related service teams. Funds were allocated to provide three additional certified peer counselor trainings targeted to the Phase 1 regions. These trainings began in May 2020 and were completed at the

end of June 2020 in support of the objective of increasing the peer workforce of individuals with lived experience in the criminal court system.

Areas of Concern

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

Recommendations to Address Concerns

To overcome the potential jail-access limitation described above, it is important to establish open communication with the jails to find out about their visitation policies, processes, and their willingness to consider potential local policy modifications to assist in improving Trueblood services. If necessary, develop policy and explore rulemaking authority that could allow certified peer counselors employed on Trueblood-related service teams to enter the jails.

Data – Enhanced Peer Support

Between March and June 2020, 16 certified peer counselors from FPATH and FHARPS teams in Phase 1 regions received the enhanced training specific to serving persons with prior criminal court system involvement.

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 (WFD) specialists for the functional areas specified in the contempt settlement agreement. Additionally, the WFD administrator position became vacant in December 2019, and this vacancy has been filled as of March 2020.

Current Status and Areas of Positive Impact

The WFD team has been involved in a range of initiatives. An initial draft of a comprehensive training plan has been circulated among OFMHS leadership. Once finalized, this document will provide guidance in the scope, process, and focus of training provided by WFD. It will also begin to define the parameters of the WFD team's functions with the broader workforce development system in the state of Washington. It should serve as a strategic document in defining the work of the WFD team and be useful as a means of communicating the team's functions to key stakeholders.

Other documents developed in support of the training plan include a series of brochures illustrating the career pathways for key work positions within the forensic mental health system. These are intended as an outreach and education tool for potential members of the workforce, to be used to increase awareness of and to stimulate interest in the field, as well as to provide information about the training and qualifications required. These brochures also provide a graphic illustration of the developmental pathway for each position, and they can be used to identify key points of engagement with potential workers to steer them toward positions in the forensic mental health workforce. These documents are currently under internal review.

WFD team members are delivering training in support of a recently implemented New Employee Orientation program for OFMHS staff. They have also been involved in developing training in an updated version of the Breaking Barriers curriculum for competency restoration, designed to train staff at the Residential Treatment Facilities, although the planned in-person training in this curriculum has been delayed by the COVID-19 pandemic.

Two trainings on the competency evaluation process were delivered to the prosecution and defense attorneys in King County on June 5 and July 14, 2020. These were well received and will be offered to other jurisdictions where there is interest. The state hospitals requested training and professional development in Trauma Informed Care. A workgroup convened with participation of the WFD Administrator and members of his team to develop the requested trainings.

Assistance has been requested from the WFD team in addressing hiring challenges faced by employers who are directly responsible for supporting elements of the Trueblood Implementation Plan, e.g., the mobile crisis responders in Clark County. Initial collaboration has begun with HCA workforce development staff to assist in addressing these needs.

Efforts to establish relationships and opportunities for collaboration within tertiary education have resulted in dialogues with Shoreline Community College and the University of Washington. Shoreline Community College has a series of courses in forensic topics, and consultation has begun to explore ways in which this may serve the needs of expanding the workforce required to serve the Trueblood class members. The University of Washington recently established The UW Center for Mental Health, Policy and the Law. This group has expressed interest in building partnerships. An introductory meeting was held on September 3, 2020.

Areas of Concern

The WFD team is on track to complete all required element tasks on time or ahead of schedule. Currently, the major areas of concern are related to the short and medium-term impacts of COVID-19. This has curtailed the in-person delivery of training, conference presentations, and related opportunities to network with those in the field with whom a strong working relationship would support our efforts. It will be important to continue to establish such relationships, to raise awareness of and to stimulate interest in forensic workforce career opportunities, and to provide education and training to prepare people to enter and successfully work in this field.

Recommendations to Address Concerns

The primary focus to address the identified concerns is to expand the reach and improve the effectiveness of online methods to reach the necessary audiences. Improvement of existing websites, enhancement of online and distance learning offerings, and presentations at virtual conferences and online classes are being pursued as potential ways to more effectively reach our audiences.

Data – Workforce Development

A search for relevant data to support strategic planning and to eventually document progress has been initiated and continues. Thus far, available workforce data from existing sources are not sufficiently specific to the forensic mental health field. It appears that more focused data will need to be collected from specific employers. Consultation with RDA and members of state workforce development organizations has been initiated and will continue.

Conclusions

Behavioral health transformation is well underway in Washington state. Several new programs began operations this past spring and summer, and the next several months promise to be a time of immense change and progress toward continued implementation of the Trueblood contempt settlement agreement as these programs ramp up toward full enrollment. Noteworthy is the recent completion of the first more than 125 required tasks and deadlines as part of the contempt settlement agreement's implementation plan. Accomplishment of this milestone shows significant progress since the final implementation plan's submission to the Court on June 27, 2019.

Excitement for milestone completion and recent program launches is tempered, however, by the challenging reality facing the United States and a number of other countries throughout the world as of September 2020. The COVID-19 pandemic continues to place significant constraints on daily life and normal operations of the state's behavioral health system. With these continued constraints comes the high likelihood, as discussed in the disclaimer, that additional COVID-19-related impacts to Trueblood initiatives are expected, efforts to mitigate the effects notwithstanding.

For the next semi-annual report to be published in late March 2021, the new programs will be fully operational with six-to-nine months of experience serving their clients, and many of the element narratives will reflect the transition from the startup phase of the first several months of service delivery, and the expected successes and challenges inherent in opening new programs, to a more focused approach based on the needs of regular sustained operations.

Appendix B – 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 (CJTC): *www.cjtc.wa.gov*

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

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

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

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

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

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

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

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

Trueblood *June 2020 Progress Report for the Court Monitor and Appendices A-K:* June | Appendix A-G | Appendix H | Appendix I | Appendix J | Appendix K

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

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

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

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

Non-Government and Partner Resources:

Disability Rights Washington: www.disabilityrightswa.org

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

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