

## CRP Issues in Minnesota

In Minnesota, the number of people deemed incompetent to stand trial has increased dramatically over the past 3 years – over 11%. This has resulted in nearly all of the beds operated by the state (most of the acute care in Minnesota is provided in community inpatient psychiatric units not in state operated program) being occupied by someone coming from jail who was deemed incompetent to stand trial. It increased so much that the state courts sought an additional \$1 million to cover the costs of the increased number of psychological exams. What's puzzling to stakeholders is the increase is at a time when there are more community services than ever before, Minnesota has Medicaid expansion and more police are trained than ever before. Mandatory mental health screening has been required since 2009 so it's not "new" that jails are aware of people with mental illnesses in their custody.

In December 2018, the Minnesota Department of Human Services issued a bulletin informing counties that when people no longer need the level of care provided at state operated programs they would be returned to the community even if they were not competent to stand trial. They did this in order to open up more beds for people coming from the community hospitals. The problem is that some of these people will simply return to jail and the reality is that there are no community competency programs. Jails often have limited drug formularies, and rarely offer therapy. The state offered to share their competency restoration curriculum, but this was not good enough.

This led to a group of stakeholders being called together by NAMI Minnesota and Mental Health Minnesota to begin researching the issue. They wrote to the new administration which took office on January 1, 2019 to repeal the bulletin because it would be detrimental to people living with mental illnesses involved in the criminal justice system.

The tension between jails and state operated services has been great over the past several years. Enactment of the 48-hour law in 2014 caused major problems in our mental health system. The law requires that anyone who is in jail and is committed be moved to a state operated program within 48-hours. The intention – to not have people with serious mental illnesses languish in jail – was good but while it solved the problems sheriffs faced, it created "flow" issues in our mental health system. Now very few people can get into state operated programs from our community hospitals. Little attention is paid to the fact that people with mental illnesses are in the jails often for months before being deemed incompetent to stand trial and then committed. Unlike other people who are committed, there is no screening to assess the level of care that is needed – they are just automatically transferred to a state operated hospital.

Prior to the 48-hour law, 52 people were admitted to Anoka Regional Treatment Center (our only large state hospital of about 100 beds) from jails and four years after the law passed 154 people were admitted from jails. Prior to the law 245 people were admitted from community hospitals and four years after it dropped to 63 and now it is even lower. People admitted from the jails have a longer length of stay leading to slow turnover for beds. These individuals, prior to the bulletin, often stayed longer than necessary because appropriate community services could not be found, even though counties pay 100% of the cost of care if an individual didn't need to be there. It's harder to place someone who has been charged with a crime. The December bulletin exacerbated the problem created by the 48-hour law. Now they have "fixed" the problem for state operated programs but created new problems in the community that will have a serious and significant impact on people with mental illnesses involved with the criminal justice system.

NAMI Minnesota pulled together stakeholders in January and began to do research. We have a document that compiles information from others states on CRP – it's not extensive but it is a start. We also examined admissions by county and found that there is great variation, even based on population. Some overlap was found from counties with few admissions and counties that have a Stepping Up initiative, (6 of the 17 counties with a Stepping Up initiative) but more research needs to be conducted to determine which strategies are leading to the difference. We know that 38 of 87 counties had no admissions to the state operated programs from jail.

The State Courts formed a Psych Services Workgroup in 2019, of which NAMI Minnesota is a member, to try to address this issue as well. Their charge is to “analyze and provide recommendations on the Court's response to mental illness in court proceedings and explore modifications to the current Psych Examiner program structure.” Several issues have already been raised, including differentiating between people who with treatment can participate in their defense, people who with treatment can be educated about the process in order to participate in their defense, and people who with treatment and education simply won't ever be able to participate in their defense due to cognitive limitations. They are looking at increasing the quality of the examiner's reports, eliminating bail for non-violent crimes to prevent decompensation, increasing the use of technology, increasing training for judges and tightening timelines.

NAMI Minnesota introduced legislation, which passed, to create a competency restoration task force. This is a complex issue and we wanted to go “upstream” in addition to creating community competency restoration programs. We truly want to understand **why** the numbers are increasing. We have also received a three-year grant to hire a staff person to focus on this issue and other areas involving youth and adults in the criminal justice system. Here is the language for the new law:

*Subdivision 1. Establishment; purpose. The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.*

*Subd. 2. Membership. (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:*

- (1) a representative appointed by the governor's office;*
- (2) the commissioner of human services or designee;*
- (3) the commissioner of corrections or designee;*
- (4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;*
- (5) a representative appointed by the designated State Protection and Advocacy system;*
- (6) the ombudsman for mental health and developmental disabilities;*
- (7) a representative appointed by the Minnesota Hospital Association;*
- (8) a representative appointed by the Association of Minnesota Counties;*
- (9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;*
- (10) a representative appointed by the Minnesota Board of Public Defense;*
- (11) a representative appointed by the Minnesota County Attorneys Association;*
- (12) a representative appointed by the Minnesota Chiefs of Police Association;*

(13) a representative appointed by the Minnesota Psychiatric Society;  
(14) a representative appointed by the Minnesota Psychological Association;  
(15) a representative appointed by the State Court Administrator;  
(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;  
(17) a representative appointed by the Minnesota Sheriffs' Association;  
(18) a representative appointed by the Minnesota Sentencing Guidelines Commission;  
(19) a jail administrator appointed by the commissioner of corrections;  
(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and

(24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

*Subd. 3. Duties. The task force must:*

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;

(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

*Subd. 4. Officers; meetings. (a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019. (b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary. (c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.*

*Subd. 5. Staff. (a) The commissioner of human services must provide staff assistance to support the task force's work. (b) The task force may utilize the expertise of the Council of State Governments Justice Center.*

*Subd. 6. Report required. (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections. (b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.*

*Subd. 7. Expiration. The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.*

NAMI Minnesota will be happy to share any information and reports that we gather or produce during the next two years. We would appreciate learning from other states as well.

Reports to Read:

Closing the “Gap” Between Competency and Commitment in Minnesota” by the Robina Institute of Criminal Law and Criminal Justice

A Comprehensive Crisis System and Speaking Different Languages by the NASMHPD

Numerous materials on the Council of State Government’s Criminal Justice Center website

Addressing Revolving Doors: Stepping Up and Opportunities for Mental Health Diversion in PA

Emptying the New Asylums by the Treatment Advocacy System

Forensic Patients in State Psychiatric Hospitals

Commentary: Jail-Based Competency Restoration. Journal of the American Academy Psychiatry Law

Competency Restoration for Adult Defendants in Different Treatment Environments. Journal of the American Academy Psychiatry Law, 2019

**Models of Competency Restoration**  
**Assembled by Pat Seppanen for NAMI MN**  
**As of 1.23.19**

NOTE: Numbers that appear in parentheses after each entry indicate the reference (references are listed by number at the end of the document).

**Definitions**

**Competency:** Competency is defined by a 1960 United States Supreme Court case, Dusky v. United States, which affirmed a defendant’s right to a competency evaluation before proceeding to trial. In this landmark case, the court outlined the basic standards for determining competency, ruling that a defendant must have a “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and a “rational as well as factual understanding of the proceedings against him.” (2)

**Principles related to competence:** Task specific, moment specific, diagnosis does not define incompetence, presumption of competence--incompetence requires a judicial determination, and threshold for competence may vary depending on task. (6)

**Incompetence:** Incompetence is predicated on two components: (1) a mental disorder or cognitive impairment and (2) a deficit in one or more competence-related abilities (i.e., understanding, appreciation, reasoning, assisting counsel) that occur as a result of the mental disorder or cognitive impairment. (1)

**Cognitive impairment** includes DSM-5’s Neurocognitive Disorders and Intellectual Developmental Disorders. (2)

**Settings for Competency Restoration Programs**

- Inpatient
- Outpatient (for non-dangerous defendants who are found incompetent to stand trial)

**State Policy**

**Required Inpatient Statutes:** Ten jurisdictions (nine states [names not specified] and the federal government) require that defendants found incompetent to stand trial be committed to an inpatient facility. (5)

**Discretionary Inpatient Statutes:** Some states have moved to a discretionary inpatient commitment regime [number of states not specified]. (5)

**Outpatient competence restoration (OCR):** Thirty-five states have specific statutes that allow for OCR; however, only 16 states actually have a functioning OCRP (Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Michigan, Nevada, Ohio, Rhode Island, Tennessee, Texas, Virginia, Washington, D.C., and Wisconsin) (5). The outpatient option adheres to the statutory requirement of providing the least restrictive alternative for mental health orders. (2)

**A model rule-based statute:** An ideal statute would accomplish two goals: First, it would erase the discrepancy in pretrial release between competent and incompetent individuals. Incompetent defendants should be subjected to the same overall pretrial release criteria as competent defendants, not assumed detainable by the mere fact of their incompetence. Second, an ideal statute would assume that a defendant eligible for pretrial release should receive outpatient treatment and would only allow a judge to refer a defendant for inpatient treatment if she has specific reason to believe that outpatient treatment would not be successful (because it has not been successful in the past, for example). (5)

The first step for effective competence restoration statutes is to pair these statutes with their pretrial release counterparts. Surprisingly, few states cross-reference the incompetence commitment procedure with the pretrial release procedure. And while many jurisdictions retain pretrial release statutes that require judges to make standards-based assessments, like flight risk and danger to society, the trend is moving toward more rule-like empirical risk assessments.<sup>213</sup> Incorporating the pretrial release criteria into the competence restoration statute avoids the inequity of incompetent defendants held before trial on vague dangerousness grounds, while competent defendants are assessed using empirical metrics. (5)

### **Common Issues**

- Misunderstandings and prejudice toward the mental ill that pervade the criminal justice system (e.g., individuals with a mental illness are more dangerous than non-mentally-ill individuals, experts can easily and accurately spot dangerousness in defendants, mentally ill people are presumptively incompetent to participate in “normal” activities or be active participants in their own medical care, and that the best place for these individuals is an institutionalized setting). (5)
- A defendant found incompetent to stand trial and hospitalized will often spend a longer time imprisoned than a competent defendant accused of the same crime and with the same criminal history background. While pretrial release is technically available to incompetent defendants in most jurisdictions, these defendants are usually not released (5)
- The lack of space in medical facilities has resulted in lengthy wait times to even begin the competence restoration process. That time is usually spent in a jail cell. While in jail, most incompetent detainees do not receive any competence restoration services. Often, they receive no mental health services whatsoever. Thus, the treatment they receive during these months of waiting is often less—far less—than the treatment convicted prisoners receive. (5)
- Mentally ill defendants are isolated in solitary confinement at much higher rates than the general population. As a defendant’s mental illness grows worse, he tends to break rules and may be sent to solitary confinement as punishment. Some defendants are also sent to isolation units for their own protection since they are more likely to be victimized by other prisoners. (5)

- This troubling state of affairs is the direct result of the laws governing competence restoration, which default to inpatient treatment with little regard for whether the defendant could be successfully restored in an outpatient setting. (5)
- Many courts still default to inpatient treatment, even if the statute does not mandate that result. One survey of state mental health directors found that, even in states with an outpatient option, outpatient treatment is rarely used. (5)
- Even if all states suddenly adopted robust outpatient competence restoration programs, most discretionary-inpatient statutes would still be in dire need of amendment. The problems are twofold: (a) no guidance for when outpatient treatment would be appropriate, or (b) vague directives on which defendants qualify for outpatient care. (5)

### **Bare Elements of a Good Model Competency Restoration Programs**

- Competency restoration is often implemented on an individualized basis, though some inpatient centers offer highly structured programs. The most common model combines these elements and involves individual treatment of any underlying mental illness combined with group education and practice modules and individual coaching. (3)
- **Common treatment protocols (1)**
  - Medication
  - Educational Treatment Programs
  - Specialized/individualized treatment programs; and
  - Cognitive remediation programs
  - Treatments for Individuals with Developmental Disabilities
- **Elements of a model competency restoration program (4)**
  1. *Objective competency assessment upon admission.* Specific deficits that result in incompetence to stand trial should be identified upon entry to the competency restoration program. These specific deficits should then be listed individually on the individualized treatment plan and targeted specifically in the course of the defendant's treatment. As mentioned above, various factors can lead to incompetence, such as psychosis, mood symptoms, mental retardation, lack of information, and so forth. Not all defendants are incompetent for the same reason, and therefore, the underlying reason leading to each defendant's incompetence should be identified by an objective competency assessment upon admission to the program.
  2. *Individualized treatment program.* Each defendant should have a treatment regimen tailored to his or her specific problems. Deficits identified in the competency assessment upon admission to the program should be listed in the individual treatment plan and addressed by specific treatment interventions.
  3. *Multimodal, experiential competency restoration educational experience.* Defendants learn material best when it is presented in multiple learning formats by multiple staff. For this reason, learning experiences should involve discussion, reading, video, and role-playing. Learning is also enhanced by experiential methods of instruction, such as a mock trial.

4. *Educational component.* A mainstay of the competency restoration program should be education regarding the following:
  - various charges
  - severity of charges
  - sentencing
  - pleas
  - plea bargaining
  - roles of the courtroom personnel
  - adversarial nature of trial process
  - evaluating evidence
5. *Anxiety reduction component.* An anxiety reduction module can be instrumental in providing relaxation techniques to defendants who may become anxious while in court.
6. *Additional education components for defendants with low intelligence.* Defendants who are incompetent due to specific knowledge deficits caused by low intelligence can often be restored to competence but may require additional exposure to the educational material. This may be addressed by providing additional learning experiences through increased lecture time as well as individual instruction using simplified terminology.
7. *Periodic reassessment of competency.* Defendants should be periodically reassessed for their progress toward restoration to competence. Periodic assessment allows the treatment teams to measure whether their treatment interventions are working, and whether additional treatment elements need to be incorporated into patients' treatment plans.
8. *Medication treatment.* Because psychotic and mood disorders are a major cause of incompetence, underlying mood and psychotic disorders must be aggressively treated with biological therapies for restoration to competence to occur.
9. *Capacity assessments/involuntary treatment.* Defendants adjudicated as incompetent to stand trial may also lack the capacity to give informed consent for treatment/medication. Because an important component of restoration to competence is medication treatment of underlying mental disorders, it is essential that clinicians address incompetence for treatment decisions per their local hospital policy and state laws. Defendants who refuse medication treatment should be evaluated for competence to make treatment decisions. Defendants who consent to medication treatment but appear incompetent to make such decisions should also be evaluated for competence to make treatment decisions.

### **Design Considerations**

- Research has shown that the first 45 days of participation in an OCRP are the most productive. (2) Other findings indicate the typical amount of time to restoration is 90-180 days or less. (6)
- Some states, New York for example, only restore individuals who are charged with a felony, a serious charge generally carrying a sentence of over a year in prison. (Lessor charges and sentences may involve less time than the length of the restoration process) (2)



- Some states have recognized, case management services are critical for addressing restorability as well as assessing the use of clinical and forensic services. The factors known to affect one's ability to become competent include employment, treatment adherence, and abstinence from substance use. Support in these areas can be health-affirming as well as cost-effective. Transportation assistance can be particularly useful in improving access to forensic and community services that assure the fairness of the judicial process. (2)
- There is consistent evidence that defendants referred for non-restoration-specific, general psychiatric hospital care are significantly less likely to regain competency than those receiving care in a formal restoration program, either inpatient or community based. (3)
- Some jurisdictions have implemented treatment programs targeted to defendants found incompetent to proceed on the basis of mental retardation or developmental disability. A recognized treatment program, is called the Slater Method after the hospital where it was developed in Rhode Island includes 5 modules: 1. the purpose of the training, review of the charges, pleas, and potential consequences; 2. courtroom personnel; 3. courtroom proceedings, trial, and plea bargain; 4. communicating with the attorney, giving testimony, and assisting in defense; and 5. tolerating the stress of the process. Prognosis is more guarded for restoration of cognitively impaired defendants. (3)
- Issues cited by authors that need to be resolved:
  - Should defendants adjudicated incompetent to stand trial receive competency restoration on dedicated, specialized competency restoration units, or be mixed in with the general inpatient psychiatric population?
  - Are treating clinicians able to perform accurate, unbiased competency assessments, or should a mental health professional not involved in the incompetent patient's treatment perform this evaluation?

## References

1. Washington State Institute for Public Policy. (January 2013). *Standardizing protocols for treatment competency to stand trial: Interventions and clinically appropriate treatment*. Downloaded from [www.wsipp.wa.gov](http://www.wsipp.wa.gov) on January 22, 2019.
2. Johnson, N.R. & Candilis, P.J. (June 2015). Outpatient competence restoration: A model and outcomes. *World J. Psychiatry*, 5(2). pp. 228-233.
3. Criminal Justice Research (no date). Competency restoration. Downloaded from [criminal-justice.iresearchnet.com](http://criminal-justice.iresearchnet.com) on January 22, 2019.
4. Noffsinger, S.G. (2001). Restoration to Competency Practice Guidelines. *International Journal of Offender Therapy and Comparative Criminology*. 45, pp 356-362. Downloaded from <http://ijo.sagepub.com/content/45/3/356>

5. McMahon, S. (March 2018). *Reforming competence restoration statutes: An outpatient model*. Downloaded from <http://dx.doi.org/10.2139/ssrn.3132700>

6. Pinals, D.A. (no date). Forensic services: Incompetent, but not restorable and incompetent but not committable: Challenges and opportunities. Powerpoint slides.

Joint Motion for Preliminary Approval  
of Settlement Agreement  
Exhibit A

A.B., by and through TRUEBLOOD, et al., v. DSHS, et al., No. 14-cv-01178-MJP

## Comprehensive Settlement Agreement

### Contents

I.	INTRODUCTION AND GOALS.....	2
II.	DEFINITIONS .....	4
III.	SUBSTANTIVE ELEMENTS.....	8
	A. Competency Evaluation .....	8
	B. Competency Restoration.....	9
	C. Crisis Triage and Diversion Supports.....	20
	D. Education and Training.....	29
	E. Workforce Development.....	32
IV.	PHASING, OVERSIGHT, AND IMPLEMENTATION.....	36
	A. Phased Implementation.....	36
	B. Oversight and Advisory Structure .....	37
	C. Dispute Resolution.....	43
	D. Implementation Plan and Process Commitments .....	44
V.	COMPLIANCE AND TERMINATION.....	45
	A. Contempt Mitigation and Substantial Compliance .....	45
	B. Termination.....	48
VI.	ADDITIONAL PROVISIONS.....	49
	A. Contempt.....	49
	B. Individual Rights.....	49
	C. Protection and Advocacy Acts.....	49

D. Terms of Agreement .....50

E. Authority to Bind .....50

F. Modifications .....50

G. Waiver .....50

H. Severability .....51

I. Successors .....51

J. Non-Waiver of Arguments and Issues .....51

K. Effect of Court Denying Motion to Approve.....51

L. Execution .....51

**I. INTRODUCTION AND GOALS**

In consideration of the Parties’ commitment to uphold this Court’s orders to provide timely competency evaluation and restoration services, the Parties enter into this Settlement Agreement. The Parties intend that implementation of this Agreement will bring Defendants into substantial compliance with this Court’s orders. The elements of the Agreement aim to deliver an array of services to better deliver the right care, at the right time, in the right place, for the right cost. The ultimate goal of each element in this Agreement is to reduce the number of people who become or remain Class Members and to timely serve those who become Class Members.

The Parties recognize that there are multiple players in the forensic and broader mental health systems. This creates challenges in establishing continuity and coordination of care and forming long-term and sustainable solutions. In furtherance of the Parties’ goals of diversion and providing timely services to Class Members, the Parties believe it is important to break down the silos between the system partners within the larger mental health system. To develop a plan that

yields successful outcomes for Class Members and enhances system collaboration and coordination, this Agreement acknowledges the value brought by every partner in the system and encourages full participation by all of its players.

In developing this Agreement, the Parties held dozens of meetings with hundreds of system partners over the six-month negotiations period.<sup>1</sup> This included meetings with:

- Class Members;
- Class Members' families;
- State Legislators;
- Mental health provider agencies and advocates;
- Behavioral Health Organizations and advocates;
- Law enforcement;
- Local jails;
- State and municipal courts and judges;
- Prosecuting attorneys;
- Defense attorneys;
- Homeless and housing providers and advocates;
- Employment support providers and advocates;
- Individual clinicians;
- Education programs for needed clinicians;
- Other departments of the administration outside DSHS;

---

<sup>1</sup> Input from these stakeholders is reflected in a publicly-available report, at: <https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2018Trueblood/2018-05-Tac-Report.pdf>. After this report was drafted, the Parties, collectively and separately, continued to meet with system partners throughout the negotiation process.

- Local Legislators and Executives; and
- Washington residents.

The solutions in this Agreement focus on pursuing effective outcomes and often incorporate demonstrated successes in current programs, entities, and systems in Washington or from other jurisdictions. In crafting these solutions, the Parties recognize the fundamental goal of this Agreement is to provide timely competency services to Class Members pursuant to the Court's orders.

## II. DEFINITIONS

1. Approval:
  - a. Final Approval: the Court's approval of this Agreement following the notice period to Class Members, resolution of any objections, and the fairness hearing.
  - b. Preliminary Approval: the Court's initial approval of this Agreement such that the notice period for Class Members begins.
2. BHA: Behavioral Health Administration.
3. CIT: Crisis Intervention Training.
4. CJTC: Criminal Justice Training Commission.
5. Class Member: All persons who are now, or will be in the future, charged with a crime in the State of Washington and: (a) who are ordered by a court to receive competency evaluation or restoration services through DSHS; (b) who are waiting in jail for those services; and (c) for whom DSHS receives the court order.

6. Co-responder program: The Mental Health Field Response Teams Program, currently administered by WASPC as a grant program, pursuant to Wash. Rev. Code § 36.28A.440.
7. Crisis triage and stabilization facility: means either a crisis stabilization unit or a triage facility as defined in Wash. Rev. Code 71.05.020.
8. Defendants: the named defendants in the lawsuit, including the Department of Social and Health Services, Eastern State Hospital, and Western State Hospital.
9. DSHS or Department: Department of Social and Health Services.
10. Executive Committee: A committee tasked with making ultimate recommendations to the Court, as specifically defined in § IV.B.4. This committee shall be composed of representatives from DSHS, OFMHS, HCA, and Plaintiffs' counsel. The use of this term in any section outside § IV.B.4 refers to the committee defined in § IV.B.4.
11. Forensic Data System: A software program designed by DSHS/BHA information technology to replace two legacy data systems at Western State Hospital and Eastern State Hospital which perform a variety of functions including tracking competency referral data consistently across state hospitals and competency restoration residential treatment facilities.
12. Forensic Risk Assessment: An assessment completed by a forensic evaluator that provides an opinion in regards to whether a criminal defendant meets the standard for not guilty by reason of insanity.
13. General Advisory Committee: The committee specifically defined in § IV.B.2-3 that will be comprised of the Court Monitor, DSHS, HCA, the Governor's office, OFMHS, Plaintiffs' counsel, and any applicable representative from outside



partners. The use of this term in any section outside § IV.B.2-3 refers to the committee defined in § IV.B.2-3.

14. HARPS: Acronym for Housing and Recovery through Peer Services. This term references a team generally consisting of one housing support specialist and two peer support specialists, all of whom have been trained in the permanent supportive housing model. HARPS teams also have access to housing bridge subsidies to facilitate maintaining or obtaining housing.
15. HCA: Health Care Authority.
16. Mature Data: Data that has been fully resolved. Distinct from “first look data” as identified in the monthly reports to the Court Monitor.
17. MCR: Mobile Crisis Responders.
18. Outstation: OFMHS offices and/or staff located in geographic regions somewhere other than the campuses of the two state hospitals.
19. OFMHS: Office of Forensic Mental Health Services; an office dedicated to forensic services within the Behavioral Health Administration of the Department of Social and Health Services.
20. Parties: the Plaintiffs and named Defendants in this case.
21. Peer Support Program: A program for providing a peer counselor certification, as described in Wash. Admin. Code § 182-538D-0200.
22. Phased Regions: the Washington State Managed Care Organizations (MCO) and Administrative Service Organizations (ASO) regions in which the changes contemplated by this Agreement will be implemented. Phase One Regions include the Spokane Region, Pierce County Region, and Southwest Washington Region.

Phase Two Regions include King County Region. Phase Three Regions may include additional regions with high rates of Class Member referral.

23. Regions: specific areas within the State of Washington as defined by the MCO/ASO boundaries/regions.
24. Residential supports: “Residential supports”, as used within any section of this Agreement means only the residential supports as described within that section.
25. State:
  - a. Where describing an obligation or action under this Agreement: Executive branch agencies of the State of Washington.
  - b. Where describing a geographic region or level of government: the State of Washington.
26. Unstably Housed: As relevant to this Agreement, individuals are unstably housed if they:
  - a. are living in a place not meant for human habitation,
  - b. are living in an emergency shelter,
  - c. are living in transitional housing,
  - d. are exiting an institution where they temporarily resided, if they resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that institution, or,
  - e. are losing their primary nighttime residence within 14 days and lack resources or support networks to remain in housing.
27. Wait times: the maximum wait times for admission for inpatient competency services or completion of in-jail evaluations as set by the Federal Court in

*Cassie Cordell Trueblood, next friend of A.B., an incapacitated person, et al., v. The Washington State Department Of Social And Health Services, et al., Cause No. 2:14-cv-01178-MJP.*

28. WASPC: Washington Association of Sheriffs and Police Chiefs.

### **III. SUBSTANTIVE ELEMENTS**

#### **A. Competency Evaluation**

1. The State will seek funding for 18 additional forensic evaluators needed to meet future predicted demand, to meet forensic evaluator demand created by the opening of additional forensic wards, to staff outstations, and to maintain compliance with the Court's injunction during periods of increased demand. The expanded evaluator capacity, when not needed to address periods of increased demand, will be used to perform the Department's other statutorily required evaluation functions, including:
  - a. Out of custody evaluations;
  - b. Forensic Risk Assessments;
  - c. Civil commitment petitions for individuals found incompetent to stand trial under Wash. Rev. Code § 10.88.086 and referred for civil commitment under Wash. Rev. Code § 71.05.280(3);
  - d. Other duties as assigned at the Department's sole and exclusive discretion;
  - e. Provided that, during periods of increased demand, the Department will prioritize the completion of in-jail evaluations over the other duties outlined in a - d.

2. Approximately 13 of these positions shall be posted and recruited between July 1, 2019 - June 30, 2020, and the remaining positions shall be posted and recruited between July 1, 2020 - June 30, 2021.
3. The Department will complete the implementation of the Forensic Data System, and use that System to collect and utilize data to anticipate, and respond to, periods of increased demand.
4. The Department will collect and utilize data to determine if the increased evaluator capacity in § III.A.1 above maintains substantial compliance with the injunction with respect to in-jail competency evaluations, and whether capacity exists to respond to periods of increased demand. In the event the amount of evaluators is inconsistent with actual need, the Department will report the same in the semi-annual report as set forth in § IV.(B)(14). The report will include a plan to address the inconsistency going forward.
5. The State will continue the use of Outstations.
6. The State will complete the currently planned implementation of and will continue the use of telehealth for competency evaluations.

**B. Competency Restoration**

1. Legislative Changes
  - a. During the 2019 legislative session, the State will support and work to achieve legislative changes to reduce the number of people ordered into competency evaluation and restoration, and to use community based restoration services, which may include changes to Wash. Rev. Code § 10.31.110, Wash. Rev. Code § 10.77.086, and

Wash. Rev. Code § 10.77.088. These efforts may include advancing requests for legislative changes through bill proposals or supporting legislation that has been proposed by others that further the goal of reducing the number of individuals ordered to receive competency evaluation and restoration services.

- b. If the State fails to pursue legislative changes intended to reduce demand for competency services to aid in reaching substantial compliance with the relevant portions of this Agreement, this will constitute material breach.

2. Community Outpatient Restoration Services

- a. The State will seek funding and statutory changes to implement a phased roll out of community outpatient restoration services in targeted areas, including Residential Supports as clinically appropriate. These restoration services will be provided in community settings instead of inpatient units of state psychiatric hospitals or other inpatient restoration facilities.
- b. Criminal defendant eligibility for community outpatient restoration services is determined by the criminal court that is making an order for restoration services pursuant to Wash. Rev. Code § 10.77.086 or 10.77.088.

- (1) The forensic navigator, as described below in § III.B.3, will provide information, consistent with state and federal law, to the criminal court to assist the criminal court in determining whether a criminal defendant is appropriate for community outpatient restoration services.

- (2) A criminal defendant's compliance will be monitored by the community outpatient restoration services provider and the forensic navigator. The forensic navigator will provide periodic updates to the criminal court about the criminal defendant's compliance in the community outpatient restoration program.
- c. In accordance with state and federal law, the State will support processes to provide criminal courts with the information necessary to create tailored conditions for release of individuals into community outpatient restoration. The provision of this information will be primarily through the use of forensic navigators as described above in § III.B.3, however, the State may elect to use other means as appropriate.
- d. The State will require community outpatient restoration service providers to accept referrals from OFMHS in accordance with an algorithm that prioritizes the intake of Class Members.
- e. The State will conduct outreach and will provide technical assistance to criminal courts and other stakeholders, upon request, to support the implementation of community outpatient restoration services, to assist with issues such as:
  - (1) The determination of criminal defendant eligibility for community outpatient restoration;
  - (2) The conditions of the criminal defendant's participation in community outpatient restoration services; and,

- (3) The use of Residential Supports and other services to encourage the use of community outpatient restoration services.
- f. If a Class Member is otherwise determined to be eligible for community outpatient restoration services by the criminal court, but is assessed by the forensic navigator as Unstably Housed, the State shall provide Residential Supports, as specified in this Agreement, for the duration of participation in a community outpatient restoration program. The Residential Supports shall not continue for a Class Member referred for inpatient services. The Residential Supports may continue for a Class Member opined to be competent under Wash. Rev. Code § 10.77.065 for up to 14 days following transmission of the competency evaluation.
- g. Forensic navigators will coordinate access to housing for all persons enrolled in community outpatient restoration services. Discharge planning for Class Members begins upon admission to the community outpatient restoration program. If HARPS services are deemed necessary, planning should begin as soon as practicable for post-discharge housing support
- h. The State will develop Residential Supports for outpatient competency restoration, as specified in this Agreement, through a procurement process to fund community outpatient restoration providers. Providers will be given the flexibility to propose and deliver residential support solutions unique to the needs of the community in which the service is provided, which may include:
  - (1) Capital development through the Department of Commerce;

- (2) Capital development through a third party source identified by the provider;
    - (3) Housing voucher programs;
    - (4) Leveraging existing housing programs locally;
    - (5) Scattered site housing programs.
  - i. The State will seek funding to support community outpatient restoration services with a broader package of treatment and recovery services, including mental health treatment, substance use screening and treatment. The restoration portion of these services may be provided in-person, remotely through live video, or via recorded video.
  - j. For criminal defendants waiting in jail, an offer of admission to the community outpatient restoration services program will occur within the constitutional timelines for restoration as outlined by the Federal Court.
3. Forensic Navigators
- a. The State will seek funding to implement a new role within the forensic mental health system. This new role, called a forensic navigator, will assist Class Members in accessing services related to diversion and community outpatient competency restoration.
    - (1) Class Members will be assigned a forensic navigator at the time that a competency evaluation order is received by the Department in the Class Member's criminal case. The navigator will gather information specific to Class Members, including what services are available for that individual Class Member, and how a community



outpatient restoration order or other court order could be supported. This information will be provided to the criminal court prior to the hearing to determine whether competency restoration should be ordered. The navigator will not make a clinical recommendation to the criminal court.

- (2) Forensic navigators will be given discretion to manage their caseload, but will do so using the following guiding principles:
  - (a) In recognition of the fact that there is a large portion of Class Members who are known to the system, and will have recently had contact with the criminal justice or forensic mental health system, forensic navigators may prioritize their efforts to divert these particular Class Members (or high utilizers as referenced in § III.C.4.a.). This prioritization may include beginning work on gathering information immediately upon being assigned the Class Member.
  - (b) In recognition of the fact that a large proportion of criminal defendants who are ordered to receive a competency evaluation will be found competent, forensic navigators may prioritize their efforts in order to provide a less intensive level of service until a finding that the Class Member is incompetent. This prioritization may include delaying intensive work on gathering information until more is

learned about the Class Member. Forensic navigators may use a standardized tool or assessment in order to assess Class Members unknown to the system.

- (3) Forensic navigators will assist criminal court personnel with understanding diversion and treatment options for individual Class Members in order to support the entry of criminal court orders that may divert Class Members from the forensic mental health system.
- (4) When a criminal court enters an order directing a criminal defendant to receive restoration services on an outpatient basis, the forensic navigator shall provide services to the criminal defendant ordered to community outpatient restoration, who shall be a client of the forensic navigators. These services will include:
  - (a) Assisting the client with attending appointments and classes related to outpatient competency restoration.
  - (b) Coordinating access to housing for the client.
  - (c) Meeting individually with each client on a regular basis.
  - (d) Performing outreach as needed to stay in touch with clients.
  - (e) Providing information to the criminal court concerning the client's progress and compliance with the court ordered conditions of the client's release. This may include appearing at criminal court hearings to provide information to the criminal court.

- (f) Coordinating client access to community case management services, mental health services, and follow up.
  - (g) Assisting clients with obtaining and encouraging adherence to prescribed medication.
- (5) The forensic navigator's services to the criminal defendant shall conclude as follows:
- (a) If, after the navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does not order the criminal defendant into community outpatient restoration services, the role of the forensic navigator shall end. The forensic navigator may facilitate a coordinated transition as described below if the circumstances warrant such coordination.
  - (b) If, after the forensic navigator has advised the criminal court as described in § III.B.3.a.(3) above, the criminal court does order the criminal defendant into community outpatient restoration services, the forensic navigator shall:
    - 1) Prior to the conclusion of community outpatient restoration services, facilitate a coordinated transition of the criminal defendant's case to a case manager in the community mental health system.
      - a) The standards for this coordinated transition shall be established through the use of care

coordination agreements, or some similar agreement. To support these coordinated transitions, the forensic navigator shall attempt to follow up with the client to check whether the meeting between the client and community-based case manager took place, or when the client is an identified high utilizer, the forensic navigator shall attempt to connect the client to high utilizer services.

- b) To support this coordinated transition, the forensic navigator will also attempt to check in with the Class Member at least once per month, for up to 60 days, but during this time, the client shall not count towards the navigator's caseload. The navigator will not duplicate the services provided by the community based case manager, but if the navigator believes the coordinated transition is not likely to be successful, the forensic navigator will follow up as appropriate.

- 2) In cases where a criminal defendant regains competency, is found guilty and is sentenced to serve a term of imprisonment in jail or prison, has criminal

charges dismissed pending a civil commitment hearing, enters or returns to jail due to a revocation of the community outpatient restoration order or the filing of new criminal charges, receives a new or amended order directing inpatient admission for restoration, or declines further services after the court ordered restoration treatment ends, the forensic navigator shall create a summary of treatment provided during community outpatient restoration, including earlier identified diversion options for the individual. Through training and technical assistance, the State will encourage third parties, including jails or prisons where a former Class Member is serving a sentence, to request this summary and related treatment records, as allowed by Wash. Rev. Code § 10.77.210.

- (c) In other situations not contemplated by this Agreement, the State shall use its discretion in deciding when to end forensic navigator services, and how to accomplish a coordinated transition.
- (6) A forensic navigator caseload will not exceed twenty-five Class Members at any given time.

4. Additional Forensic Bed Capacity

a. The State will open additional forensic beds at Western State Hospital and Eastern State Hospital, pursuant to existing funding authorized in the 2018 capital budget. The projected availability of additional forensic beds is as follows:

(1) Develop two forensic wards at Eastern State Hospital by December 31, 2019 (25 beds each for total of 50 beds)

(2) Convert two Western State Hospital civil geriatric wards to two forensic wards by December 31, 2019 (21 beds each for a total of 42 beds)

b. If the State is unable to open the beds in accordance with the projected schedule above, the State shall provide notice to the Executive Committee that additional time is needed, including the projected delay, and the reasons for the delay. This notice shall allow the State an additional six months of time to open the beds. If the State needs additional time beyond this six-month period, the State may request a further extension of time from the Court.

5. Closure of Maple Lane and Yakima

a. In the event wait times for Class Member admission for inpatient competency services reach a median of 13 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Yakima Competency Restoration Program. The Yakima Competency Restoration Program will close, notwithstanding the median wait times

described in this paragraph, no later than December 31, 2021. Failure to close the Yakima Competency Restoration Program by December 31, 2021 constitutes a material breach of this Agreement.

- b. In the event wait times for Class Member admission for inpatient competency services reach a median of 9 days or less for four consecutive months, based on mature data, the State will begin ramp down of the Maple Lane Competency Restoration Program. The Maple Lane Competency Restoration Program will close, notwithstanding the median wait times described in this paragraph, no later than July 1, 2024. Failure to close the Maple Lane Competency Restoration Program by July 1, 2024 constitutes a material breach of this Agreement

**C. Crisis Triage and Diversion Supports**

1. Crisis Triage and Diversion Capacity:
  - a. During Phase One of this Agreement, the State will seek funding to increase overall capacity for crisis stabilization units and/or triage facilities by 16 beds in the Spokane Region. These beds will address both urban and rural needs. During Phase One of this Agreement, the State will seek to make funds available for enhancements to similar existing or currently funded facilities in the Southwest and Pierce Regions, subject to the identification of appropriate enhancements by community providers in the Southwest and Pierce Regions.
  - b. In Phase One, the State will assess the need for Crisis Triage and Stabilization capacity for Phase Two Regions, and any gaps in existing

capacity in Phase One Regions, and will report the same to the General Advisory Committee. The report will identify existing resources in the Phased Regions, and will include a plan to increase capacity in the Phased Regions. The State will seek funding to increase capacity in accordance with this plan and the schedule set out in § IV.A and the implementation plan in § IV.D. This process will repeat for subsequent phases.

**2. Residential Supports for Crisis Triage and Diversion**

- a. The State will seek funding to provide short-term housing vouchers to be deployed throughout Crisis Triage and Stabilization Facilities. These short-term vouchers will be disbursed in accordance with the phased schedule set forth in § IV.A. These short-term vouchers will:
  - (1) Be disbursed by the Crisis Triage and Stabilization Facilities, based on a clinical assessment of need.
  - (2) The initial housing voucher will cover up to a maximum of 14 days.
  - (3) At the discretion of the crisis triage and stabilization provider, the short-term housing voucher may be extended up to an additional 14 days.
- b. The State will seek funding to create residential support capacity associated with the community outpatient competency restoration program in each Region. These Residential Supports will be implemented in accordance with the phased schedule set forth in § IV.A. In addition to the short-term vouchers described in § III.C.2.a. above, this residential support capacity must offer housing support options that are designed to target individuals



who are clinically-assessed to need more intensive support and stability immediately following discharge from Crisis Triage and Stabilization Facilities. These Residential Supports are intended to provide an individual with a better chance of remaining stable while awaiting more permanent housing solutions, including but not limited to the HARPS program.

(1) Individuals eligible to use this residential support capacity will meet all of the following criteria:

- i. Have had at least one prior contact with the forensic mental system in the past 24 months, or, were brought to a Crisis Triage or Stabilization Facility via arrest diversion under Wash. Rev. Code § 10.31.110 as determined by the crisis triage and stabilization provider;
- ii. Need assistance accessing independent living options and would benefit from short term housing assistance beyond the 14-day vouchers;
- iii. Are diagnosed with an acute behavioral health disorder and are assessed to need housing support beyond what is offered through the Crisis Triage and Stabilization Facilities or the short term voucher as described in § III.C.2.a;
- iv. Are Unstably Housed;
- v. Are not currently in the community outpatient competency restoration program, and;

- vi. Do not meet Involuntary Treatment Act (Wash. Rev. Code 71.05) commitment criteria.
- (2) The State shall seek funding to add 10% more Residential Supports as described in § III.C.2.b to the community outpatient restoration program in each Region, with the 10% capacity to be used for this population. In Phase One, the Parties project that the anticipated capacity at any given time will be five individuals in the Pierce Region, three individuals in the Southwest Region, and two individuals in the Spokane Region.
- (3) The HARPS housing support program shall also be made available to individuals within this population, for individuals clinically-assessed to benefit from the HARPS program.
- (4) When high utilizers, as defined in § III.C.4.a., are identified through their use of the crisis triage and diversion system, they shall be provided access to the Residential Supports and services as described in § III.C.2.b above.

**3. Mobile Crisis and Co-responder Response Programs**

- a. The State will seek funding for Co-Responder Programs as follows:
  - (1) The State shall seek funding to provide law enforcement agencies with dedicated qualified mental health professionals to assist officers in field response to promote diversion of people experiencing behavioral health crisis from arrest and incarceration.

- (2) The Parties appreciate the leadership and affirmative efforts taken by the Legislature and the WASPC in establishing a mental health field response team program as described in Wash. Rev. Code § 36.28A.440. The Parties wish to build upon programs like these. Therefore, in the 2019-2021 biennium, the State shall seek \$3 million in additional funding to expand the mental health field response program administered by WASPC pursuant to HB 2892 for the purpose of implementing or expanding response team programs in law enforcement or behavioral health agencies located in the Phase One Regions. In the event WASPC determines that the sum appropriated exceeds the needs of these three Regions during Phase One, WASPC may disburse some grant funding to support Phase Two implementation, including law enforcement or behavioral health agencies located in King County. The failure to secure \$3 million in funding to expand Wash. Rev. Code § 36.28A.440 program grants as set forth in this paragraph shall not be deemed a material breach. § V.A.2 does not apply to this paragraph.
- (3) The State's implementation plan, as described in § IV.D., shall describe how the State will support and encourage the integration of these programs into the reforms contemplated by this Agreement.

- (4) During Phase One of this Agreement, the State shall perform an assessment of law enforcement agency co-responder mental health staffing needs in order to guide future funding requests.
  - (5) If, during the implementation of this Agreement, it becomes apparent that WASPC has not been appropriated funds for, or is otherwise unable to administer the Co-Responder Program in a manner consistent with, the phased implementation schedule outlined in § IV.A, the Executive Committee will meet and develop recommendations for future action by the Parties regarding use of co-responder programs.
- b. The State will seek funding for Mobile Crisis Response (“MCR”) behavioral health services as follows:
- (1) The State will seek funding to increase MCR services to respond to people experiencing behavioral health crisis in the community. The State will request a plan for the provision of MCR services in each Phased Region, as required by the phased schedule identified in § IV.A. The State will seek funding for MCR services for each Phased Region. This process will be designed to create flexibility that will allow each Phased Region to tailor this resource to meet their local needs.
  - (2) Each Phased Region will be asked to propose new MCR service resources within their Region, including proposing the numbers, credentialing, and location of mental health professionals. Each

regional plan will be tailored to meet the urban and rural needs of the individual Region, considering the need for timely response throughout the entire Region.

(3) The regional plans, and the resulting contracts for services, will require that providers make available MCR services on a twenty-four (24) hour, seven (7) day per week basis that may be accessed without full completion of intake evaluations and/or other screening and assessment processes. The State will request a recommendation from WASPC and regional MCR providers as to reasonable response times in each Phased Region. In the regional plans and the resulting contracts for services, the contracting entities will include response time targets, after considering the WASPC and regional MCR providers' recommendations. During Phase One, the State will institute reporting requirements to gather data on response times of MCR services. In subsequent phases, the Parties will use this data to inform future funding requests, and possible contractual requirements to meet response time targets.

c. Co-response teams of law enforcement and mental health professionals will be encouraged to rely on MCRs to accept individuals they have identified as needing mental health services, including people eligible for mental health diversion pursuant to Wash. Rev. Code § 10.31.110.

- d. The State will seek funding to cover reasonable administrative costs requested by WASPC to enable it to meet the requirements of § III.C.3.a.2 and § III.C.3.b.3 above.

**4. Intensive Case Management Program for High Utilizers**

- a. The State is developing a model to identify those most at risk of near-term referral for competency restoration. This identified population shall be referred to as high utilizers. The model is designed to identify persons who are likely to be referred for a competency service within the next six months.

The model will use available data and include factors such as:

- (1) Prior referrals for competency evaluation;
  - (2) Prior referrals for competency restoration;
  - (3) Prior inpatient psychiatric treatment episodes;
  - (4) Criminal justice system involvement, and;
  - (5) Homelessness.
- b. In the semi-annual reports required under § IV.B.14, the State will report on whether or not the model is effective in identifying persons who are likely to be referred for a competency service in the next six months, and the status of outreach to identified high utilizers. This report shall be reviewed by the Oversight and Advisory Committees outlined in § IV.B., and the Executive Committee may make recommendations regarding adjustment of the model.

- c. The services provided to this group shall include:
  - (1) Whenever an identified high utilizer is referred for competency evaluation, they shall be offered intensive case management services.
  - (2) The intensive case management program will be developed with a phased implementation as outlined in § IV.A that adheres to the following principles:
    - (a) The program will not duplicate services offered through health and behavioral health benefits provided under other programs, but will leverage services otherwise available and enhance the services available to the high utilizer.
    - (b) The program will have the ability to provide case management services for individuals who have significant barriers to accessing behavioral health and community supports.
    - (c) The initial participation period in the program for each individual will be six months.
- d. Program services may be provided through community behavioral health agencies through direct contracts with the State. During the initial participation period, the program shall offer:
  - (1) Funding for engagement activities for those meeting the high utilizer definition.

- (2) Housing supports, using the HARPS model, which includes:
    - (a) Securing and maintaining housing,
    - (b) Peer support,
    - (c) Rent or other housing support subsidies, in the amount of up to \$1200 per month for up to six months.
  - (3) Transportation assistance.
  - (4) Training on accessing resources and other independent living skills.
  - (5) Support for accessing healthcare services and other non-medical services.
- e. The case management program will include an outreach and engagement activities component for those currently identified as high utilizers, which may occur outside the context of a competency referral.

**D. Education and Training**

- 1. Crisis Intervention Training (CIT)
  - a. The State will seek funding to strengthen and expand behavioral health crisis training for law enforcement and corrections officers. At a minimum:
    - (1) The State shall seek funding to offer the 40 hour enhanced CIT course, to reach a target of 25% of officers on patrol duty in each law enforcement agency within the Phased Regions. The funding will be modeled after the existing funding model used by CJTC, including the current model for any backfill costs, which assumes a State contribution for 16 hours of backfill costs, out of the 40 hours. The 25% target will be measured as reported by CJTC. This target



may be limited by CJTC's ability to offer the necessary number of courses during each phase, so long as the reason is not strictly the unavailability of funding. If CJTC offers a training different from the 40 hour enhanced CIT course, the Parties may mutually agree that this training may count towards satisfying this target. Whenever possible, the State shall ensure that the agencies serving the areas of highest population density in the Phased Regions meet this training target before other agencies with lower population density.

- (2) The State shall seek funding to ensure that corrections officers and 911 dispatchers employed by governmental entities within each Phased Region, except those employed by the Washington State Department of Corrections or Federal entities, receive at least eight hours of CIT provided by CJTC, or by an entity approved by CJTC for this purpose.
  - (3) In the semi-annual report, the State shall include data from CJTC on completion rates of training, and barriers to local jurisdictions to attending the training.
- b. The State and Plaintiffs' counsel will invite WASPC and CJTC to meet and discuss how to better deliver behavioral health crisis training to officers employed by agencies with ten or fewer officers on staff.
  - c. All training efforts described in this section will be made in accordance with the phased implementation schedule set forth in § IV.A.

2. Technical Assistance

- a. The State will seek funding for state or contracted resources to develop and provide educational and technical assistance to jails. These efforts will be made in accordance with the phased implementation schedule set forth in § IV.A. The State will include the involvement of peer support specialists in providing this educational and technical assistance.
- b. The State will work with Washington's designated Protection and Advocacy System (as designated in Wash. Rev. Code § 71A.10.080), law enforcement entities and associations, and peer support specialists to develop guidance on mutually agreeable best practices for diversion and stabilization of Class Members and potential Class Members in jail during Phase One of this Agreement. To develop this guidance, initial best practices will be proposed by the State, and reviewed and approved by Washington's designated Protection and Advocacy System.
  - (1) These best practices will at minimum address pre and post-booking diversion, identification of need and access to treatment, guidelines for administration of involuntary medication, continuity of care, use of segregation, and release planning.
  - (2) In delivering education and technical assistance to jails, the State will develop a plan to proactively engage all jails in the State of Washington, in accordance with the phased implementation schedule set forth in § IV.A. This shall involve offering on-site

trainings to jails and a standard method for jails to seek technical assistance and receive timely responses.

- c. The State may leverage the existing training and technical assistance work of law enforcement entities and associations, as appropriate.

**E. Workforce Development**

1. Enhanced Peer Support Specialists

- a. The State will develop an enhanced Peer Support Program for individuals that includes specialized training in criminal justice. This program will include individuals participating in the core curriculum, and then participating in the specialized enhanced program for criminal justice. The State will provide ongoing training for enhanced peer support specialists and targeted training and support to assist with establishing these positions in programs purchased by the State.
- b. The State will encourage the use of this enhanced Peer Support Program by integrating the enhanced peer role into the systems developed throughout this Agreement. The Department recognizes the challenges in employing peers with criminal justice lived experience, but is supportive when the nature of that past experience makes them an appropriate candidate for working with individuals with mental illness. This includes the use of enhanced peer support specialists in the intensive case management program (§ III.C.4.), the community outpatient competency restoration program (§ III.B.2), and the HARPS program (§ III.C.4.d.(2)). The State

will explore whether it is feasible to obtain any federal funding for enhanced peer support specialists, to encourage the wider use of this role.

2. Workforce Development; Degree and Certification Programs

a. The State will seek funding to hire, or contract with, workforce development specialists. The positions will be assigned to specific workforce functional areas to include:

- (1) Community, including crisis response, homeless, in-home, residential, and clinic based services,
- (2) In-patient, including residential treatment facilities, private hospitals, and state hospitals,
- (3) Law enforcement and corrections, including jails and prisons.

b. Workforce development specialists may conduct or manage the following duties:

- (1) Participate in workforce development workgroups with stakeholders such as state hospitals, community healthcare organizations, law enforcement, and jails;
- (2) Conduct training needs surveys/gaps analysis;
- (3) Assist in the development of a master training plan(s);
- (4) Develop and coordinate training including standardized training manuals and guidelines;
- (5) Collaborate with other community-based, organizational workforce development staff;
- (6) Conduct training program(s) evaluations; and

- (7) Other duties as assigned at the sole and exclusive discretion of the State.
- c. The functions and duties outlined in this subsection may be implemented with direct hiring, contracting, or any combination thereof.
  - d. The workforce development specialists may collaborate with other workforce development efforts (for example, the workforce development efforts of the Economic Services Administration), as appropriate.
  - e. The State will produce a report annually describing the activities of the workforce development specialists outlined in this subsection, and making recommendations about the specific workforce development steps necessary to ensure success of this Agreement. The State will distribute this report to key and interested legislators. This report will also be distributed to the Executive Committee, and that Committee shall consider whether to adopt those recommendations for possible inclusion in future phases of the Agreement. The annual schedule for this report shall be set as to align with the phased approach of this Agreement, and to allow for consideration of the Executive Committee's recommendations in the established state budget process.
  - f. The State will assess the need and target areas for training programs, certification programs, and possible degree programs. The State may collaborate with colleges, including community and technical colleges, and universities to accomplish this task, but shall also have discretion to

accomplish this task through other means. This assessment shall include, but not be limited to, the following elements:

- (1) Existing training, certifications, and degree programs in Washington for relevant professions; for example, nursing, psychiatry, psychology, counseling, law enforcement, or other professions determined at the discretion of the State.
  - (2) Programs for relevant professions in other states.
  - (3) Statewide staffing needs for all programs covered by this Agreement for a period of the subsequent ten years.
- g. Upon completion of the assessment in § III.E.2.f. above, the State shall produce a report regarding that assessment that may be shared with appropriate committees of the Legislature. The report will include:
- (1) High, medium, and low cost recommendations, and
  - (2) Long, medium, and short term recommendations for future action regarding training and certification programs.
- h. While the State shall pursue the elements outlined this subsection in good faith, the State is not required to establish new degree or certification programs pursuant to this Agreement.
- i. In addition to the requirements outlined in § III.E.2.a-h. above, the State will make all reasonable efforts to fill the positions required to timely implement all phases of this Agreement, as outlined in § IV.A. Reasonable efforts may include the use of incentives.

#### **IV. PHASING, OVERSIGHT, AND IMPLEMENTATION**

##### **A. Phased Implementation**

1. The Parties agree that the implementation of the programs and services described in this Agreement shall occur in phases. In each phase, the State will focus its efforts toward specifically identified and agreed upon Regions for each of the elements outlined in this Agreement. The Parties have agreed to at least three phases for purposes of implementation, which will run parallel to the Legislative biennia beginning with the 2019-2021 biennium. The Parties agree to the phased roll out to specific Regions as follows:
  - a. Phase One: the State will focus implementation efforts in the Southwest, Spokane and Pierce Regions. This phase will run parallel with the 2019-2021 biennium.
  - b. Phase Two: the State will focus implementation efforts in the King Region. This phase will run parallel with the 2021-2023 biennium.
  - c. Phase Three: the Parties agree there will be a review of the progress during the 2021-2023 biennium of the Phase One and Two Regions. The Executive Committee will then make a decision as to whether the State should a) expand or modify the programs in Phases One and Two for purposes of Phase Three; or b) if Phase One and/or Two have been successful, identify and focus efforts in new high-referral Regions for purposes of Phase Three; or c) some combination of the above.
  - d. Following Phase Three: The Executive Committee will determine as to whether the State should expand or modify programs in additional Regions

through the phasing process. This process shall continue until the termination of this Agreement.

2. In order to begin implementation in each of the Phased Regions as quickly as possible, upon approval of the Agreement the Parties agree to immediately seek approval from the Court to use contempt fines to staff project managers for the identified Regions in Phase One and Two, as well as a single administrative support position to support these project managers. The Parties shall also seek approval from the Court to use contempt fines to provide the funding necessary to begin development of components of this Agreement, which may include housing supports, provision of case management, high utilizer supports, and outreach and communications regarding implementation of the Agreement, as agreed upon by Parties. The use of contempt fines for this purpose is not meant to supplant or otherwise modify the State's obligations under this Agreement to seek funding for and implement programs and changes described in this Agreement, but instead to ensure that the implementation of Phase One may begin as quickly as possible and that elements of the Agreement have the best chance of overcoming unforeseen funding and implementation challenges. Disbursement of the fines will occur upon Final Approval of this Agreement by the Court.

**B. Oversight and Advisory Structure**

1. Defendants will use a sustainable oversight structure to inform and provide supervision for high-level policy-making, planning, and decision-making on targeted issues, and for the implementation of this Agreement. A description of this structure is set forth below.



2. The Parties agree to the appointment of a General Advisory Committee to be comprised of the Court Monitor, DSHS, HCA, Governor's office, OFMHS, and Plaintiffs' counsel, and the Parties agree to invite several representatives from local partners to join the General Advisory Committee, to include, but not limited to:
  - a. A Judge Representative
  - b. A Prosecutor Representative
  - c. A Defender Representative
  - d. Behavioral health treatment program Representative
  - e. A Housing Provider Representative
  - f. A Consumers and families Representative
  - g. A Law Enforcement Representative and/or a CJTC Representative
  - h. A Jail Representative
  - i. Plaintiffs' Counsel Representative(s)
  - j. Court Monitor Team Representative
  
3. The General Advisory Committee's main purpose shall be to provide local community feedback, to flag issues, to review data and outcomes, and to make recommendations at specific decision points during the implementation of this Agreement. The General Advisory Committee will be a consulting body to the Executive Committee, but will not be tasked with decision-making or making contact with the Court. Any recommendation of the General Advisory Committee shall be reviewed and considered by the Executive Committee. The General Advisory Committee shall be specifically empowered to make recommendations to the Executive Committee on the following decisions:

- a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should focus on the expansion or modification of services in the Regions included in Phases One and Two, or some combination thereof.
  - b. Identification of areas or issues of concern in the implementation of the Agreement based on stakeholder feedback.
  - c. Reviewing implementation reports and implementation data, and based on that review, making recommendations for changes or modifications based on areas or issues of concern that have been identified in implementation.
4. There will also be a smaller Executive Committee that will be tasked with making decisions and ultimate recommendations to the Court. This Committee shall be composed of representatives from DSHS, OFMHS, HCA and Plaintiffs' counsel. The Executive Committee may elect to consult with others outside of the Executive Committee by agreement.
5. The Executive Committee shall be specifically empowered to make decisions regarding items 5.a., 5.c., and 5.d. below. The Executive Committee will make agreed upon recommendations to the Court regarding 5.b. below.
  - a. The nature of the Phase Three implementation as outlined in this Agreement, as contemplated in § IV.A.1.c. This includes whether Phase Three should proceed to expand into Regions not included in Phases One and Two, or whether Phase Three should instead be focused on the

- expansion or modification of services in the Regions included in Phases One and Two.
- b. Changes or modifications based on areas or issues of concern that have been identified in implementation.
  - c. Overseeing the commission of the semi-annual implementation reports and data collection. The Executive Committee may elect to expand or modify the elements for data collection beyond those expressly identified in this Agreement.
  - d. Whether the State should expand or modify programs in additional Regions through the phasing process beyond Phase Three. This process shall continue until the termination of this Agreement.
6. If the Executive Committee is unable to reach consensus on a particular issue, they may engage the use of an agreed upon neutral to resolve the issue. Issues not resolved through a neutral may be presented to the Court for consideration. This process is distinct from the process described regarding material breach below in § IV.C.
  7. Each identified entity on the Executive Committee will be solely responsible for choosing its representative(s) to the Executive Committee.
  8. Defendants are empowered to (1) provide guidance to state agencies and the Parties about implementation and (2) make decisions regarding the implementation of the Agreement not otherwise identified for review by the General Advisory Committee or Executive Committee.

9. The local partner representatives on the General Advisory Committee will be appointed as determined by the Executive Committee. The Executive Committee will also determine whether to make fixed term appointments or to rotate invitations.
10. The General Advisory Committee will meet quarterly. Twice per year the quarterly meeting will be focused on gathering input from stakeholders and community partners. Twice per year the quarterly meeting will be focused on reviewing the semi-annual report and data. This does not limit what may be covered in any quarterly meeting, but simply gives guidance on each meeting's focus.
  - a. General Advisory Committee meetings shall be convened in person and via WebEx or a similar remote participation option.
11. The Executive Committee will meet quarterly in alignment with the General Advisory Committee. The Executive Committee may also meet on an as needed basis, and may be convened by the Court Monitor or by majority agreement of the Executive Committee.
  - a. Executive Committee meetings shall be convened in person, via WebEx, or via a similar remote participation option.
12. The Parties may also meet with stakeholders independently on an as needed basis.
13. The General Advisory Committee will be supported by OFMHS, the Trueblood project manager, and Research and Data Analysis within DSHS.
  - a. The Trueblood project manager will create a project plan, manage the General Advisory Committee and its meetings, and manage and schedule the Executive Committee meetings.

- b. The regional project managers will support implementation of this Agreement through efforts such as support through technical assistance, outreach, trainings, summits, and education to local communities. These efforts shall be made in accordance with the phased implementation schedule in § IV.A. This may include incorporation of and cooperation with any work being done in support of the Trueblood Diversion Programs.
  - c. The State will support data collection and analysis. Data points for analysis shall be included in the implementation plan described below in § IV.D. Data points will be reviewed and refined over time based on the recommendations of the Executive Committee.
  - d. The raw data gathered pursuant to this Agreement shall be made publically available to the extent permitted by law.
14. The State shall produce a monitoring report semi-annually. This report shall include, at a minimum:
- a. Data reporting as described throughout this Agreement
  - b. Data analysis of the various data elements
  - c. Updates on the status of the phase programs, based on each of the elements outlined in the Agreement
  - d. Areas of concern or struggle in implementation
  - e. Areas of positive impacts or programming in implementation
  - f. Recommendations for addressing areas of concern or struggle

**C. Dispute Resolution**

1. Where one Party believes that the other Party is in material breach of the Agreement, the Parties shall engage the Executive Committee in a good faith effort to resolve the allegation of material breach.
2. This process shall be initiated by one Party sending written notice to the other Party that they believe the Party has materially breached the Agreement. The written notice shall specify the section of the Agreement that the Party believes has been materially breached, and explain in detail how that section has been materially breached, and specify the facts and information that support the conclusion.
3. Within ten days, the responding Party shall provide a written response. This written response shall respond to each allegation of material breach, and explain in detail the responding Party's position on the alleged breach, and specify the facts and information that support that position.
4. Upon receipt of the written response, the Parties shall schedule a time to meet and confer within three business days in order to determine if the written response resolves the allegation of material breach.
5. If the allegation of material breach is not resolved by the written exchange and the subsequent meet and confer, the Parties shall schedule a mediation session with an agreed upon neutral. The mediation session must be held within 14 days, unless this timeline is modified by an agreement of the Parties, or if the Parties are unable to secure the services of an agreed neutral within that timeframe.
6. If, after completion of the mediation, the Parties have not resolved the allegation of material breach, the Party alleging a breach may seek relief from the Court.

7. At each of the identified steps regarding material breach, the opportunity to cure any alleged breach shall be considered.

**D. Implementation Plan and Process Commitments**

1. Defendants will develop an implementation plan beginning on the date the Court gives its Preliminary Approval of the Agreement. A preliminary plan to lay the foundation for implementation and overall planning will be completed within 90 days after the Court gives its Final Approval of this Agreement. A final implementation plan, which accounts for any funding or legislative changes accomplished by the Legislature in the 2019 session will be completed within 60 days from the end of the 2019 Legislative session. Certain tasks related to the implementation within each Region may be reserved to the project management plans to be implemented by each regional project manager.
2. Defendants will develop the preliminary and final implementation plans using input from Plaintiffs' Counsel and the Court Monitor. The implementation plan will:
  - a. Identify and sequence tasks necessary to fulfill the commitments and ultimately achieve the exit criteria;
  - b. Consider estimates produced by the TriWest Bed Flow Analysis, if available;
  - c. Set clear and accountable timelines through the termination of this Agreement;
  - d. Assign responsibility for achieving each task to the appropriate agency or entity;

- e. Describe how reporting processes shall be established to report on the data elements specified under this Agreement, as well as the development of the ongoing implementation reports;
  - f. Develop collaboration models for regional project managers and regional implementations to problem-solve challenges encountered; and
  - g. Describe the communication and outreach activities to inform the community, stakeholders, and policy makers about the access to services and processes described in this Agreement, including development of documentation that provides sufficient information to explain the purpose of and use of services established by this Agreement, and encourage use of those services.
3. Defendants will submit to the Court for approval the preliminary and final implementation plans, which shall describe how the Defendants will fulfill the commitments of this Agreement.
  4. Defendants will comply with the implementation plan that is approved by the Court, and any amendments, pursuant to this Agreement.
  5. The Parties will repeat this process for creating a final implantation plan for each future Phased Region during subsequent phases of the Agreement.

## **V. COMPLIANCE AND TERMINATION**

### **A. Contempt Mitigation and Substantial Compliance**

1. Assuming the Court's Final Approval of this Agreement, contempt fines will be suspended beginning December 1, 2018. The fines will continue to be calculated,



but no payment on those fines shall be made. The suspended contempt fines shall be calculated using the current rates under the existing Court orders.

- a. At the end of each phase, if the State is in substantial compliance, all suspended fines will be waived.
2. If the funding made available for this Agreement is inadequate to implement the identified elements during any phase, this will constitute material breach. In considering whether funding is inadequate, funds available from third party sources shall be considered, and supplemental budget requests made during any phase shall also be considered. No allegation of material breach based on inadequate funding may be made until after the completion of the 2019 Legislative Session.
3. Given the scope and breadth of this Agreement, the Parties agree that a material breach of a particular element does not necessarily constitute material breach of the entire Agreement, unless otherwise specified herein. For purposes of this Agreement, and unless otherwise specified herein, "material breach" is defined as a failure to be in "substantial compliance" with the Agreement, and substantial compliance means something less than strict and literal compliance with every provision of this Agreement. Rather, deviations from the terms of the Agreement may occur, provided any such deviations are unintentional and minor, so as not to substantially defeat the object which the Parties intend to accomplish, or to impair the structure of the Agreement as a whole. This Agreement is a product of extensive work with stakeholders and input from experts in their fields. It is an informed and thoughtful estimation of the best plan to resolve the ongoing constitutional crisis before the Court. However, the Parties recognize and acknowledge the need for

flexibility in developing the comprehensive changes proposed, and that the purpose and intent of each element could be achieved by alternative methods. The Parties further agree to give due consideration to the totality of any decisions or actions taken by the Legislature in implementing this Agreement to determine if the spirit of the Agreement, if not the letter, has been upheld before pursuing an allegation of material breach for any element that does not specifically identify what constitutes material breach.

4. Plaintiffs agree to engage in an ordered process in order to raise any allegation of material breach under this Agreement. The process is more fully described in § II.B.6 of the Oversight and Advisory Structure section, but at a minimum this will include (1) bringing the allegation to the attention of the Executive Committee for possible resolution, (2) engaging in a mediation session with an agreed upon neutral, and then (3) if the issue cannot be resolved, by bringing a motion in Court to seek payment of suspended fines, restart contempt fines, increase future contempt fines, or any other appropriate relief.
  - a. If suspended fines are ordered to be paid by the Court, a reasonable schedule shall be set by the Court for payment of the suspended amount on an installment basis. The first installment payment of the suspended amount shall be made at the earliest opportunity after the Legislature has an opportunity to make an appropriation for this purpose.
  - b. In assessing suspended contempt fines due to a finding of material breach, the Court may look to the magnitude and impact of any such breach to determine if a lesser or more proportionate sanction is appropriate.

**B. Termination**

1. This Agreement terminates when Defendants demonstrate substantial compliance with the following requirements:
  - a. Completed evaluations for Class Members ordered to receive in-jail evaluations are filed with local criminal courts within the shorter of
    - a) 14 days of the in-jail evaluation order being received by Defendants, or
    - b) 21 days of the criminal court ordering the in-jail evaluation;
  - b. Admission for inpatient evaluation services for Class Members ordered to receive inpatient evaluations within the shorter of a) 7 days of the inpatient evaluation order being received by Defendants or b) 14 days of the criminal court ordering the inpatient evaluation;
  - c. Admission for inpatient restoration services for Class Members ordered to receive inpatient restoration within the shorter of a) 7 days of the inpatient restoration order being received by Defendants or b) 14 days of the criminal court ordering the inpatient restoration;
  - d. Substantial compliance with § V.B.1.a-V.B.1.c has been achieved for nine consecutive months, and evidence does not establish that the State will be unable to continue compliance with the Court's injunction. Alternatively, the State has achieved substantial compliance in 14 of 16 months, and evidence can establish that the two months where substantial compliance was not achieved are outliers. If inpatient evaluations have such a low volume of referrals in any given month as to make substantial compliance with that category hinge on a small number of cases, due consideration will

be given to the totality of compliance rather than looking only to the rate of compliance.

- (1) However, after six consecutive months of substantial compliance in any category, § V.B.1.a-V.B.1.c above, the State may request that certain obligations under this Agreement be suspended pending the full nine months of compliance.

## **VI. ADDITIONAL PROVISIONS**

### **A. Contempt**

Nothing in this Agreement shall be deemed to limit the Court's powers of contempt or any other power possessed by the Court.

### **B. Individual Rights**

Nothing in this Agreement shall be deemed to limit the ability of any individual Class Member to obtain individual relief of any kind to which they would otherwise be entitled under state or federal law other than for the claims for systemic injunctive relief adjudicated by this action.

### **C. Protection and Advocacy Acts**

Nothing in this Agreement shall be deemed to limit the ability of Disability Rights Washington (DRW) to fulfill its federal mandates pursuant to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801, *et seq.*, and the regulations promulgated thereto, 42 C.F.R. § 51 *et seq.*, the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. §15041, *et seq.*, and the regulations promulgated thereto, 45 C.F.R. § 1386 *et seq.*, and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.

**D. Terms of Agreement**

This Agreement contains all the terms and conditions agreed upon by the Parties. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Parties hereto.

The Parties have participated, and had an equal opportunity to participate, in the drafting and approval of drafting of this Agreement. No ambiguity shall be construed against any Party based upon a claim that the Party drafted the ambiguous language.

**E. Authority to Bind**

Signors of this Agreement represent and warrant they have full power and authority to enter into this Agreement and to carry out all actions required of them to the extent allowed by law. Each of the signors warrants that he/she has fully read and agrees to all the terms and conditions contained herein.

**F. Modifications**

Distinct from the process set forth in the Oversight and Advisory structure section, § II.B.5, this Agreement may be amended by mutual agreement of the Parties and approval of the Court. In order to be binding, such amendments must be in writing, signed by persons authorized to bind each of the Parties, and approved by the Court. The Parties further agree to work in good faith to obtain Court approval of necessary amendments or modifications.

**G. Waiver**

The provisions of this Agreement may be waived only by an instrument in writing executed by the waiving Party and approved by the Court. The waiver by any Party of any breach of this Agreement shall not be deemed or be construed as a waiver of any other breach, whether prior, subsequent or contemporaneous of this Agreement.

**H. Severability**

The provisions of this Agreement are severable. If any court holds any provision of this Agreement invalid that invalidity shall not affect the other provisions of this Agreement.

**I. Successors**

This Agreement shall inure to the benefit of and be binding upon the legal representatives and any successor(s) of Plaintiffs and Defendants.

**J. Non-Waiver of Arguments and Issues**

This Agreement represents a compromise of the issues addressed herein. Neither party waives the right to assert legal or factual arguments in any future dispute arising during the term of this Agreement, or in the event that the Agreement ends, terminates, or becomes null and void, for any reason.


**K. Effect of Court Denying Motion to Approve**


If, for any reason, the Court does not ultimately approve this Agreement as a fair, reasonable, and adequate settlement of the Trueblood litigation as between the Plaintiffs and Defendants, this Agreement shall be null and void.


**L. Execution**


This Agreement may be executed in counterparts, each of which will be deemed to be an original and all of which taken together shall constitute a single instrument. This Agreement may be executed by signature via facsimile transmission or electronic mail which shall be deemed the same as an original signature.

**COUNSEL FOR PLAINTIFFS**


By:  Dated: 8/16/2018  
DAVID CARLSON, WSBA #35767  
Disability Rights Washington

By:  Dated: 8/16/2018  
KIM MOSOLF, WSBA #49548  
Disability Rights Washington

By:  Dated: 8/16/2018  
ALEXIA POLASKI, WSBA #52683  
Disability Rights Washington

By:  Dated: 8/16/2018  
CHRISTOPHER CARNEY, WSBA #30325  
Carney Gillespie Isitt PLLP

**FOR THE DEFENDANTS:**

By:  Dated: 8/16/2018  
CHERYL STRANGE  
Secretary  
Washington State Department of Social and Health Services

**COUNSEL FOR DEFENDANTS:**

By:  Dated: 8/16/18  
AMBER L. LEADERS  
Assistant Attorney General  
WSBA NO. 44421

By:  Dated: August 16, 2018  
NICHOLAS A. WILLIAMSON  
Assistant Attorney General  
WSBA NO. 44470

By:  Dated: 8/16/18  
RANDY C. HEAD  
Assistant Attorney General  
WSBA NO. 48039

CERTIFICATION OF ENROLLMENT

**ENGROSSED SECOND SUBSTITUTE SENATE BILL 5444**

Chapter 326, Laws of 2019

66th Legislature  
2019 Regular Session

FORENSIC MENTAL HEALTH CARE--COMPETENCY EVALUATIONS AND RESTORATION

EFFECTIVE DATE: July 28, 2019

Passed by the Senate April 24, 2019  
Yeas 48 Nays 0

CYRUS HABIB

**President of the Senate**

Passed by the House April 15, 2019  
Yeas 97 Nays 0

FRANK CHOPP

**Speaker of the House of Representatives**

Approved May 9, 2019 2:20 PM

JAY INSLEE

**Governor of the State of Washington**

CERTIFICATE

I, Brad Hendrickson, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SECOND SUBSTITUTE SENATE BILL 5444** as passed by the Senate and the House of Representatives on the dates hereon set forth.

BRAD HENDRICKSON

**Secretary**

FILED

May 13, 2019

**Secretary of State  
State of Washington**



---

**ENGROSSED SECOND SUBSTITUTE SENATE BILL 5444**

---

AS AMENDED BY THE HOUSE

Passed Legislature - 2019 Regular Session

**State of Washington**

**66th Legislature**

**2019 Regular Session**

**By** Senate Ways & Means (originally sponsored by Senators Dhingra, O'Ban, Darneille, Wagoner, Frockt, Kuderer, and Nguyen; by request of Office of the Governor)

READ FIRST TIME 03/01/19.

1 AN ACT Relating to providing timely competency evaluations and  
2 restoration services to persons suffering from behavioral health  
3 disorders within the framework of the forensic mental health care  
4 system consistent with the requirements agreed to in the Trueblood  
5 settlement agreement; amending RCW 10.31.110, 10.77.086, and  
6 10.77.088; adding a new section to chapter 10.77 RCW; and creating a  
7 new section.

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

9 NEW SECTION. **Sec. 1.** The legislature recognizes that there has  
10 been a nationwide increase in the number of individuals with  
11 behavioral health disorders in the criminal justice system. The  
12 legislature also recognizes that reforms must be made to our own  
13 behavioral health systems and services to meet the increasing demands  
14 in our state, to provide timely competency evaluations and  
15 restoration services, and to comply with federal court orders issued  
16 in *A.B., by and through Trueblood, et al., v. DSHS, et al.*, No.  
17 15-35462 ("Trueblood"). The legislature acknowledges that these  
18 reforms will require the support of a broad range of stakeholders,  
19 including local law enforcement, prosecuting attorneys, defense  
20 attorneys, community members, and health care providers. The  
21 legislature further acknowledges the significant efforts of the

1 parties to the Trueblood litigation to establish a roadmap and  
2 framework within their settlement agreement for proposed systemic  
3 reforms to the forensic mental health care system. It is the intent  
4 of the legislature to enact appropriate reforms consistent with the  
5 goals agreed to in the Trueblood settlement agreement, to continue to  
6 engage with stakeholders and community partners to address the needs  
7 of this vulnerable population, and to ensure that the public safety  
8 needs of our communities are met.

9 NEW SECTION. **Sec. 2.** A new section is added to chapter 10.77  
10 RCW to read as follows:

11 (1) Subject to the limitations described in this section, a court  
12 may appoint an impartial forensic navigator employed by or contracted  
13 by the department to assist individuals who have been referred for  
14 competency evaluation.

15 (2) A forensic navigator must assist the individual to access  
16 services related to diversion and community outpatient competency  
17 restoration. The forensic navigator must assist the individual,  
18 prosecuting attorney, defense attorney, and the court to understand  
19 the options available to the individual and be accountable as an  
20 officer of the court for faithful execution of the responsibilities  
21 outlined in this section.

22 (3) The duties of the forensic navigator include, but are not  
23 limited to, the following:

24 (a) To collect relevant information about the individual,  
25 including behavioral health services and supports available to the  
26 individual that might support placement in outpatient restoration,  
27 diversion, or some combination of these;

28 (b) To meet with, interview, and observe the individual;

29 (c) To present information to the court in order to assist the  
30 court in understanding the treatment options available to the  
31 individual to support the entry of orders for diversion from the  
32 forensic mental health system or for community outpatient competency  
33 restoration, and to facilitate that transition; and

34 (d) When the individual is ordered to receive community  
35 outpatient restoration, to provide services to the individual  
36 including:

37 (i) Assisting the individual with attending appointments and  
38 classes relating to outpatient competency restoration;

39 (ii) Coordinating access to housing for the individual;

1 (iii) Meeting with the individual on a regular basis;

2 (iv) Providing information to the court concerning the  
3 individual's progress and compliance with court-ordered conditions of  
4 release, which may include appearing at court hearings to provide  
5 information to the court;

6 (v) Coordinating the individual's access to community case  
7 management services and mental health services;

8 (vi) Assisting the individual with obtaining prescribed  
9 medication and encouraging adherence with prescribed medication;

10 (vii) Planning for a coordinated transition of the individual to  
11 a case manager in the community behavioral health system;

12 (viii) Attempting to follow up with the individual to check  
13 whether the meeting with a community-based case manager took place;

14 (ix) When the individual is a high utilizer, attempting to  
15 connect the individual with high utilizer services; and

16 (x) Attempting to check up on the individual at least once per  
17 month for up to sixty days after coordinated transition to community  
18 behavioral health services, without duplicating the services of the  
19 community-based case manager.

20 (4) Forensic navigators may submit nonclinical recommendations to  
21 the court regarding treatment and restoration options for the  
22 individual, which the court may consider and weigh in conjunction  
23 with the recommendations of all of the parties.

24 (5) Forensic navigators shall be deemed officers of the court for  
25 the purpose of immunity from civil liability.

26 (6) The signed order for competency evaluation from the court  
27 shall serve as authority for the forensic navigator to be given  
28 access to all records held by a behavioral health, educational, or  
29 law enforcement agency or a correctional facility that relates to an  
30 individual. Information that is protected by state or federal law,  
31 including health information, shall not be entered into the court  
32 record without the consent of the individual or their defense  
33 attorney.

34 (7) Admissions made by the individual in the course of receiving  
35 services from the forensic navigator may not be used against the  
36 individual in the prosecution's case in chief.

37 (8) A court may not issue an order appointing a forensic  
38 navigator unless the department certifies that there is adequate  
39 forensic navigator capacity to provide these services at the time the  
40 order is issued.

1       **Sec. 3.** RCW 10.31.110 and 2014 c 225 s 57 are each amended to  
2 read as follows:

3       (1) When a police officer has reasonable cause to believe that  
4 the individual has committed acts constituting a (~~(nonfelony)~~) crime  
5 (~~(that is not a serious offense as identified in RCW 10.77.092)~~), and  
6 the individual is known by history or consultation with the  
7 behavioral health organization, managed care organization, behavioral  
8 health administrative services organization, crisis hotline, or local  
9 crisis services providers to suffer from a mental disorder, in  
10 addition to existing authority under state law, as an alternative to  
11 arrest, the arresting officer (~~(may)~~) is authorized and encouraged  
12 to:

13       (a) Take the individual to a crisis stabilization unit as defined  
14 in RCW 71.05.020(~~(+6)~~). Individuals delivered to a crisis  
15 stabilization unit pursuant to this section may be held by the  
16 facility for a period of up to twelve hours. The individual must be  
17 examined by a mental health professional within three hours of  
18 arrival;

19       (b) Take the individual to a triage facility as defined in RCW  
20 71.05.020. An individual delivered to a triage facility which has  
21 elected to operate as an involuntary facility may be held up to a  
22 period of twelve hours. The individual must be examined by a mental  
23 health professional within three hours of arrival;

24       (c) Refer the individual to a mental health professional for  
25 evaluation for initial detention and proceeding under chapter 71.05  
26 RCW; or

27       (d) Release the individual upon agreement to voluntary  
28 participation in outpatient treatment.

29       (2) If the individual is released to the community, the mental  
30 health provider shall make reasonable efforts to inform the arresting  
31 officer of the planned release (~~(within a reasonable period of time~~  
32 ~~after the)~~) prior to release if the arresting officer has  
33 specifically requested notification and provided contact information  
34 to the provider.

35       (3) In deciding whether to refer the individual to treatment  
36 under this section, the police officer (~~(shall)~~) must be guided by  
37 (~~(standards)~~) local law enforcement diversion guidelines for  
38 behavioral health developed and mutually agreed upon with the  
39 prosecuting authority(~~(, which)~~) with an opportunity for consultation  
40 and comment by the defense bar and disability community. These

1 guidelines must address, at a minimum, the length, seriousness, and  
2 recency of the known criminal history of the individual, the mental  
3 health history of the individual, ~~((where))~~ if available, the  
4 opinions of a mental health professional, if available, and the  
5 circumstances surrounding the commission of the alleged offense. The  
6 guidelines must include a process for clearing outstanding warrants  
7 or referring the individual for assistance in clearing outstanding  
8 warrants, if any, and issuing a new court date, if appropriate,  
9 without booking or incarcerating the individual or disqualifying him  
10 or her from referral to treatment under this section, and define the  
11 circumstances under which such action is permissible.

12 (4) Any agreement to participate in treatment shall not require  
13 individuals to stipulate to any of the alleged facts regarding the  
14 criminal activity as a prerequisite to participation in a mental  
15 health treatment alternative. The agreement is inadmissible in any  
16 criminal or civil proceeding. The agreement does not create immunity  
17 from prosecution for the alleged criminal activity.

18 (5) If an individual violates such agreement and the mental  
19 health treatment alternative is no longer appropriate:

20 (a) The mental health provider shall inform the referring law  
21 enforcement agency of the violation; and

22 (b) The original charges may be filed or referred to the  
23 prosecutor, as appropriate, and the matter may proceed accordingly.

24 (6) The police officer is immune from liability for any good  
25 faith conduct under this section.

26 **Sec. 4.** RCW 10.77.086 and 2015 1st sp.s. c 7 s 5 are each  
27 amended to read as follows:

28 (1)(a)(i) If the defendant is charged with a felony and  
29 determined to be incompetent, until he or she has regained the  
30 competency necessary to understand the proceedings against him or her  
31 and assist in his or her own defense, but in any event for a period  
32 of no longer than ninety days, the court(~~(÷~~

33 ~~(A))~~) shall commit the defendant to the custody of the secretary  
34 ~~((who shall place such defendant in an appropriate facility of the~~  
35 ~~department for evaluation and treatment; or~~

36 ~~(B) May alternatively order the defendant to undergo evaluation~~  
37 ~~and treatment at some other facility or provider as determined by the~~  
38 ~~department, or under the guidance and control of a professional~~  
39 ~~person. The facilities or providers may include community mental~~

1 ~~health providers or other local facilities that contract with the~~  
2 ~~department and are willing and able to provide treatment under this~~  
3 ~~section. During the 2015-2017 fiscal biennium, the department may~~  
4 ~~contract with one or more cities or counties to provide competency~~  
5 ~~restoration services in a city or county jail if the city or county~~  
6 ~~jail is willing and able to serve as a location for competency~~  
7 ~~restoration services and if the secretary determines that there is an~~  
8 ~~emergent need for beds and documents the justification, including a~~  
9 ~~plan to address the emergency. Patients receiving competency~~  
10 ~~restoration services in a city or county jail must be physically~~  
11 ~~separated from other populations at the jail and restoration~~  
12 ~~treatment services must be provided as much as possible within a~~  
13 ~~therapeutic environment.)~~) for competency restoration. Based on a  
14 recommendation from a forensic navigator and input from the parties,  
15 the court may order the defendant to receive inpatient competency  
16 restoration or outpatient competency restoration.

17 (A) To be eligible for an order for outpatient competency  
18 restoration, a defendant must be clinically appropriate and be  
19 willing to:

20 (I) Adhere to medications or receive prescribed intramuscular  
21 medication; and

22 (II) Abstain from alcohol and unprescribed drugs.

23 (B) If the court orders inpatient competency restoration, the  
24 department shall place the defendant in an appropriate facility of  
25 the department for competency restoration.

26 (C) If the court orders outpatient competency restoration, the  
27 court shall modify conditions of release as needed to authorize the  
28 department to place the person in approved housing, which may include  
29 access to supported housing, affiliated with a contracted outpatient  
30 competency restoration program. The department, in conjunction with  
31 the health care authority, must establish rules for conditions of  
32 participation in the outpatient competency restoration program, which  
33 must include the defendant being subject to medication management and  
34 regular urinalysis testing for defendants who have a current  
35 substance use disorder diagnosis. The outpatient competency  
36 restoration program shall monitor the defendant during the  
37 defendant's placement in the program and report any noncompliance or  
38 significant changes with respect to the defendant to the department  
39 and, if applicable, the forensic navigator.

1        (D) If a defendant fails to comply with the restrictions of the  
2 outpatient restoration program such that restoration is no longer  
3 appropriate in that setting or the defendant is no longer clinically  
4 appropriate for outpatient competency restoration, the department  
5 shall remove the defendant from the outpatient restoration program  
6 and place the defendant instead in an appropriate facility of the  
7 department for inpatient competency restoration for no longer than  
8 the time allowed as if the defendant had been initially placed into  
9 inpatient competency restoration, in addition to reasonable time for  
10 transport to or from the facility. The department shall notify the  
11 court and parties of the change in placement before the close of the  
12 next judicial day. The court shall schedule a hearing within five  
13 days to review the placement and conditions of release of the  
14 defendant and issue appropriate orders. The standard of proof shall  
15 be a preponderance of the evidence, and the court may in its  
16 discretion render its decision based on written submissions, live  
17 testimony, or remote testimony.

18        (E) The court may not issue an order for outpatient competency  
19 restoration unless the department certifies that there is an  
20 available appropriate outpatient competency restoration program that  
21 has adequate space for the person at the time the order is issued or  
22 the court places the defendant under the guidance and control of a  
23 professional person identified in the court order.

24        (ii) The ninety day period for ~~((evaluation and treatment))~~  
25 competency restoration under this subsection (1) includes only the  
26 time the defendant is actually at the facility and is in addition to  
27 reasonable time for transport to or from the facility.

28        (b) For a defendant whose highest charge is a class C felony, or  
29 a class B felony that is not classified as violent under RCW  
30 9.94A.030, the maximum time allowed for the initial period of  
31 commitment for competency restoration is forty-five days. The forty-  
32 five day period includes only the time the defendant is actually at  
33 the facility and is in addition to reasonable time for transport to  
34 or from the facility.

35        (c) If the court determines or the parties agree that the  
36 defendant is unlikely to regain competency, the court may dismiss the  
37 charges without prejudice without ordering the defendant to undergo  
38 restoration treatment, in which case the court shall order that the  
39 defendant be referred for evaluation for civil commitment in the  
40 manner provided in subsection (4) of this section.

1 (2) On or before expiration of the initial period of commitment  
2 under subsection (1) of this section the court shall conduct a  
3 hearing, at which it shall determine whether or not the defendant is  
4 incompetent.

5 (3) If the court finds by a preponderance of the evidence that a  
6 defendant charged with a felony is incompetent, the court shall have  
7 the option of extending the order of commitment or alternative  
8 treatment for an additional period of ninety days, but the court must  
9 at the time of extension set a date for a prompt hearing to determine  
10 the defendant's competency before the expiration of the second  
11 restoration period. The defendant, the defendant's attorney, or the  
12 prosecutor has the right to demand that the hearing be before a jury.  
13 No extension shall be ordered for a second or third restoration  
14 period as provided in subsection (4) of this section if the  
15 defendant's incompetence has been determined by the secretary to be  
16 solely the result of a developmental disability which is such that  
17 competence is not reasonably likely to be regained during an  
18 extension. The ninety-day period includes only the time the defendant  
19 is actually at the facility and is in addition to reasonable time for  
20 transport to or from the facility.

21 (4) For persons charged with a felony, at the hearing upon the  
22 expiration of the second restoration period or at the end of the  
23 first restoration period in the case of a defendant with a  
24 developmental disability, if the jury or court finds that the  
25 defendant is incompetent, or if the court or jury at any stage finds  
26 that the defendant is incompetent and the court determines that the  
27 defendant is unlikely to regain competency, the charges shall be  
28 dismissed without prejudice, and the court shall order the defendant  
29 be committed to a state hospital as defined in RCW 72.23.010 for up  
30 to seventy-two hours starting from admission to the facility,  
31 excluding Saturdays, Sundays, and holidays, for evaluation for the  
32 purpose of filing a civil commitment petition under chapter 71.05  
33 RCW. The criminal charges shall not be dismissed if the court or jury  
34 finds that: (a) The defendant (i) is a substantial danger to other  
35 persons; or (ii) presents a substantial likelihood of committing  
36 criminal acts jeopardizing public safety or security; and (b) there  
37 is a substantial probability that the defendant will regain  
38 competency within a reasonable period of time. In the event that the  
39 court or jury makes such a finding, the court may extend the period  
40 of commitment for up to an additional six months. The six-month



1 period includes only the time the defendant is actually at the  
2 facility and is in addition to reasonable time for transport to or  
3 from the facility.

4 **Sec. 5.** RCW 10.77.088 and 2016 sp.s. c 29 s 411 are each amended  
5 to read as follows:

6 (1) ~~((a))~~ If the defendant is charged with a nonfelony crime  
7 which is a serious offense as identified in RCW 10.77.092 and found  
8 by the court to be not competent, then the court:

9 (a) Shall dismiss the proceedings without prejudice and detain  
10 the defendant for sufficient time to allow the designated crisis  
11 responder to evaluate the defendant and consider initial detention  
12 proceedings under chapter 71.05 RCW, unless the prosecutor objects to  
13 the dismissal and provides notice of a motion for an order for  
14 competency restoration, in which case the court shall schedule a  
15 hearing within seven days to determine whether to enter an order of  
16 competency restoration.

17 (b) At the hearing, the prosecuting attorney must establish that  
18 there is a compelling state interest to order competency restoration  
19 treatment for the defendant. The court may consider prior criminal  
20 history, prior history in treatment, prior history of violence, the  
21 quality and severity of the pending charges, any history that  
22 suggests whether or not competency restoration treatment is likely to  
23 be successful, in addition to the factors listed under RCW 10.77.092.  
24 If the prosecuting attorney proves by a preponderance of the evidence  
25 that there is a compelling state interest in ordering competency  
26 restoration, then the court shall order competency restoration in  
27 accordance with subsection (2) (a) of this section.

28 (2) (a) If a court finds pursuant to subsection (1) (b) of this  
29 section that there is a compelling state interest in pursuing  
30 competency restoration treatment, then the court ~~((i))~~ shall commit  
31 the defendant to the custody of the secretary ~~((who shall place such~~  
32 defendant in an appropriate facility of the department for evaluation  
33 and treatment;

34 ~~(ii) May alternatively order the defendant to undergo evaluation~~  
35 ~~and treatment at some other facility or provider as determined by the~~  
36 ~~department, or under the guidance and control of a professional~~  
37 ~~person. The facilities or providers may include community mental~~  
38 ~~health providers or other local facilities that contract with the~~  
39 ~~department and are willing and able to provide treatment under this~~

1 ~~section. During the 2015-2017 fiscal biennium, the department may~~  
2 ~~contract with one or more cities or counties to provide competency~~  
3 ~~restoration services in a city or county jail if the city or county~~  
4 ~~jail is willing and able to serve as a location for competency~~  
5 ~~restoration services and if the secretary determines that there is an~~  
6 ~~emergent need for beds and documents the justification, including a~~  
7 ~~plan to address the emergency. Patients receiving competency~~  
8 ~~restoration services in a city or county jail must be physically~~  
9 ~~separated from other populations at the jail and restoration~~  
10 ~~treatment services must be provided as much as possible within a~~  
11 ~~therapeutic environment.)~~ for competency restoration. Based on a  
12 recommendation from a forensic navigator and input from the parties,  
13 the court may order the defendant to receive inpatient competency  
14 restoration or outpatient competency restoration.

15 (i) To be eligible for an order for outpatient competency  
16 restoration, a defendant must be clinically appropriate and be  
17 willing to:

18 (A) Adhere to medications or receive prescribed intramuscular  
19 medication; and

20 (B) Abstain from alcohol and unprescribed drugs.

21 (ii) If the court orders inpatient competency restoration, the  
22 department shall place the defendant in an appropriate facility of  
23 the department for competency restoration under (b) of this  
24 subsection.

25 (iii) If the court orders outpatient competency restoration, the  
26 court shall modify conditions of release as needed to authorize the  
27 department to place the person in approved housing, which may include  
28 access to supported housing, affiliated with a contracted outpatient  
29 competency restoration program. The department, in conjunction with  
30 the health care authority, must establish rules for conditions of  
31 participation in the outpatient competency restoration program, which  
32 must include the defendant being subject to medication management and  
33 regular urinalysis testing for defendants who have a current  
34 substance use disorder diagnosis. The outpatient competency  
35 restoration program shall monitor the defendant during the  
36 defendant's placement in the program and report any noncompliance or  
37 significant changes with respect to the defendant to the department  
38 and, if applicable, the forensic navigator.

39 (iv) If a defendant fails to comply with the restrictions of the  
40 outpatient competency restoration program such that restoration is no

1 longer appropriate in that setting or the defendant is no longer  
2 clinically appropriate for outpatient competency restoration, the  
3 department shall remove the defendant from the outpatient restoration  
4 program. The department shall place the defendant instead in an  
5 appropriate facility of the department for inpatient competency  
6 restoration for no longer than twenty-nine days regardless of any  
7 time spent in outpatient competency restoration, in addition to  
8 reasonable time for transport to or from the facility. The department  
9 shall notify the court and parties of the change in placement before  
10 the close of the next judicial day. The court shall schedule a  
11 hearing within five days to review the placement and conditions of  
12 release of the defendant and issue appropriate orders. The standard  
13 of proof shall be a preponderance of the evidence, and the court may  
14 in its discretion render its decision based on written submissions,  
15 live testimony, or remote testimony.

16 (v) The court may not issue an order for outpatient competency  
17 restoration unless the department certifies that there is an  
18 available appropriate outpatient restoration program that has  
19 adequate space for the person at the time the order is issued or the  
20 court places the defendant under the guidance and control of a  
21 professional person identified in the court order.

22 (b) The placement under (a) (~~(i) and (ii)~~) of this subsection  
23 shall not exceed (~~fourteen~~) twenty-nine days (~~in addition to any~~  
24 unused time of the evaluation under RCW 10.77.060. The court shall  
25 compute this total period and include its computation in the order.  
26 The ~~fourteen-day period plus any unused time of the evaluation under~~  
27 RCW 10.77.060 shall)) if the defendant is ordered to receive  
28 inpatient competency restoration, or shall not exceed ninety days if  
29 the defendant is ordered to receive outpatient competency  
30 restoration. The court may order any combination of this subsection,  
31 not to exceed ninety days. This period must be considered to include  
32 only the time the defendant is actually at the facility and shall be  
33 in addition to reasonable time for transport to or from the  
34 facility(~~(~~

35 ~~(iii) May alternatively order that the defendant be placed on~~  
36 ~~conditional release for up to ninety days for mental health treatment~~  
37 ~~and restoration of competency; or~~

38 ~~(iv) May order any combination of this subsection))~~.

39 (~~(b)~~) (c) If the court has determined or the parties agree that  
40 the defendant is unlikely to regain competency, the court may dismiss

1 the charges without prejudice without ordering the defendant to  
2 undergo restoration treatment, in which case the court shall order  
3 that the defendant be referred for evaluation for civil commitment in  
4 the manner provided in ~~((e))~~ (d) of this subsection.

5 ~~((e))~~ (d)(i) If the proceedings are dismissed under RCW  
6 10.77.084 and the defendant was on conditional release at the time of  
7 dismissal, the court shall order the designated crisis responder  
8 within that county to evaluate the defendant pursuant to chapter  
9 71.05 RCW. The evaluation may be conducted in any location chosen by  
10 the professional.

11 (ii) If the defendant was in custody and not on conditional  
12 release at the time of dismissal, the defendant shall be detained and  
13 sent to an evaluation and treatment facility for up to seventy-two  
14 hours, excluding Saturdays, Sundays, and holidays, for evaluation for  
15 purposes of filing a petition under chapter 71.05 RCW. The seventy-  
16 two hour period shall commence upon the next nonholiday weekday  
17 following the court order and shall run to the end of the last  
18 nonholiday weekday within the seventy-two-hour period.

19 ~~((2))~~ (3) If the defendant is charged with a nonfelony crime  
20 that is not a serious offense as defined in RCW 10.77.092:

21 The court may stay or dismiss proceedings and detain the  
22 defendant for sufficient time to allow the designated crisis  
23 responder to evaluate the defendant and consider initial detention  
24 proceedings under chapter 71.05 RCW. The court must give notice to  
25 all parties at least twenty-four hours before the dismissal of any  
26 proceeding under this subsection, and provide an opportunity for a  
27 hearing on whether to dismiss the proceedings.

Passed by the Senate April 24, 2019.

Passed by the House April 15, 2019.

Approved by the Governor May 9, 2019.

Filed in Office of Secretary of State May 13, 2019.

--- END ---