Washington State Health Care Authority

Recovery Navigator Program

Uniform Program Standards Guide

2024-2025 Revision of the Recovery Navigator Program Uniform Program Standards

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Overview

In 2021, the Engrossed Substitute Senate Bill 5476 established a Recovery Navigator Program (RNP) in Section II§1. As part of this program, each Behavioral Health Administrative Services Organization (BH-ASO) must create and implement a RNP that offers community-based outreach, intake, assessment, and connections to services for individuals with substance use disorder (SUD). This includes providing intensive case management and recovery coaching services for those with SUD and mental health conditions, including co-occurring conditions. The RNP must also assist in coordinating access to various community resources, such as treatment and recovery support services, for youth and adults referred from diverse sources.

In 2023, Second Engrossed Second Substitute Senate Bill 5536- Section XXV§1 updated RCW 71.24.115:

> "Each behavioral health administrative services organization shall establish recovery navigator programs with the goal of providing law enforcement and other criminal legal system personnel with a credible alternative to further legal system involvement for criminal activity that stems from unmet behavioral health needs or poverty. The programs shall work to improve community health and safety by reducing individuals' involvement with the criminal legal system through the use of specific human services tools and in coordination with community input. Each program must include a dedicated Project manager and be governed by a policy coordinating group comprised, in alignment with the core principles, of local executive and legislative officials, public safety agencies, including police and prosecutors, and civil rights, public defense, and human services organizations."

Section XXV§8, codified in RCW 71.24.115(8), provided a definition of the core principles being referenced, as "for the purposes of this section, the term "core principles" means the core principles of a law enforcement assisted diversion program, as established by the law enforcement assisted diversion national support bureau in its toolkit, as it existed on July 1, 2023." This documentation is maintained through a dedicated website and can be found in the Toolkit.

Uniform Program Standards: Legislative directive

In 2021, under Section II§2 of ESSB 5476, the authority was charged with establishing a set of consistent program guidelines (Standards) that all Behavioral Health Administrative Services Organizations (BH-ASO) must observe when developing their Recovery Navigator Programs (RNP). The legislation indicated these Standards should be based on the key components of the Law Enforcement Assisted Diversion (LEAD) program and cover areas such as project management, community engagement, Biopsychosocial Assessment[1], intensive case management, coordination of care, access to stabilization housing when appropriate, and collaboration with the legal system.

The authority was directed to create these Standards from the LEAD program to accommodate an expanded population of individuals with substance use disorders, including those with co-occurring mental health conditions, and allow for referrals from various sources, in addition to law enforcement.

In 2023, Second Engrossed Second Substitute Senate Bill 5536- Section XXV§1 updated the RCW language to direct HCA, by June 30, 2024, to revise its uniform program standards for BH-ASOs to follow in the design of their recovery navigator programs to achieve fidelity with the core principles. The law was further amended to ensure the following:

[1] Biopsychosocial assessment in this context is described in more detail under the 'Initial Interaction' section.

> "By June 30, 2024, the authority shall revise its uniform program standards for behavioral health administrative services organizations to follow in the design of their recovery navigator programs to achieve fidelity with the core principles. The uniform program standards must be modeled upon the components of the law enforcement assisted diversion program and address project management, field engagement, biopsychosocial assessment, intensive case management and care coordination, stabilization housing when available and appropriate, and, as necessary, legal system coordination for participants' legal cases that may precede or follow referral to the program. The uniform program standards must incorporate the law enforcement assisted diversion framework for diversion at multiple points of engagement with the criminal legal system, including prearrest, prebooking, prefiling, and for ongoing case conferencing with law enforcement, prosecutors, community stakeholders, and program case managers. The authority must adopt the uniform program standards from the components of the law enforcement assisted diversion program to accommodate an expanded population of persons with substance use disorders, including persons with co-occurring substance use disorders and mental health conditions, provide for referrals from a broad range of sources, and require prioritization of those who are or likely will be exposed to the criminal legal system related to their behavioral health challenges. In addition to accepting referrals from law enforcement and courts of limited jurisdiction, the uniform program standards must provide guidance for accepting referrals on behalf of persons with substance use disorders, including persons with co-occurring substance use disorders and mental health conditions, from various sources including, but not limited to, self-referral, family members of the individual, emergency department personnel, persons engaged with serving homeless persons, including those living unsheltered or in encampments, fire department personnel, emergency medical service personnel, community-based organizations, members of the business community, harm reduction program personnel, faith-based organization staff, and other sources within the criminal legal system, so that individuals are engaged as early as possible within the sequential intercept model."

2021 Recovery Navigator Program uniform standards committee

To develop the first draft of the Uniform Program Standards in 2021, the Washington Health Care Authority (HCA) convened an ad-hoc committee of statewide and local partners with the goal of developing standards modeled after components of the Law Enforcement Assisted Diversion (LEAD) program. This committee met several times weekly from June 2021 through August 2021 to discuss the core principles of LEAD and how they would apply to the RNP.

The revised standards document will build upon the original standards and is further intended to inform the development, hiring, implementation, and operation of regional programs to ensure standardization of practices.

RNP Uniform Program Standards design and collaboration across multiple regions

The Uniform Program Standards document serves as the guide for Behavioral Health Administrative Service Organizations to follow in the design of their Recovery Navigator Programs. The UPS is built upon and seeks to achieve fidelity with the Law Enforcement Assisted Diversion (LEAD) core principles (RCW 71.24.115). In support of this partnership and to ensure consistency between Recovery Navigator programs and the LEAD core principles, BH-ASOs must work closely with HCA and the LEAD Support Bureau when evaluating or updating their program design.

Other prearrest and pre-booking diversion programs that follow the LEAD model also operate in communities across the state. To support communication and collaboration across these various programs, HCA will work with the BH-ASOs, the Washington State Association of Sheriffs and Police Chiefs (WASPC), and the LEAD Support Bureau to enhance coordination of programs funded through RCW 71.24.115, RCW 71.24.589 and RCW 36.28A.450 to work towards fidelity to the LEAD core principles.

Regional Recovery Navigator Program plan

Each BH-ASO is required to submit to HCA a Program Plan that is consistent with the Uniform Program Standards; such plans must address developmentally appropriate pathways and connections for youth, young adults, and adults.

The BH-ASOs are required to update their Program Plans in response to any material revision to the Standards according to the timeline laid out in their contract language or as identified by HCA. The revised plans will be reviewed and approved by HCA as part of the contracting process to assess any potential impacts to program operations.

Recovery Navigator Program design

Priority population

The purpose of Recovery Navigator Programs is to provide a credible alternative to further legal system involvement for criminal activity that stems from unmet behavioral health needs or poverty.

These programs aim to help those who are at risk of being arrested or those who have already been involved in the criminal legal system. Recovery Navigator Programs must prioritize individuals who are at risk or potentially exposed to the criminal legal system in connection with unlawful behavior related to substance use or other behavioral health issues. *Many people who need and deserve care will be referred to these services, and the ability to serve everyone who might benefit may be limited by program capacity; resources must be prioritized toward those at risk of immediate exposure to the legal system.*

Recovery Navigator Programs should be designed to serve those who cannot, on their own, access whatever safety-net services might be locally available. Recovery Navigator Programs establish a new system of response and care for people who live with unmanaged behavioral health needs, deep experiences of complex trauma, cognitive disabilities, persistent poverty, and often lifelong experiences of punishment, failure, betrayal, and marginalization—people who are not served by office-based, appointment-based, abstinence-focused, and time-delimited care.

Coordination and communication between law enforcement, prosecutors, program staff, medical providers, and community partners is essential to the success of these program. (See Governance section.)

Lived experience

RNP staff must include people with lived experience with a behavioral health disorder and the criminal legal system to the extent possible, though it is not required that the presence or absence of specific lived experience or length of sobriety be a condition of employment. Having staff members with lived experience increases buy-in from participants and engagement during outreach.

Recovery is non-linear and looks different for everybody, and providers who have pre-existing policies that are not in alignment with these guidelines are encouraged to talk with their regional RNP administrator regarding policy decisions surrounding requirements for length of time someone has been in recovery to be considered for a position.

Diversity, equity, and inclusion

RNPs should be staffed in a manner that reflects the visible and invisible diversity of the communities they serve, and specifically, should have the experience and cultural humility to effectively engage diverse participants and partners. The BH-ASOs should make every attempt to ensure a system that intentionally seeks a diverse workforce (e.g., BIPOC peers, LGBTQIA2S+ peers, peers with visible and non-visible disabilities) during hiring and contracting processes.

Competencies

All program staff will incorporate culturally specific elements into day-to-day operations and have extensive experience working within the community and working with vulnerable populations. The BH-ASOs must demonstrate an ability to meet the diverse needs of their regional population in the RNP plan.

Hours of operation and geographic coverage

Programs are expected to be available to accept referrals daily from 9 a.m. to 5 p.m., whether on a weekday or a weekend. Programs that are no longer in their initial implementation phase are expected to have a plan in place for accepting referrals outside of the standard workday hours as resources permit, building toward 24/7 response capability for all referrals while prioritizing response capability for law enforcement referrals.

In the case of after-hour referrals, some individuals may also be referred to the Washington Recovery Helpline or crisis services to assist them with time-sensitive requests where other local service providers are not available, depending on the severity of their behavioral health symptoms and needs.

Geographic coverage is a required component of the Recovery Navigator Program Plan maintained by the BH-ASOs, with the goal of ensuring that the programs are responsive to the needs of the community members. The RNP staffing model will ensure coverage in each of Washington's 39 counties. To have regional coverage, it is the intent of staffing models to include a minimum of two program staff who live in (or very close by) and are assigned in each of the counties, whenever possible. This coverage can be ensured by having administrative and case management staff in central hubs and the outreach and referral staff in communities.

Staff roles and responsibilities

To develop clearly set roles and responsibilities, RCW 71.24.115 was enacted:

> "Each behavioral health administrative services organization must have a substance use disorder regional administrator for its recovery navigator program. The regional administrator shall be responsible for assuring compliance with program standards, including staffing standards. Each recovery navigator program must maintain a sufficient number of appropriately trained personnel for providing intake and referral services, conducting comprehensive biopsychosocial assessments, providing intensive case management services, and making warm handoffs to treatment and recovery support services along the continuum of care. Program staff must include people with lived experience with substance use disorder to the extent possible. The substance use disorder regional administrator must assure that staff who are conducting intake and referral services and field assessments are paid a livable and competitive wage and have appropriate initial training and receive continuing education."

BH-ASOs may be able to take advantage of economies of scale whereby Project managers, program supervisors and outreach coordinators work across programs.

Regional Recovery Navigator administration

BH-ASOs are required to have a substance use disorder regional administrator, termed regional administrator, for its recovery navigator program. The regional RNP administrator is responsible for assuring compliance with program standards and for developing and maintaining a regional resource assessment for their region that captures existing local, state, and federally funded community-based access points. This resource assessment will map existing agencies and funding sources that provide outreach and intervention programs.

As part of the resource assessment, the RNP administrator will support program managers in identifying and engaging with the region's accountable communities of health, local health jurisdiction, local behavioral advisory committee, local and tribal law enforcement, criminal court system partners, and any other community-driven partner groups that oversee programs that could be complementary to the RNP.

Where applicable, these partnerships should be memorialized through interagency agreements or Memorandums of Understanding, such as formalizing participation in the Policy Coordinating Group (PCG). These agreements are not required for informal engagement and outreach efforts.

This role will also be responsible for coordinating and communicating with HCA, and with the LEAD Support Bureau regarding technical assistance. (Refer to Partnerships section.)

Project management

Project Management ensures that the Uniform Program Standards for RNP are implemented with fidelity to the LEAD model and that program outreach and communication are coordinated amongst similar existing programs in that geographical area. The project managers in a BH-ASO region will work in conjunction with the Regional

RNP administrator and participate in periodic meetings to ensure that the Administrator is aware of any barriers, challenges, or successes. If the BH-ASO can demonstrate that there is no risk of compromising adherence to the Uniform Program Standards, then project management roles that exist within other outreach, diversion, and LEAD programs may be leveraged to support operation of Recovery Navigator Programs. This would also be accomplished if there is available bandwidth to support the additional programs within the catchment area.

Due to the varying number of counties present in a region, or the size of the region, the regional RNP administrator may encompass project management functions. As programs expand and grow in response to increased funding support, the project management role will need to evolve as well. In some cases, individual Project managers will need to expand into teams that include multiple staff members, and when possible, there should be a concerted effort to move toward contracting with an independent agency within the community to assume project management duties.

Stakeholders and community partners have differing reasons for approaching the table and engaging with the program and may have varying levels of faith in its capacity to foster meaningful change, and partner involvement and commitment may ebb and flow accordingly. Project managers must identify the interests, needs, and goals of each partner organization and work to ensure that RNP contributes to improving each partner's situation and addresses each partner's legitimate needs within the scope of this program.

Project managers should be responsive to differing needs and interests as represented in the Policy Coordinating Group (PCG) and ensure that the PCG meets with enough frequency to provide oversight and guidance to this multi-partner effort, to the project manager(s), and to demonstrate progress towards goals for the community including a prosecutor-supported prebooking diversion program.

Within this work, project management will be inclusive of the viewpoints of those with lived experience (whether in the criminal legal system, the behavioral health system, or both), as well as focus on engaging community voices that have been historically under-represented. The project management team must equally be responsive to community public safety needs and expectations. Any changes to the project management role are subject to review and approval by HCA and must be represented in the Program Plan.

At the direction of the PCG, the project manager coordinates implementation of the program and intersections with systems outside the health field, including public safety, law enforcement, and civil rights advocacy, through activities which could include but are not limited to the following:

- Establishing connections with community partners/resources (e.g. courts, law enforcement, Tribes, faith-based organizations, emergency medical services/fire departments, neighborhood and business leaders, local health jurisdictions, behavioral health treatment providers, medical providers, social services, harm reduction organizations, legal groups, people with lived experience, elders, family members and other supports determined by individuals in need)
- Scheduling and convening the PCG meetings that bring together the community partners involved in making the policy-level decisions supporting the program
- Developing interagency agreements with these partners to support the utilization and referral to the RNP. These collaborations should be memorialized through multiparty releases of information (ROIs), data share agreements, and memoranda of understanding (MOUs)
- Approving and enrolling community referrals consistent with resources and priorities established by the PCG
- Identifying concerns and objections of local community partners related to the operation of the program that create implementation barriers and highlighting these issues to the PCG and to local, regional, and state leaders as appropriate
- Identifying gaps in accessing services as part of continual resource mapping to inform future expansion of resources in the area
- Facilitating efforts and enhancements related to data collection, data reporting, and program evaluation

- Working with the PCG to identify emerging public safety and order dynamics that are driving public demand for enforcement (e.g. public drug use) and devising ways in which RNP resources can alleviate the conditions and respond to individuals who may otherwise become the focus of enforcement due to public concern

The project manager acts as community liaison, engaged with information sharing and program transparency by soliciting community support and communication to individuals in the community. The project manager's decision-making must follow the Uniform Program Standards, so that the individual needs of program participants, partner expectations, and community safety needs are harmonized and upheld and remain foremost in the purview of procedural policy.

Outreach and case management functions

The outreach and case management team must blend lived experience with direct service skills and have access to clinical expertise along with professional, expert supervision and support. The team must have the knowledge and expertise to effectively identify behavioral health issues, to provide care, avoid harm, and make connections to appropriate care and resources. Some regions may choose to create dedicated Outreach teams while others might cross-train all their staff so that the outreach and case management roles are shared across the team. All Case Managers are expected to spend time in the field regardless of how the BH-ASO chooses to structure their teams. Each individual staff member may bring some or all these skills and contribute to that holistic team composition.

Outreach and case management teams can benefit from having staff with academic training and professional experience, as well as staff who bring expertise built from first-hand experiences (such as histories of substance use, mental illness, homelessness, criminal legal involvement, family disruption). Both lived experience and outstanding skills contribute to collective capacity and overall blended competencies that support person-centered care.

Outreach and referral

Outreach and Referral is an integral component of the Recovery Navigator Program, and regional programs must include staff members who spend much of their time in the field. Outreach and referral staff will be available to respond and engage upon referral, ensuring prompt availability and attention for those who are identified as in need of services. In addition, these positions are public and highly visible, so staff experience with conflict resolution and de-escalation techniques and staff safety must be a consideration. (See Safety for more information about Safety Standards for the RNP.)

RNP staff engaged in outreach will:

- Respond to referrals; prioritizing responding to law enforcement calls, while responding as capacity permits to community-based and emergency response referral
- Facilitate warm hand-offs to external services and providers
- Engage with criminal court system partners to receive pretrial diversion referrals
- Provide short-term assistance while addressing the immediate needs of the individual (the outreach function is not long term, intensive field-based case management)
- Follow-up with program participants in the community when there is indication of disengagement
- If operating strictly as an Outreach team, coordinate with case management staff to engage new and existing program participants in the field when case managers are unable to do so for reasons including but not limited to conflicting obligations with other participants, or lack of information about where the individual may be found
- Collect data related to the individuals referred to the program and provide data to the project manager

Case management

The Recovery Navigator Program provides intensive, participant-driven, field-based case management services, delivered within a low-barrier/no-barrier framework that incorporates principles of harm reduction, and helps participants access services that meet their self-identified needs.

Case managers, who may also provide referral and outreach services, operate in field-friendly teams responsible for participant support, systems navigation, and field engagement. The case management team must blend lived experience with the competency and expertise required to conduct biopsychosocial assessments, recognize behavioral health conditions and monitor status, and accurately identify appropriate care and resources for complex behavioral health needs.

This position will identify holistic services through an integrated service framework that increases protective factors while decreasing risk factors through a person-centered, participant-driven decision-making process. In this relationship, the participant has direct control of their self-identified goals. Case managers ensure that the individual's needs are being met and may be able to assist outreach and referral staff (if separate from case management) to ensure immediate field-based response when a referral is made.

Case managers work with the individual to develop and implement an agreed-upon, individual intervention plan. To ensure the full continuum of services are considered, the case manager's resources for referrals will be inclusive of available resources within the community, encompassing all potential sources within their "toolbox." Once an intervention plan has been developed, staff will make all attempts to ensure continual access to services, with a warm hand-off to an external resource, when applicable.

The RNP case manager is a "golden thread" of steady, consistent connection and care coordination, even when external services are playing a role. (See Case management classifications for additional information and requirements.)

Case managers coordinate services the individual is receiving or may be referred to, with the goal of preventing duplicative efforts and unnecessarily re-engaging with the individual's behavioral health history (i.e. multiple assessments). The staff work together as part of a care team focusing on the individual through a holistic lens that includes their legal system involvement, which may include assisting with coordinating the resolution of any existing or new criminal cases while supporting them in navigating any judicial conditions they may be facing.

Naloxone and overdose awareness and training

All staff working directly with participants are required to be trained in overdose prevention and response; and, as funding allows, to carry and be prepared to administer Naloxone to respond to overdoses. In addition, as funding allows, staff should be authorized to distribute Naloxone to any individual they encounter who may be at risk of overdose, as well as people enrolled in case management services.

Care team supervision

The supervisor(s) of RNP staff will possess the necessary professional training, competencies, and skills to support, direct, and oversee program staff as well as individuals who are experiencing behavioral health symptoms.

This includes providing guidance and leadership to ensure the safety of staff doing outreach, referral, and case management. Core competencies and qualifications for care team supervision include:

- Professional competencies and training to provide support and feedback to RNP staff when handling difficult cases
- Training in crisis support, trauma informed care, de-escalation and conflict resolution, and suicide prevention training

- Understanding of the multitude of behavioral health symptoms related to mood, psychotic, attention, and substance use disorders, and relevant evidence-based treatment responses to those disorders
- Understanding of behavioral health treatment and harm reduction systems to support program staff to help facilitate appropriate referrals into services
- Experience and knowledge of the court system and related criminal legal diversion programs

This position must also be able to provide supervision, crisis support, trauma informed care, de-escalation and conflict resolution, and suicide prevention as well as to support training on these topics to the program staff. In addition, they should have experience in taking adequate case notes, using electronic health records, staffing participant cases, and be able to meet other formal supervision expectations for team members.

The care team supervisor(s) must be able to support program staff, while holding them accountable to the best practice requirements of the RNP. Supervisors should be capable of the training and oversight of staff working with individuals with complex behavioral health needs and ensure that the whole team has access to skilled clinical supervision and understands how such services can support engagement. This position, as deemed necessary and/or appropriate, must be able to provide outreach, referral, and case management to ensure team flexibility during implementation and sustainment phases of their area's Recovery Navigator Program.

Partnerships and governance

Community partners

Community partnerships are crucial for building and maintaining strong relationships between Recovery Navigator Programs, other organizations, and surrounding communities. These partnerships establish trust and credibility between organizations and communities. By engaging with community members, organizations can gain a better understanding of their needs, priorities, and concerns, and tailor their services and programs to meet the needs of individuals served through the Recovery Navigator Program. RCW 71.24.115 provides that:

> "The authority shall arrange for technical assistance to be provided by the LEAD national support bureau to all behavioral health administrative services organizations, the authority, contracted providers, and independent stakeholders and partners, such as prosecuting attorneys and law enforcement."

In determining the best ways to support community outreach efforts related to RNP, the BH-ASO Administrator can coordinate with HCA staff and to call upon the expertise of the LEAD Support Bureau to develop strategies to engage with their local communities and ensure that the Recovery Navigator Programs are reflective of local input. Technical assistance is also available on many other topics as well, such as consultation on refining staff roles or help with plan development, while the support of community partnerships is a central area of focus.

The list below should not be considered as exhaustive or limiting program administrators and program managers in whom they might seek to engage in their communities, and programs are encouraged to seek partnerships that represent unique opportunities for fostering collaboration:

- Local law enforcement agencies
- City and/or county court systems, including probation and/or pretrial service departments
- Local fire departments
- Syringe service programs
- Public health services and supportive services for people who use drugs
- Programs for unhoused people
- Recovery cafes
- Support organizations that allow evidence-based practices including behavioral health medications
- Therapeutic courts
- Community behavioral health agencies
- Faith-based groups
- Tribes and non-Tribal, Indian health care providers (IHCPs)
- Federally qualified health centers
- Housing assistance programs
- Providers of medications for addiction treatment
- Opioid treatment programs
- Business organizations
- Neighborhood public safety groups

Governance

Recognizing the importance of shared and structured leadership to develop and achieve consistent goals, policies, and practices, each RNP site is collaboratively stewarded by local stakeholders who are familiar with and/or responsible for addressing the problems the program is intended to solve.

There are two organizational components, the Policy Coordinating Group and the Operational Work Group, each with a distinct purpose. Despite their different roles, each of these bodies is committed to reducing harm, fostering healing, and improving the community together.

Policy coordinating group

Each RNP shall establish a Policy Coordinating Group (PCG) as the policymaking and stewardship body for the RNP. The PCG is composed of senior members of their respective agencies who are authorized to make decisions on behalf of their offices.

The PCG should include high-ranking representatives of local law enforcement (police and/or sheriff's departments), public health agencies, local government (e.g. mayor's office, city/county council , county executives), public defender's offices, prosecutor's offices, courts, Family Youth System Partner Round Tables, civil rights and/or racial justice organization(s), community representatives, and the business community.

Depending on community-specific issues, the PCG may also include religious leaders, subject-matter experts (such as in housing, behavioral health, employment, sex worker advocacy), tribes, Urban Indian Health Programs, and court/jail system partners. If RNP Project managers encounter challenges in convening necessary PCG partners, they are encouraged to consult with the LEAD Support Bureau to consider solutions.

Together, the PCG's members aim to:

- Develop the local vision for RNP
- Make policy-level decisions for the initiative and within their respective agencies
- Ensure that sufficient resources are dedicated for the success of the initiative
- Review, approve, and modify overarching policies to reflect the site's intentions, including (but not limited to) participant eligibility criteria, inclusion/exclusion criteria, and diversion-eligible criminal charges and exclusionary criteria (if any)

In addition, the PCG is responsible for establishing and stewarding evaluation, communications, and budget plans, as well as memorializing any written agreements that support program partnerships such as those in support of pre-booking and pre-trial diversion efforts.

The PCG will include diverse and representative membership to ensure programs are meeting cultural needs of the population, recognizing that much of this will be beyond what can be embedded and contained in any one small team. BH-ASOs are encouraged to leverage existing advisory groups that align with these needs; however, such groups are not intended to replace the stewardship of a properly constituted PCG. The PCG will also set expectations for response times for law enforcement arrest diversions by that area's RNP, along with what response times are workable and appropriate for community or social referrals to the program.

The PCG is responsible for developing and approving operational protocols consistent with Recovery Navigator Program standards. These protocols identify ways to respond to law enforcement referrals and social contact referrals and any necessary operational procedures to support program participants. Essentially, these protocols document the who, what, where, when, and how of the program. In many cases, the project manager is charged with drafting the documents, using input from and review by the PCG.

Operational workgroup

While the PCG shapes policy and priorities, the Operational Workgroup (OWG) supports day-to-day direct operations, including care coordination and case management. Operating as a multi-disciplinary team, operational partners come together through the OWG to collectively discuss and address operational, administrative, and participant-specific issues.

The work of the OWG can be organized into two categories: **administrative operations** among the partners (improving day-to-day operations and efficacy, identifying emerging community or operational issues, and identifying policy proposals for the PCG), and **participant case conferencing** (wherein police, prosecutors,

community partners, and case management devise ways to coordinate their responses to a particular participant, and help one another identify new approaches that may work better).

The composition of an OWG will vary with each site, but it should include partners who are involved in implementing the daily activities for RNP, along with others who are particularly affected by the issues RNP is intended to address. In addition to the project manager, case managers and supervisors, law enforcement officers, and line prosecutors, OWG members might include neighborhood and business representatives. Other direct services providers may participate if that fosters efficient and productive collaboration.

Just as the PCG fosters knowledge, insight, respect, and agreement by providing a structured framework for intentional conversations among diverse policymakers and agency leaders committed to finding better solutions, the OWG provides similar opportunities for collective learning and informed decision-making for people who face RNP's challenges daily: case management staff and supervisors, law enforcement officers, prosecutors,[2] neighborhood representatives, and business owners.

The OWG will staff new cases that are referred to the RNP along with current program participants; not every participant must be staffed at any meeting. The OWG will focus on awareness of needs, contracting for support and care for diverse populations as appropriate, and building partnerships that can be activated depending on needs of an individual participant (deaf/hard of hearing, language needs, physical accessibility, peer outreach for members of communities not reflected in RN team composition).

Coordination and participation within the Operational Workgroup must follow the guidelines in the Release of Information (ROI) section.

[2] Public defense is generally represented at the PCG, but may find that participating in OWG presents conflict of interest issues. Some public defense programs are organized in a way that these conflict issues can be avoided, and this can be determined at the local level in each program.

Eligibility, referral, and engagement

Program is voluntary and non-coercive

Individuals referred to the Recovery Navigator Program have the right to decline participation without any penalties or future repercussions by the service provider (such as denial of services at future point), though there may be other outcomes related to declining the offer of a diversion referral. For example, if an individual declines to be referred in an arrest or booking diversion, they may be booked into jail and/or referred to prosecution for the offense that would have been diverted.

An individual is under no obligation to engage in services if referred by law enforcement, in accordance with RCW 10.31.110, but there are specific steps that must be completed for a pre-booking diversion if that is the option they choose to pursue. They must complete an intake assessment and sign a multiparty ROI, allowing for case conferencing, as the two mandatory conditions for diversion of charges referred to RNP by law enforcement.

RNP is not a court-ordered program or a prosecutor diversion program where referral to RNP would be set as a condition for compliance with a court sentence and exists to offer an alternative to traditional court proceedings. RNP should not provide ancillary services to therapeutic court participants when dedicated funding for therapeutic courts is available in that jurisdiction, as part of jail reentry, or under deferred prosecution. A specific framework for pretrial diversion referral under SB 5536 is discussed later in these standards.

Abstinence from substance use is not a requirement for any aspect of the Recovery Navigator Program. RNP will not utilize urinalysis testing or other invasive means intended to determine substance use. Services will be built around individually developed goals and following a plan crafted by the program participant and may be adjusted depending on individuals' situation and choices. BH-ASOs and/or contractors must have policies in place that indicate situations in which an individual might be involuntarily discharged from the RNP. The RNP should link to/be able to engage crisis services (e.g. Designated Crisis Responders) when indicated as necessary.

Balancing law enforcement and community referrals

Recovery Navigator Programs must serve and prioritize individuals who are actually or potentially exposed to the criminal legal system with respect to unlawful behavior connected to substance use, mental health, co-occurring disorders, other behavioral health issues, and/or poverty. The priority population for RNP includes individuals who have frequent contact with first responders and/or law enforcement as a result of unmet behavioral health needs, and who could benefit from being connected to supportive resources and public health services when amenable. The primary function of RNP is connection and stabilization with respect to a variety of social determinants/vulnerability factors.

There are several types of referrals into RNP:

- *Point of arrest referrals* by law enforcement
- *Social contact referrals* by law enforcement
- *Community referrals* from an entity other than law enforcement, such as service providers, community members, and friends/family.

Point-of-arrest referrals

The Recovery Navigator Program places significant emphasis on prioritizing law enforcement referrals. Arrest diversion grants law enforcement officers the authority to refer individuals to the RNP as an alternative to arrest or to booking them into jail or referring them for prosecution. This aims to divert individuals who may have committed legal violations away from the criminal court system and towards the necessary support and resources to address any underlying issues that may have contributed to their behavior. By doing so, the RNP

hopes to reduce recidivism rates and promote community safety and be in alignment with statutory requirements found in RCW 10.31.110, RCW 13.40.042, ESB5476§13, and 2E2SSB 5536.

Social contact referrals

A social contact referral from a law enforcement officer means that an eligible individual can be referred into a RNP without waiting for the moment of potential arrest, so long as the officer has a strong basis to believe the individual is exposed to enforcement and engages in law violations related to behavioral health or poverty.

Community referrals

Community referrals are referrals from any source other than law enforcement. People who enter RNP via community referrals should be consistent with the target population who enter through arrest diversion or social contact referrals by law enforcement – that is, exposed to enforcement due to law violations (documented, observed or persuasively established by the referral source—there need not have been prior arrests) related to Behavioral Health issues or poverty. The project manager is responsible for drafting operational procedures governing community referrals for approval by the PCG, and is responsible for approving community referrals consistent with that direction. If the referral is deferred to another service provider by way of a warm handoff or referred to services that do not involve a case management relationship, the project manager will track the reason for the deferred referral.

The project manager, through the Policy Coordinating Group, will ensure that operational procedures include a process which Referral and Outreach staff will follow when having to prioritize referrals from Law enforcement, and will also establish a timeline and engagement process for expanding referral intercept points, but only when capacity exists to take the referrals being recruited. Programs must be situated to accept referrals from community sources, including but not limited to: self-referral, family members of the individual, emergency department personnel, persons engaged with serving homeless persons, including those living unsheltered or in encampments, fire department personnel, emergency medical service personnel, community-based organizations, local business owners, harm reduction program personnel, faith-based organization staff, and other sources within the criminal legal system, as outlined within the Sequential Intercept Model. When need exceeds capacity, prioritization of individuals identified by law enforcement is essential, but it is valuable to track the unmet referral need from community sources in order to understand pathways for future expansion.

Pretrial diversion

It is important to identify where possibilities exist for diverting people away from the criminal legal system at the earliest possible opportunity, preferably through deflection prior to moments of crisis or at arrest/ as an alternative to arrest; ideally, the criminal legal process is interrupted long before prosecutors and the courts get involved. To that end, RNP program capacity must prioritize referrals earlier in the process but may take pretrial referrals if capacity allows.

2E2SSB 5536 enacted RCW 69.50.4017 which creates an Alternative to Prosecution through pretrial diversion option for jurisdictions which contain a RNP, AJA, or LEAD program.

Case management template for court reporting

To ensure that individuals referred to RNP services through a criminal court system are guaranteed consistent, low-barrier services, that align with the principles of harm reduction further outlined in these standards, the individualized interventions and outcomes associated with receiving case management through the RNP program must be reported to the court system in a standardized manner, both when reporting the results of an intake screening and for periodic (at least monthly) reporting on programmatic progress to the court.

RNP does not function as a probation or supervision-focused program, and sample templates for reporting to a referring court have been developed to maintain consistent coordination between RNP staff and court-system partners across the State.

The sample template is attached as an appendix to these standards and should be used or adapted by RNP program staff for any submission to the court supervising a pretrial diversion made to RNP. The templates are designed to ensure provision of accurate, adequate, and high-level information sufficient to allow a court to confirm whether pretrial diversion conditions have been met, without creating the impression that the court is overseeing the substantive course of case management or invading the confidentiality of the program participant.

Written agreement between system partners

In the process of working with potential referring courts to establish the terms and conditions of pretrial diversion to RNP, programs must ensure that the framework for accepting pretrial diversion referrals is memorialized in writing, in a format such as a memorandum of agreement (MOA) and is not reliant on verbal agreements. In the absence of a written agreement between court partners and RNP, the program should not be accepting pretrial diversion referrals.

The terms of any written agreement to accept pretrial diversion referrals must at a minimum provide that

- RNP case managers do not function as probation counselors
- RNP case managers will not be compelled or required by the courts to share information that could lead to adverse action against the participant(s) they are assisting
- RNP case managers will not be subpoenaed by court or prosecutor regarding RNP services or the client's progress related to RNP services
- Reporting forms are established that align with RNP principles

(A sample MOA is included in the appendices, and support for the MOA process can be provided upon request by the LEAD Bureau.)

Referral prioritization

Pretrial referrals that would cause the case managers to exceed caseload standards should not be accepted , taking into consideration their priority to receive pre-booking and community referrals. When programs encounter programmatic issues with caseload capacity, that situation should be shared with the BH-ASOs and HCA and discussed with the LEAD Support Bureau during technical assistance provision, so that those challenges may be addressed at a strategic level in the future.

Information-sharing between RNP and the courts or prosecutors in a pretrial posture follows the same approach that applies for case conferencing of any non-diverted cases. When case managers coordinate with prosecutors there are several areas of coordination to consider, such as ensuring that pending cases don't unnecessarily compromise a participant's progress, that information is accurate, that it doesn't create a specific basis for adverse action against the participant, and that it doesn't create a false impression through omission.

Multi-agency case coordination

Multi-agency case coordination is a fundamental element of the LEAD model and can only occur with the agreement of all operational partners to strictly observe the LEAD/RNP "Golden Rule" that "no one can be worse off because they chose to participate and share information with their case manager, and their case manager chose to share it with other partners."

Pursuant to the multiparty ROI, RNP case managers routinely coordinate with police, prosecutors, judges, other service providers, and neighborhood leaders, as needed, to ensure that a participant's stabilization plan is well understood and supported. In part, this is to help ensure that no partner inadvertently impedes that plan due to lack of knowledge and, to the extent possible, avoids taking actions that might compromise the plan's success.

While the RNP is centered on prebooking referral (or even earlier in the Sequential Intercept Model via community referrals or prearrest referrals from law enforcement), other criminal legal system agencies like courts and prosecutors may also initiate referrals in a pretrial or post-disposition posture. It is essential that

post-court filing referrals do not dominate case management slots to ensure assistance is available at the earliest possible stage.

Field-based engagement

The RNP is operationalized largely in the field, by meeting the individual where they are physically present, while breaking down barriers to accessing services. Whether responding to law enforcement or working with community referrals, outreach staff engage individuals who are not actively seeking care in medical or behavioral health treatment facilities. This does not preclude program staff from engaging with individuals who are already receiving behavioral health or medical services.

The RNP should be staffed by organizations which are experienced in community-based outreach and field-based response. RNP staff arrange access to office-based treatment and care whenever appropriate. Efforts should be made to ensure that initial engagements are conducted in-person, whenever possible. If geographical barriers prevent an in-person meeting, virtual communication via video or telephone may be utilized as a viable alternative.

Individuals who are referred to the RNP should be initially contacted in their community and not transported outside of that community, unless that is their specific request. This initial outreach and conversation by program staff should occur where the referral is made, regardless of the type of referral. Once a relationship is established, a participant who is amenable or volunteers may be transported to appointments by peers, first responders, or emergency medical response. Any transportation provided by RNP staff should be undertaken as part of The case management plan and in accordance with the care team or transportation option developed by the care team.

There may be no movement past field engagement for some time, and protracted field engagement may be needed. In addition, the services required will often focus less on substance use than on other needs, and this may continue for months or years—and that is still recovery-based engagement. (See Case management section.)

Response times

According to RCW 71.24.115, HCA was directed to consider response times in development of the standards:

> "In developing response time requirements within the statewide program standards, the authority shall require, subject to the availability of amounts appropriated for this specific purpose, that responses to referrals from law enforcement occur immediately for in-custody referrals and shall strive for rapid response times to other appropriate settings such as emergency departments and courts of limited jurisdiction."

Response times for programs responding in urban settings are expected to be responsive to community needs and flexible around external factors such as traffic, ideally within 30 minutes upon receiving the referral. Response times for rural areas frequently include a significant travel time component, and so a longer response time is still recognized as appropriate.

Specific needs and expectations about response times should be worked out with local law enforcement agencies in advance whenever possible, being mindful of local conditions and realistic about the outreach team's capabilities. If the initial contact cannot be made in person, an initial phone or virtual conversation would be acceptable when followed up by field-based services soon after.

If providers experience challenges in meeting these response times due to staffing shortages or other circumstances, the regional RNP administrator and/or HCA program managers will work with them to identify solutions to improve services, which may include amendments to the Recovery Navigator Program plan.

Initial interaction

There are two required components to becoming enrolled into RNP case management: Completion of an intake assessment and signing a multi-party release of information (ROI) to allow system partners to appropriately share information.

Assessment

A biopsychosocial assessment is identified by RCW 71.24.115 as a required element of the Recovery Navigator Program, functioning as a brief but detailed wellbeing screening administered by outreach and referral staff members. In this context the term Biopsychosocial Assessment does not refer to a clinical assessment for diagnostic purposes and may be administered by staff without clinical credentials, but must be an in-depth assessment of a participant's past family and health history, including:

- Any known diagnoses relevant to physical and behavioral health
- Treatment and service history and experiences
- Substance use patterns
- Legal system history and current involvement
- Resources and supports
- Existing service relationships
- Immediate obligation, opportunities and risks (including interpersonal power dynamics and exploitation)
- legal obstacles
- Housing/shelter history and current living situation
- Any current crisis conditions
- Goal

This assessment becomes the foundation of the individual intervention plan and completing it is one of two requirements (the other being signing the multi-party ROI) for a pending charge to be diverted and not filed. This may occur during the initial meeting with program staff but may take place after that initial meeting as well. Time limits for completing intake will be established by the PCG and may vary depending on the kind of referral made (arrest diversions typically have a shorter window to complete intake than a community or social contact referral).

Enrollment into case management

The individual will become a program participant if they are interested in case management and ongoing support, and then complete the necessary intake and multi-party release of information (ROI) that permits case conferencing and legal system coordination.

After indicating that they would like to receive services and have completed the ROI, RNP staff will work with the individual to engage with referral services once they have built trust and a relationship with the participant. (See Confidentiality and Privacy for more information regarding the consent process.)

Once a relationship has been established, program staff will attempt to enroll individuals into a health insurance plan, if eligible and not already enrolled. This will help with connecting to additional resources and addressing the medical co-morbidities for the priority population. More information on Medicaid enrollment may be found on the Healthplan Finder website.

Time limit

There will be no fixed time limit for participation in the RNP. This will remove barriers which prevent individuals from engaging multiple times along the trajectory of their recovery. Recovery Navigator Programs are not crisis response programs nor a program that provides transactional, short-term interventions.

This model allows a person to access the support they need to re-establish services and connection, no matter how long it takes and regardless of how many times the person needs to reconnect. However, every community will want to use its resources efficiently and effectively, which means that case management slots should not be

allocated for an extended period to disconnected participants who do not respond to sustained outreach efforts. If an individual loses contact, and then contacts the RNP, program staff will engage that individual despite the amount of time which has passed.

Fundamental framework and standard of care

RNP is intended to change the systems to which individuals who use drugs are relegated and provide an alternative framework that is person-centered and acknowledges that substance use is best addressed in the community.

Addressing disparities in the criminal legal system

The Recovery Navigator Program is designed to help communities build a different system of care and an alternative to the criminal legal system. RNPs should be intentional in outreach and case management to ensure individuals who have historically been disproportionately impacted by the criminal legal system have access to the program and its related services.

To ensure that RNP addresses racial inequities, BH-ASOs must provide access to education and training resources to enhance knowledge and awareness of diversity, equity, and inclusion issues, specifically for those involved in the criminal legal system. These resources must explore the potential impact of one's own beliefs towards those with backgrounds different from their own and how those beliefs can impact the people we serve and the continuum of care for substance use disorder and for individuals who have problematic substance use, unaddressed behavioral health, and/or living in poverty.

Training and education should be designed to bring together and highlight diverse experiences and create more welcoming and inclusive spaces for RNP staff and program participants.

Person-centered care

The Recovery Navigator Program staff must adhere to the following guidelines. Training resources will be provided by the Washington Health Care Authority and/or LEAD Support Bureau.

Trauma-informed approach and trauma-informed care perspectives

Trauma-informed policies, practices, and approaches that create a safe and supportive environment are required elements for the Recovery Navigator Program plan. Addressing and understanding underlying psychological trauma, recognizing self-sabotaging trauma responses as such, and listening to program participants and working to integrate their voices into their Individual Intervention Plan is key.

RNP staff are trained in utilizing trauma informed practices for both procedural work and, if applicable, clinical work. RNP's commitment is to increasing access to care, and RNP staff will strive to eliminate unnecessary processes.

For law enforcement officers (as well as prosecutors and other criminal legal partners such as probation officers), understanding the connections among trauma, its connection to substance use, and trauma-related behaviors can shift their perceptions of why people use substances or engage in criminal activity to support their ongoing substance use. By drawing this connection, we enhance their understanding of what works to reduce associated harms, while building capacity to effectively respond to situations that may involve people whose words, attitudes, and actions may reflect their traumatic experiences.

Harm-reduction framework

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences sometimes associated with drug use. It is also a social justice movement built on a belief in and respect for the rights of people who use drugs. In the context of RNP and the LEAD framework, harm reduction is practiced by meeting individuals where they physically and mentally are and working with individually to improve their respective health, stability, physical safety, access to lawful income, community connection, and hopes for meaningful lives.

This framework acknowledges the reality that continued unlawful behavior is likely to result in law enforcement responses, and that reducing negative interactions with law enforcement is therefore a goal of harm reduction. Abstinence is not a requirement of harm reduction, nor may it be an immediate or even eventual goal. Harm

reduction prioritizes the voice and experience of the individual involved in drug use and supports that person in self-identified goals. These goals may include opportunities to incrementally reduce harmful behaviors.

Although harm reduction encourages incremental change, a commitment to harm reduction does not minimize nor ignore public health and public safety consequences associated with stigmatization of people who use drugs, stigma around the criminalization of drugs and people who use them, and stigmatization of other approaches to substance use or mental illnesses.

The goal of RNP is to use a framework of engagement – not separation and punishment – to reduce negative impacts often associated with substance use such as transmission of infectious diseases and overdose. The BH-ASOs will provide policies and procedures aligned with program requirements that encompass the following mandates:

- Participants are engaged where they are regardless of the severity of their substance use
- Participants are not penalized or denied services if they do not achieve or aim for abstinence from substances
- Participants continue to receive support even when they continue to struggle or engage in unlawful activity

The policy and procedures should demonstrate how services may be modified to ensure that the engagement fits the individualized need of the participant.

Cultural appropriateness

It is essential that the RNP tailors to the needs of different racial and ethnic groups, American Indian/Alaskan Native individuals, LGBTQIA2S+ people, immigrants, refugees, people whose first language is not English, people with disabilities, and other populations.

All aspects of the program, including outreach, case management, and project management, are intended to be provided from a culturally specific and mindful framework. Programs should show understanding of barriers faced by historically under-served or inadequately served populations in accessing standard systems of care. Further, programs should not refer participants back into those same systems expecting success.

Programs will consider culturally appropriate care when working with American Indian/Alaskan Native populations and incorporate best practices for connections to Indian Health Care Providers (IHCP) for Tribal members or those that access services as a medical home at a Tribe. RNPs will be mindful of how programs can ensure retention of current services when possible or when services are already established with an IHCP. Program Managers should take intentional steps to work with tribes within the program catchment area. HCA-Office of Tribal Affairs is available to provide technical assistance and support.

Training and staff competencies

All BH-ASOs must ensure that staff who are conducting services have appropriate initial training and receive continuing education. HCA shall arrange for technical assistance to be provided by the LEAD Support Bureau. The RNP administrator employed through the BH-ASO will maintain a training plan in the Recovery Navigator Program plan. The plan will describe how staff will have access to formal training, including the following:

- CPR and medical first aid
- Overdose prevention, recognition, and response
- Safety training
- Motivational interviewing
- Shared decision-making processes for services
- Building relationships
- Strength-based approaches for goal development
- Confidentiality, HIPAA, and 42 CFR Part 2 training
- Harm reduction
- Trauma- informed responses
- Cultural appropriateness
- Government-to-government training for Tribal collaboration
- Working with American Indian/Alaska Native individuals
- Diversity training
- Mental health first aid
- Conflict resolution and de-escalation techniques
- Crisis intervention
- Suicide prevention

Safety

Programs will develop and provide safety protocols for the staff as well as participants in this program. Program staff are expected to have the ability to remain in contact and request support as needed during day-to-day operations and outreach activities. In areas where there is no cell phone access, alternative measures such as long-range radio communicators or mobile hotspots will be considered.

Programs must note which measures they will take to ensure that staff and participants are safe in situations where an individual is being transported. Safety protocols regarding transporting individuals will be in place and reflect programmatic needs.

In addition, the safety protocols will describe a process for mandatory reporting, similar to WAC 246-16-220, if there is any indication of child, domestic, elderly abuse. In addition, the safety policies must document a process the staff will take when an individual is a danger to self, others, and/or property. This will require partnership with local mobile crisis response teams, designated crisis responders, and law enforcement to assist when necessary.

Examples of safety protocols:

- SAMHSA Toolkit for Behavioral Health Crisis Care
- Staff will not be alone in an isolated place without a clear, safe exit or visibility
- Staff vehicle will always be within view of the program staff member

Golden thread service coordination

Individuals referred to RNP staff may have a multitude of needs that must be addressed to achieve stabilization and set the stage to address problematic activities associated with their quality of life. Case managers work to address the participant's social determinants of health, including legal advocacy and access to a stable legal income stream.

Intensive Case management through RNP provides support in accessing these services and additional assistance in many aspects of the participant's life. Case management is the "golden thread" that stays with the participant over time and works to address setbacks and barriers. The BH-ASO must summarize existing resources within the community in their Recovery Navigator Program plan and demonstrate how RNP staff will leverage those resources through their Case management activities.

Individual intervention plan

This coordination of services will include individualized interventions with a culturally directed service coordination plan which the participant creates through a shared decision-making process with the case manager. Case management will occur in a way that reaches and supports the individual physically and mentally with the goal of connecting and weaving the various indicated services along the continuum of care.

Caseload

All RNP case managers are expected to work with a blend of very active participants (Light Case management or LCM and Intensive Case management or ICM) as well as those who still need proactive engagement in the field initiated by the team (Outreach Referral and Outreach Status). The average caseload should be no more than 20 people between these various classifications. No case manager's caseload should exceed 25 unless it can be demonstrated that a temporary increase does not negatively impact the established level of care for program participants. The national average caseload for intensive case management is around 12 to 15 individuals per case manager, and programs are encouraged to keep this in mind as they determine the appropriate caseload balance between individuals in outreach and LCM/ICM status.

There are situations where RNP caseloads may exceed the 20 participants per case manager average, whether due to an influx of new referrals, heightened engagement from case management participants, re-engagement from individuals who had previously been out of reach for an extended period, or other mitigating factors.

Programs are expected to plan and prepare for such eventualities in advance, and to establish guidelines for case managers to follow when considering how to balance active participants and those who could be considered inactive but able to re-engage, allowing for their status to be switched from LCM/ICM back to Outreach.

Technical assistance from the LEAD Support Bureau is available to address staffing and caseload understanding as individual programs will vary in their needs.

Case management staffing should be paced to expand slightly ahead of current caseloads as resources permit, and referral recruitment and program participation should be paced to land slightly under the levels that can be supported by anticipated funding. This combination is designed to ensure that there is always room for highest priority new referrals, especially from law enforcement for individuals who would otherwise be destined for jail and prosecution. Individuals who have the most frequent contact with law enforcement or emergency services in the surrounding community are often in greatest need of sustained effort to build trust; maintaining an appropriate caseload ensures available capacity to be responsive to these and other needs of those served.

Case management classifications

The following are considerations for determining level of engagement and to assist care team supervision and case management in determining an appropriate caseload. There is no time limit for participating in RNP, and no universal goal or marker of success for all participants. Programs are encouraged to develop protocols for

identifying individuals who no longer need regular support but might return if circumstances change, ensuring that case management slots are being used efficiently.

Outreach referral

Referral made, no screening completed, formal Intake not complete, and individual is not interested in services. Contact information may have been provided for future follow-up.

Outreach status

Referral made, screening completed, individual not interested in case management but indicates need for occasional support. This status could also apply to individuals who decline a prebooking diversion referral in lieu of arrest or citation but indicates interest in engagement later. Referral and Outreach RNP staff may check on the individual periodically to monitor safety and stage of motivation and readiness to engage in services.

Light case management

Referral made, screening completed, individual has indicated an interest in basic services (e.g., referral to housing). The individual has completed the intake process and is considered a program participant and is included in staffing and case conferencing.

Intensive case management

Referral made, screening completed, individual identified as in need of intensive case management through case conferencing. Individuals receiving intensive case management could possess several comorbidities, might be experiencing homelessness, and could require more peer-driven assistance and care coordination.

Cross-agency communication

RNP works to address crime and public disorder by building a coordinated, non-punitive, community-based system of care to reduce unlawful and problematic behavior of people whose conduct stems from complex behavioral health challenges or poverty.

Legal system coordination (both pre-existing cases and any new potential charges) is a fundamental part of the service coordination between case manager and program participant. There are often opportunities to avoid new criminal filings that would compromise the Individual Intervention Plan, via case conferencing pursuant to a Release of Information (ROI). This is the benefit that the case manager will explain to the participant when discussing the ROI that permits information-sharing with legal system partners when needed and in the interest of the participant.

Program managers will ensure that necessary multi-party releases and memorandums of understanding are in place to promote cross agency communication for service coordination purposes (See Appendices for sample documents).

Officers or prosecutors are essential to care coordination discussions as these allow them to benefit from and contribute to the collective conversation. This subsequently provides access to knowledge and insights both about individual participants and about the larger landscape. Most importantly, engaging in these multi-agency conversations can help officers and prosecutors avoid unintentionally disrupting a participant's progress with unnecessary court appearances, conditions, and incarceration. In turn, law enforcement officers often have access to real-time information about participants and about current dynamics on the street that can be helpful to case managers and to other members of the multi-disciplinary OWG.

HCA is involved with integrating parallel projects and working towards systems which coordinate with one another (Clubhouse Services, Recovery Housing, other recovery supports, HOST, Health Engagement Hubs, or other programs funded as part of Washington State's legislative response to State v. Blake and intended to complement one another). BH-ASOs must identify low barrier resources in the community and include narrative detailing areas of collaboration as part of any revisions or updates to the RNP Plan.

Confidentiality, privacy, and data collection

Policy

Information shall be shared in a way that protects individuals' confidentiality rights as service and treatment consumers and that protects individuals' constitutional rights if involved in legal processes.

Release of information

To support coordination of care, program participants, once enrolled, must sign a multi-party release of information (ROI) allowing partners to appropriately share information. The multi-party ROI is an essential precondition for ongoing care coordination among RNP operational partners, allowing case managers to share information as needed and appropriate with police, prosecutors, judges, other care providers, and even neighborhood businesses and government officials, if to do so is in the participant's best interest.

During outreach or field-based engagement, an ROI to share personally identifiable information (PII) is not necessary to establish a relationship, but completion of the ROI is a required element of program participation and marks a transition away from outreach status and to official program enrollment. The enrolled participant needs to have a ROI in place to coordinate services between the Recovery Navigator Program, the criminal legal system, and other agencies providing services.

Consent to participate

Separate from the multi-party ROI, a *Consent to Participate* document is a program participation requirement and should be completed prior to sharing any PII data with the Washington State Health Care Authority. To evaluate services and the regional and state level impacts, participant level data is needed, so processes should be developed and maintained that facilitate this information gathering and sharing, while still allowing individuals the option to opt out of sharing identifiable information with HCA at the referral and outreach stage. If a program participant does not sign a consent, only non-identifiable data may be shared. (A sample procedure can be found in the appendix.)

The confidentiality policy is applied to all interactions between individuals, Recovery Navigator Program personnel and partners.

Data collection and evaluation

The collection and review of data are essential elements in assessing the project's individual and systemic outcomes and ongoing quality improvement.

The Health Care Authority (HCA) is responsible for organizing data collection and reporting of referral, outreach, and case management. The RNP Data Collection Workbook is provided to BH-ASOs and their contractors and is submitted to HCA every quarter. The variables and data categories align with metrics associated with other similar programs, as well as prescribed data definitions found in the Behavioral Health Data System data guide.

In alignment with RCW 71.24.115(6), these data are then presented to the Substance Use and Recovery Services Advisory Committee for discussion and quality improvement.

In implementing, expanding, and operating RNP, BH-ASOs and involved partners will give due consideration to identify and access relevant, available, and reliable data necessary to support fidelity, efficiency, and efficacy and to contribute to current or future evaluation efforts related to the Washington State Institute for Public Policy (WSIPP) study on RNP and LEAD programs outlined in RCW 71.24.909.

HCA is responsible for the regular review of the programs funded by the BH-ASOs and will work closely with the BH-ASOs to develop a process to ensure adherence to uniform program standards and fidelity to the LEAD core principles.

Appendices

Definitions

Community-based organizations: A public or private nonprofit organization that is representative of a community or significant segments of a community; and provides educational, health, social support, or other related services to individuals in the community.

Developmentally appropriate: A term that refers to engagement and services and/or supports that account for varying rates of mental, emotional, and social development-based and age-related milestones designed to meet the needs of specific populations.

Field-based: A phrase referring to a specific region where data, outreach, or referrals are sourced or intended. "Field" can refer to alleys, parks, encampments, or any community-based setting or location where engagement for the purpose of SUD outreach and referral would be beneficial. Examples: Hospitals, treatment centers, youth drop-in centers, temporary housing, schools, dispensaries. Field-based programs should feature or arrange for street-level behavioral health and medical services. Where such services exist, they should be engaged and supported to expand, not duplicated.

Holistic services: Services that consider the individual's overall physical, mental, spiritual, and emotional well-being to promote increased quality of life and optimal health outcomes.

Outreach: The intentional act of meeting people where they are physically and mentally to engage in conversation and extend program offerings. Outreach services typically are mobile and integrate teleservices when applicable. This includes identification of historically underserved and marginalized individuals and engagement of these individuals in assessment and ongoing supportive services as necessary.

Peer: A general term for individuals who have the lived experience of recovery from mental health, substance use, and/or traumatic conditions, and who have specialized training and supervision to guide and support people toward increased wellness who have experienced similar conditions.

Recovery: A process of change through which individuals improve their health and wellness, live a self- directed life, and strive to reach their full potential, as determined by individuals' own, respective understandings of their recovery paths. There are four major dimensions that support a life in recovery: health, home, purpose, and community. [3]

Regional Recovery Navigator Program plan: A program plan submitted by every behavioral health administrative services organization that demonstrates the ability to fully comply with statewide program standards that is set in place prior to receiving funding for implementation and ongoing administration.

Social determinants of health (SDOH): The conditions in the environments where people are born, live, learn, work, play, worship, and age that are shown to affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.[4]

[3] "Recovery Support Tools and Resources, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved July 27, 2021 from https://www.samhsa.gov/brss-tacs/recovery-support-tools-resources

[4] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved July 29, 2021, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Supporting documents

The following links and examples are provided as recommended templates to use for operational aspects of the Recovery Navigator Program

- 2021 Uniform Program Standards
    - *The UPS from 2021 includes several examples of forms used during the initial implementation period of the Recovery Navigator Program to develop support documents at the regional level. The examples provided in the 2021 Standards are available for historical reference and comparison, and include:*
        - Release of Information
        - LEAD ROI Example
        - RNP Participant Consent Form
        - RNP Participant Screening Form
        - RNP Participant Intake Narrative
        - LEAD New Client Intake Example
        - Program Staff Job Descriptions
        - Sample Staffing Model
- Sequential Intercept Model
    - *The Sequential Intercept Model link here contains multiple resources related to the model*
- Pretrial diversion MOA
    - *The pretrial diversion section of the Uniform Program Standards begins* *on page 17*
- Pretrial Diversion Progress Report
    - *The pretrial diversion section of the Uniform Program Standards begins* *on page 17*
- Pretrial Diversion Assessment Confirmation Report
    - *The pretrial diversion section of the Uniform Program Standards begins* *on page 17*

Memorandum of Agreement Between and Among
LEAD Programs, Recovery Navigator Programs, and Arrest and Jail Alternative Programs
and Courts and/or Prosecutors
Regarding Pre-trial Diversion or Pre-Filing Diversion Referrals for Services
Version 2.0 January 2025

1. PURPOSE

This Memorandum of Agreement ("MOA") is made between and among the undersigned Court or Prosecutor and the LEAD Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity program ("LEAD"), Recovery Navigator Program ("RNP"), and/or Arrest and Jail Alternative Program ("AJA") operating in the jurisdiction served by the Court or Prosecutor.

2. BACKGROUND/PROGRAM ORIGINS & PURPOSE

In recent years, Washington State's legislature has recognized and funded three aligned programs intended to offer means for some illegal conduct that appears to be related to unmet behavioral health needs and/or extreme poverty to be addressed through diversion to community-based case management and legal system coordination, in lieu of jail booking and referral for prosecution. These legislative funding initiatives occurred via Senate Bill 5380 (2019), which established funding to implement LEAD in several new jurisdictions, administered by the Health Care Authority ("HCA"); House Bill 1767 (2019), which established the AJA program, administered through the Washington Association of Sheriffs and Police Chiefs ("WASPC"); and Engrossed Substitute Senate Bill 5476 (2021), which established RNP programs, administered by HCA. By statute, both RNP and AJA are explicitly aligned to varying degrees with the LEAD model. All operate on the principle that social workers work with people who are exposed to legal system involvement related to behavioral health issues, seek to establish trust with participants, and do not serve as the mechanism through which participants face adverse legal consequences as a result of leaning into the case management relationship and sharing their struggles.

The LEAD model was originated in Seattle, WA, in 2011, to enhance public safety by building a community-based alternative to jail and prosecution for people whose unlawful behavior stems from unmet substance use needs, mental health challenges, or extreme poverty. In the years since, LEAD has been replicated in dozens of communities across the nation, as well as within Washington State. An independent University of Washington evaluation conducted from 2014-2015, and published in peer-reviewed journals from 2017-2019, found that the LEAD approach reduced recidivism (across all offenses), decreased felony filings and jail and prison utilization, and improved shelter, housing, and lawful income outcomes, compared to those processed through the standard jail and court system. Subsequent evaluations of LEAD initiatives around the country have found similar impacts.

3. ENGROSSED SENATE BILL 5536

In May 2023, the Washington State Legislature passed Engrossed Senate Bill 5536, which further defined how all three of these programs may be used.

The bill explicitly encourages pre-booking diversion to LEAD, AJA, and RNP programs, or to other resources, for drug possession and public use offenses, without limitation, reinforcing the existing pre-booking diversion focus of all three programs.

The bill goes on to specify that, in jurisdictions that have such programs, defendants who do have possession or public use charges filed may make a motion for pre-trial diversion, and if approved, the

Court will direct those defendants to LEAD, AJA, or RNP service providers to conduct an assessment (which is not further defined in the statute, but in those programs, is an in-depth psychosocial assessment identifying complex factors that may be related to instability, health issues, criminal behavior, and other areas in need of support, including but not limited to problematic drug use).[1] After the service provider reports back to the Court that an assessment has been completed, the defendant may be granted pre-trial diversion, and, after service provider(s) file progress reports with the Court, the defendant's charge may be dismissed after a finding of substantial compliance.

While not specifically provided for by ESB 5536, nothing in the legislation precludes prosecutors from also referring would-be defendants to LEAD, RNPs, and AJA programs for services in lieu of filing charges. Courts may also refer defendants to available therapeutic court options.[2]

ESB 5536 directs service providers for LEAD, RNP, and AJA programs to whom pre-trial diversion referrals are made to (i) file under seal a written confirmation of a defendant's assessment and a statement indicating the defendant's enrollment or referral to specific services[3] and (ii) report to the Court no less than monthly on the defendant's progress;[4] these progress reports will also be filed under seal.

LEAD historically has provided pre-booking and pre-arrest diversion services and has not received pre-trial diversion referrals; both RNP and AJA programs, aligned with LEAD, have reflected these historical principles.

However, it is also true that in the LEAD model, case managers do often provide information to courts and prosecutors as part of their regular role. In addition to their diverted cases, many participants also have non-diverted cases pending in court or in prosecutors' filing queues. As a central element of the LEAD model, and consistent with the multi-party Release of Information ("ROI") signed by each participant, case managers often share information with prosecutors and judges to foster case coordination and informed decision-making that enables those entities to adjust their approach to support, and not compromise, the participant's recovery path. This established framework for sharing accurate information that does not create a misleading impression with courts and prosecutors, while ensuring that the case manager is not the cause of adverse consequences to their client, can be adapted to provide a framework for pre-trial and pre-filing diversion to LEAD, AJA, and RNP services.

ESB 5536 further provides that defendant's pre-trial diversion may be revoked, after a hearing, for failure to substantially comply with recommended "treatment or services."[5,6]

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[1] ESB 5536, Section 9(2)-(6), page 10
[2] ESB 5536, Section 9(1), page 10
[3] ESB 5536, Section 9(4), page 12
[4] ESB 5536, Section 9(6), page 13
[5] ESB 5536, Sec 9(10), page 13
[6] Due process in a diversion or probation revocation proceeding generally requires an evidentiary hearing with cross-examination of witnesses.

4. CONSIDERATIONS

Case managers cannot function as probation officers or testify against their clients;[7] LEAD, RNP & AJA participation cannot cause or augment adverse consequences for any individual.

The LEAD model (and aligned RNP and AJA programs) rely on the "golden rule" that no one may be worse off for participating in these programs. Otherwise, participants would not continue to voluntarily share sensitive information about their challenges and problems with case managers, and those case managers, in turn, would not continue to voluntarily share that information with police and prosecutors as needed for care coordination. It is essential that participants feel able to speak candidly with their case managers, including a willingness to share information about ongoing embarrassing or illegal activity; such candor enables case managers to develop informed and realistic plans to reduce problematic behavior, and sharing such information with police and prosecutors allows them to thoughtfully and responsibly exercise their discretion in ways that often support, but in any event do not unnecessarily impede, someone's recovery path.

When case managers share information with law enforcement and prosecutors, they must always be truthful and must not create a false impression but are also careful not to provide information sufficiently detailed as to catalyze action by law enforcement or put police or prosecutors in a difficult position if they withhold action.

In the LEAD model, participation does not confer immunity from enforcement in future instances of misconduct. However, if a participant continues to engage in unlawful behavior, the worst that should happen is that they are treated as they would be in the ordinary course of business. Information shared by or about a participant must not be the basis of adverse action taken against the participant, barring truly extraordinary circumstances.

A corollary is that case managers do not function as probation officers. They will provide only truthful information to courts, prosecutors, and law enforcement, and do not mislead, but they are not the channel through which specific violations of court probation or evidence of new crimes may be produced. This boundary enables them to maintain a relationship of confidence with participants; exceptions to this rule would damage the foundations of the model.

LEAD, RNP & AJA programs have capacity constraints and must ensure that pre-booking and pre-arrest referrals can be prioritized.

LEAD, RNP, and AJA programs are not funded to match the scale of potential appropriate referrals anywhere in the state. Referrals from courts and prosecutors should not reduce or eliminate capacity for pre-booking diversion, the primary role these programs are intended to play, to engage individuals earlier in the sequential intercept model, reduce cost and increase efficacy.

Given the limited capacity of these programs, it will be important for courts to prioritize which cases are the best match for referral to LEAD, RNP, and AJA programs where they exist. These programs are a good match for individuals who are chronically exposed to the legal system, appear to struggle with

[7] Except under extraordinary circumstances

complex behavioral health issues, and lack individual or family resources with which to address those problems. They are not the ideal match for casual/recreational drug users, individuals who are having a one-off contact with the legal system, or individuals who have access to substantial private resources.

The LEAD model caseload standard is that case managers should average no more than 20 participants, and no case manager should exceed 25 participants. This is already high for intensive case management (generally 12-15 clients per case manager). Above these levels, the efficacy of the intervention is difficult to maintain. It is understood that LEAD, RNP, & AJA programs must decline referrals that would drive caseloads over these standards. The programs will make an effort to communicate to HCA or WASPC (their funders) that demand exceeds capacity, for their awareness, in the event that appropriate referrals must be declined for this reason.

5. AGREEMENTS

Considering this history and purpose, and consistent with both law and the LEAD model, this MOA affirms the following agreements among the parties:

5.1. Function of Program in Pre-trial or Pre-Filing Referral Context

5.1.a. The referring Court or Prosecutor acknowledges that the primary role of LEAD, RNP, and AJA programs is to engage individuals at points on the sequential intercept model ahead of referral for prosecution; that resources are limited; and that caseload limits require that case managers average no more than 20 individuals and that no case manager exceed 25 individuals. While these programs will attempt to serve all appropriate referrals, capacity limits may preclude taking additional referrals from courts/prosecutors. The parties agree that, should that situation emerge, the programs will make every effort to communicate with referring courts/prosecutors and identify additional resources or problem-solve, and will convey the capacity issues to the HCA (as funder for LEAD and RNP programs) or to WASPC (as funder for AJA programs).

5.1.b. The goal of engagement in the programs is to improve participants' situations, foster stabilization and recovery as defined by SAMHSA/RCW 18.205.020(3), reduce illegal activity, and reduce problems and impact for the community.

5.1.c. The referring Court or Prosecutor will endeavor not to refer to the programs any individuals who have expressed that they have the resources and desire to pursue treatment or services elsewhere.

5.1.d. The referring Court or Prosecutor will bear in mind that, for some individuals with significant mental illness or other serious challenges, it may take considerably more than 30 days to gain the confidence and capacity to sign the ROI that is required for program participation.

5.1.e. The referral will include any known contact or location information for the individual referred. The program will make best efforts, including repeated field outreach if appropriate, to locate and engage the referred individual. If the individual is not engaged because of capacity or staffing issues at the program, the program will forthrightly inform the referring Court or Prosecutor on the assessment reporting form attached to this Agreement, or any future version created to effectuate this Agreement.

5.1.f. If the program, after the intake interview, concludes that the referred individual has need for or could benefit from recovery or behavioral health supports, and appropriate supports are available in the community, the programs will so inform the referring Court under seal, along with defense and prosecution; or the referring Prosecutor, if the referral was pre-filing (in which case there would not normally be defense counsel assigned; copies will be provided to defense counsel if they have appeared and this is known to the program). The program will indicate whether it will be providing services or whether it will refer or has referred the individual for care elsewhere, and will confirm whether any other program to which the individual is being referred has agreed to provide care.

5.1.g. If the program, after the intake interview, concludes that the referred individual has need for or could benefit from recovery or behavioral health supports, but determines that appropriate/needed resources are not reasonably available in the community or accessible to the referred individual, the program will so inform the Court, prosecutor, and defense, under seal. Under such circumstances, the referring Court or Prosecutor will presumptively deem the completion of the intake assessment to satisfy the requirements of pre-trial diversion, and agree to dismiss the case, or to adjourn the case in contemplation of dismissal without additional active conditions, for a period not greater than 12 months.

5.1.h. If the program, after the intake interview, concludes that a referred individual has no need for recovery or behavioral health supports, the program will so inform the referring Court under seal with copies to defense and prosecution; or the referring Prosecutor, if the referral was pre-filing (in which case there would not normally be defense counsel assigned; copies will be provided to defense counsel if they have appeared and this is known to the program). As provided in SB 5536, the defendant may then obtain a dismissal by completion of community service in an amount to be set by the Court not to exceed 120 hours.

5.2. Inter-Agency Practices

5.2.a. The referring Court will work with the programs to establish a simple procedure for filing reports and documents under seal.

5.2.b. Within 45 days of referral (to allow time to complete intake and submit report), the program will report back to the referring Prosecutor or (under seal) to the referring Court either (i) that the participant completed an intake interview within 30 days of receipt of the referral, or (ii) that the participant did not. If extenuating circumstances are known to the program, that fact will be shared with a level of general detail sufficient for the Court or Prosecutor to consider extending the time to complete the referral. If the Court or Prosecutor extends the time to complete the referral, the Court or Prosecutor will notify the program so it can continue attempts at outreach and engagement.

5.2.c. Thereafter, the program will provide monthly updates on the participant's progress, with the understanding that unnecessary details will not be provided, information that would be embarrassing or stigmatizing to the defendant will be generalized to prevent that harm, and no specific information about illegal conduct will be provided. The program will not mislead the Court or Prosecutor as to the participant's progress, and must not allow an implication to arise from lack of information that a known problematic situation is unproblematic. If the situation is problematic, and there is no notable progress to report, the program will indicate, "there is nothing helpful to report at this time." The report will

indicate if there has been no engagement by the individual after multiple in-field outreach efforts.

5.2.d. In the event that the program refers the participant to another organization for services as reporting in the initial assessment report, the program may arrange for that primary service provider to submit reports to the Court or referring Prosecutor, in lieu of ongoing reports from the LEAD, RNP or AJA program. In all respects, the Court or referring Prosecutor will handle these reports in the same manner provided for herein for reports from the LEAD, RNP or AJA programs, filing them under seal and noting that they are exempt from public disclosure. The contents of these reports, and any supplementary reporting or communication to the Court or referring Prosecutor by such additional providers will be governed by those providers' understanding of clinical best practice and their obligations under federal and state privacy laws.

5.2.e. The signatories agree that, as referrals are made and reports are provided to the Court or Prosecutor, challenges in implementation and functioning not addressed by this MOA will be discussed collaboratively with the goal of resolving the issue in keeping with the legislative goals manifested in SB 5536.

5.3. Service Approach

5.3.a. The programs will endeavor to provide participants with trauma-informed, low-barrier care and support, using research-based approaches such as Stages of Change and Motivational Interviewing, consistent with LEAD core principles and the SAMHSA definition of recovery, as codified in Washington at RCW 18.205.020(3), and will attempt to access any available supports, services, housing, treatment, or care that the participant is interested in pursuing and that, in the provider's professional opinion, would benefit the participant.

5.3.b. Program services will be provided by staff with access to clinical supervision in behavioral health care (either on staff or contracted).

5.4. Public Records Requests and Testimony

5.4.a. The referring Court or Prosecutor will maintain any reports or documents from the service provider in a designated portion of their case file and will give the defendant and their legal counsel, as well as the programs, notice of any public records request that could reasonably be interpreted as requiring release of those documents or reports; such notice will be provided at least 14 calendar days in advance of producing the record(s) or report(s) to any requester, and the referring Court or Prosecutor will abide by the legislative prohibition on disclosure of pre-trial diversion assessment or progress reports.

5.4.b. The referring Court or Prosecutor agree not to subpoena or call a case manager or other program staff to testify against a participant in the event a revocation hearing is held, and further agrees not to subpoena program records. It is understood that nothing herein impairs the defendant's 6th Amendment right to subpoena witnesses including the case manager or other staff. Revocation, where necessary and appropriate, would be based on positive evidence such as a new alleged illegal act or testimony of other witnesses, or the absence of evidence of progress, subject to existing case law and due process frameworks for probation or diversion revocation.

5.4.c. Nothing herein precludes program staff from voluntarily addressing the Court, at the request of defense, prosecution, or the Court, or communicating with prosecutors, with

the objective of care and case coordination, according to the professional judgement of program staff and pursuant to the program ROI, and subject to established program guidelines that communication is truthful and not misleading.

6. Term and Termination

This agreement is effective upon signing by the entity seeking to refer cases (Court or Prosecutor), and the receiving program's project manager or funding entity. It will remain in effect unless the agreement is modified or revoked in writing.

7. Signatures

Agreed and Affirmed by the Undersigned Parties on Behalf of Their Agencies:

Name and Title Organization	Date
Name and Title Organization	Date
Name and Title Organization	Date

Pretrial Diversion Monthly Progress Report

file under seal/exempt from public disclosure

(RCW 69.50.[XXX]/Chapter 1, Laws of 2023, 1st Special Session)

~~This is a fillable form.~~ Version dated October 2023

Case management agency name	
Name of person completing this form	
Date form is completed	
Participant name	

Areas of participant's focus; check all that apply.	Use this space to provide summary notes on progress, if relevant and helpful.
☐ Housing/shelter	
☐ SUD services	
☐ Mental health services	
☐ Other medical services	
☐ Public benefits/income	
☐ In-home support	
☐ Family support	
☐ Legal services	
☐ Other	
☐ Never engaged despite multiple in-field (not phone or email) outreach efforts over at least two months.	
☐ Nothing helpful to share in this reporting period.	
If there are barriers to access/availability of services in participant's areas of focus, please summarize here.	

Pretrial Diversion Assessment Status Report

(RCW 69.50.[XXX]/Chapter 1, Laws of 2023, 1st Special Session)

DO NOT FILE ANY COMPLETED ASSESSMENTS WITH COURT OR SERVE ON PROSECUTOR.
INSTEAD, FILE ONLY THIS ASSESSMENT STATUS REPORT.

Case management agency name

Name of person completing this form

Date form is completed

Participant name

Assessment status	Is the assessment completed?	Yes	No	Date completed, if applicable:
	Is the assessment in progress?	Yes	No	Date begun, if applicable:

If assessment has been completed, are services needed?	Yes	No	Not yet known
If services are needed, is the person enrolled in reporting agency's case management program?	Yes	No	In progress
If the person is not enrolled in reporting agency's case management services, referred to/enrolled in other services?	Yes	No	In progress

If services are needed, what are the areas of need? (check all that apply)

Housing/shelter	Public benefits/income
SUD services	Skilled nursing/adult family home
Mental health services	In-home support
Other medical services	Family support
Legal services	Other (describe in the text box below)

If services are needed, are services secured and/or pending? Yes No Barriers/gaps (see below)

If you have indicated above that services are needed but are not reasonably available to this individual due to barriers or gaps, briefly explain the nature of the gaps or barriers here.

Pretrial Diversion Assessment Confirmation Report

file under seal/exempt from public disclosure

(RCW 69.50.[XXX]/Chapter 1, Laws of 2023, 1st Special Session)

DO NOT FILE ASSESSMENT WITH COURT OR SERVE ON PROSECUTOR

~~This is a fillable form.~~

Date form is completed					
Assessment status	Completed?	Yes	No	Date completed, if applicable:	
	In progress?	Yes	No	Date begun, if applicable:	

If assessment has been completed, are services needed?	Yes		No		Not yet known	
If services are needed, is the person enrolled in reporting agency's case management program?	Yes		No		In progress	
If the person is not enrolled in reporting agency's case management services, referred to/enrolled in other services?	Yes		No		In progress	

If services are needed, what are the areas of need? (check all that apply)		Housing/shelter
		SUD services
		Mental health services
		Other medical services
		Public benefits/income
		Skilled nursing/adult family home
		In-home support
		Family support
		Legal services
		Other

If services are needed, are services secured and/or pending?	Yes		No	
If services are needed but not reasonably available to this individual, note that here and briefly explain nature of availability/access barrier(s) in the box below.	Services not available			

Explain barriers to access:	