Washington State Health Care Authority

Report to the Legislature

Involuntary Treatment Act Work Group

Follow-up report

Second Engrossed Second Substitute Senate Bill 5720; Section 103(2)(c); Chapter 302; Laws of 2020

June 30, 2022

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Executive summary

Second Engrossed Second Substitute Senate Bill 5720 passed in March 2020 and was signed into law by Governor Jay Inslee on April 2, 2020. The overall intent of the bill is to update, streamline, and modify Revised Code of Washington (RCW) 71.05 and RCW 71.34. These two chapters address involuntary treatment guidelines for adults and youth aged 13-17, better known as the Involuntary Treatment Act (ITA).

Section 103 of the bill requires that Health Care Authority (HCA) convene an ITA Work Group, which will produce two reports to the Office of the Governor and the Washington State Legislature. This report is the second of those two reports. Section 103 describes the initial scope and function of the work group as follows:

> (2) The work group shall:
>
> (b) Commencing January 1, 2021, meet at least six times to evaluate: (i) The implementation of one hundred twenty hour initial detention, and the effects, if any, on involuntary behavioral health treatment capacity statewide, including the infrequency of detentions, commitments, revocations of less restrictive alternative treatment, conditional release orders, single bed certifications, and no-bed reports under RCW 71.05.750; (ii) other issues related to implementation of this act; and (iii) other vulnerabilities in the involuntary treatment.
>
> (c) (i) develop recommendations for operating the crisis system based on the evaluation in (b) of this subsection; and (ii) disseminate those recommendations to stakeholders and report to the governor and the appropriate committees of the legislature no later than June 20, 2022.

Report highlights

Bringing together expertise from across Washington State, this work group reviewed the known effects of the 120-hour initial detention change. The implementation of recommendations from the first report was used as the starting point for further discussion and considerations. From these recommendations, 13 requests were moved forward through HCA's data division and provided for the purpose of this current report: These requests, and the answers to them, can be viewed in detail in Appendix A of this report.

This work group also discussed barriers preventing access to ITA services. The work group specifically noted issues around supporting the most successful programs, funding parity for Substance Use Disorder (SUD) and Mental Health (MH) treatment, and data collection of necessary aspects of the ITA system.

Background

Work group activities

The work group met six times between January and November of 2021. Due to the COVID-19 public health emergency, all meetings were held virtually. The Health Care Authority (HCA) used Zoom and Microsoft Teams to staff the meeting with multiple facilitators to ensure accessibility for all work group members.

The first meeting started with introductions and identifying the scope of the work group. The three co-chairs (Clay See representing long term inpatient providers; Anne Mizuta representing Washington Association of Prosecuting Attorneys; and Minette Smith: representing behavioral health peer counselors) continued with identifying the expectations for attendance and contributions of all members along with discussing the scope for the work group.

Throughout the process, the co-chairs consolidated the findings and recommendations to build this report with the intent to assist further evaluations of the changes to the ITA system. The report seen here is the final product of the work group and includes the findings and recommendations for the legislature's consideration.

Involuntary Treatment Act (ITA) work group January 2021 data recommendations

The initial data recommendations from the first ITA work group includes an analysis of certain identified data and the suggestion to begin tracking other data. From these recommendations 14 requests were moved forward through HCA's data division and provided for the purpose of this current report:

- Annual count of ITA investigations
- Annual count of ITA investigations resulting in initial detention
- Annual count of 14 day commitments for both substance use disorder (SUD) facilities and Evaluation and Treatment Centers
- Annual count of single bed certifications
- Annual count of no available bed reports
- Annual count of individuals released on 90/180 day less restrictive orders (LRO: a court order upon release from inpatient treatment requiring the individual to participate in behavioral health treatment in the community setting)
- Annual count of individuals released on LRO resulting from the 14-day petition prior to hearing, after the 14-day hearing, or at any time during the ITA process
- Annual count of 14 day hearings and hearing outcomes
- Annual count of individuals who are evaluated for involuntary treatment after completing a 14 day commitment (30-, 60-, and 90-day intervals post commitment)
- Annual count and comparison of individuals evaluated for involuntary treatment after 72 and 120 hour detentions (individuals who are not subsequently committed)
- Annual count of re-investigation rates (30-, 60-, and 90-days)
- Annual count of individuals who are detained after having 72 hour detention and 120 hour detentions (detained, but not committed, for 14 days)
- Annual count of individuals who have multiple detentions between 6 and 12 months

- Count of individuals who have multiple commitments after 72 and 120 hour detentions within 6 and 12 month periods

Each of the answers to these requests can be found in Appendix A of this report.

Work Group membership

Office of the governor appointed members

- Health Care Authority: David Reed
- Department of Health: Julie Tomaro
- Department of Social and Health Services: Jenise Gogan
- Prosecuting Attorney: Anne Mizuta, Co-Chair
- BH Peer: Minette Smith, Co-Chair
- Attorney General's Office: Robert Antanaitis
- Designated Crisis Responders: Courtney Hesla
- BH-ASOs: Jeffrey Hite
- MCOs: Sasha Waring
- Advocate NAMI: Brad Forbes/Katherine Seibel
- Advocate MOMI: Jerri Clark
- Family member or individuals with BH experience: Diane Weiner
- Short Term Inpatient Provider: Terri Card
- Long Term Inpatient Provider: John (Clay) See, Co-Chair
- Family and Parent Representative: William Oliver
- Defender Association: Kari Reardon
- Law Enforcement: Tony Lockhart
- Health Care Authority: Zephyr Forest

Other participants and observers

Legislators and legislative staff

- Representative: Lauren Davis
- Senator: Manka Dhingra
- Senate Staff: Kevin Black
- Senate Staff: Ashley Jackson

Other participants and observers

- Facilitator HCA: Allison Wedin
- Observer HCA: Keri Waterland

Work group recommendations

Data coordination and gathering

Including the 14 requests moved forward in January 2021 and included in Appendix A, the work group found a distinct need for further data considerations on Assisted Outpatient Treatment (AOT: a form of less restrictive treatment court ordered in the community for up to 18 months to prevent relapse or behavioral health deterioration), Least Restrictive Alternatives (LRA: a program of individualized treatment in a less restrictive setting than inpatient treatment), and 120-hour initial detentions. The primary focus is identifying areas that systemically provide the highest quality of outcomes post discharge from ITA services. With the ITA system providing services specifically for individuals with immediate needs, the focus on post discharge data will greatly improve the analysis of the ITA system's impact on individuals' recovery.

These identified areas for further data coordination and collection include:

- Percent of people discharged into stable housing
- Percent of people discharged that are engaged in something meaningful (work, school, volunteerism, sports, community activities)
- Percent of people feeling optimistic for their future
    - Do you feel like you can achieve self-directed goals?
    - Do you feel like you are able to contribute meaningfully to your relationships?
    - Do you feel a sense of belonging in the community and relationships you've established?
- Percent that have not been incarcerated

Some of this data can be cross referenced between existing data collected on individuals receiving treatment. Data that is not currently collected will be gathered through a series of surveys or means befitting the highest data standards. The recommended categorization of the data would be based on lengths of time after discharge (one month, six months, one year, and three years) cross referenced with the services provided (Initial Detention, AOT, LRA) from each specific provider. The collaboration, collection and analysis of this data will likely require additional funding from the legislature and coordination among multiple agencies.

Defining and funding treatment

The work group recognizes that the change from a 72-hour initial detention to a 120-hour initial detention, effective January 1, 2021, affords an increased opportunity to engage a person in active treatment prior to the 14-day hearing. The group discussed their different perspectives and experiences, what defines active treatment, including intake and assessment, treatment planning, individual and group therapy, engagement and motivational interviewing, group therapy, milieu therapy, psychoeducation, voluntary medication and, at times, involuntary medication. Exploring new or additional funding models to serve the wide range of ITA services could enhance the system of care.

1. The work group recommends the state consider establishing a statutory definition of "active treatment" for individuals detained for inpatient involuntary behavioral health treatment.
2. The work group recommends increased oversight of involuntary facility treatment documentation to ensure individuals are receiving active treatment prior to the 14-day hearing including consideration of involuntary medication when appropriate.

3. The work group recommends that involuntary facilities consider involuntary medications during the initial 120-hour detention and base those decisions on clinical appropriateness and safety needs versus awaiting a 14-day commitment order.
4. The work group recommends the state gather data from involuntary facilities as to whether they medicate involuntarily prior to the 14-day hearing.
5. The work group recommends the state explores changes to Medicaid reimbursement that supports parity for treatment across the mental health and substance use disorder providers.
6. The work group recommends the state explores financial incentives for quality of care, and specialized certification for inpatient facilities (analogous to Diagnosis-Related Group (DRG) systems or Expanded Community Services (ECS) funding for physical health).

Add diversion programs, improve intensive outpatient services, expand workforce, and peer services

The work group recognizes a continued shortage of available beds for treatment at inpatient facilities for SUD and MH in both voluntary and involuntary settings. The work group also recognizes that involuntary treatment may be experienced as traumatic by those who are in crisis. Thus, it is important to provide individuals appropriate settings to seek voluntary treatment or to participate in intensive services in their own community. Additional outpatient services (both voluntary and involuntary) would increase these opportunities and free up inpatient bed capacity.

To increase bed capacity overall and provide LRAs to inpatient treatment, the work group recommends the state:

1. Establish and fund Peer Respite Centers specifically run by peers in locations statewide. Example models include programs such as Soteria Houses, Open Dialogue, and Respite Centers currently being developed.
2. Establish and fund Assisted Outpatient Treatment (AOT) programs statewide. This would include educating courts, Designated Crisis Responders, providers, and communities in the implementation process.
    - During the drafting of this report, the Washington State Legislature passed HB 1773 with funding for each region within Washington to develop AOT programs and hire appropriate staff at the Behavioral Health Administrative Services Organizations (BHASOs) and HCA.
3. Utilize data collection and oversight of Least Restrictive Orders (LROs; a version of a LRA ordered by a court) to increase statewide consistency across all LRA treatment programs.
4. Increase training for outpatient providers and expand transition teams for individuals both being admitted to and discharged from these services. E2SSB 5071 from the 2022 legislative session is an example of the desired programs and teams mentioned in this recommendation.
5. Strengthen communication and discharge planning for individuals being discharged on an LRO, including communication with families and other natural supports to increase the likelihood of recovery.
6. Consider third party or court oversight of the statutorily defined minimum delivery of LRA treatments that a Behavioral Health Agency (BHA) must provide to an individual on an LRO.

7. Examine mental health parity laws, and ways for all types of insurers (including private insurers) to expand coverage for crisis and involuntary treatment, so individuals can access intensive care without having to disrupt relationships with their current providers. Opportunities may exist based on HB 1688 that passed in the 2022 legislative session.
8. Consider expanding the criteria for AOT to include those who have had numerous voluntary hospitalizations, not just involuntary hospitalizations.
9. The work group also recognizes a severe workforce shortage in the behavioral health field and recommends the legislature find ways to fund workforce development and provide employment incentives, as well as continue building peer support programs and other intensive programs (such as PACT teams) statewide. This will be critical to a functional AOT system.

Training opportunities and community educations

The work group recognizes the increase to 120-hour detentions as an opportunity for involuntary treatment providers to better engage individuals in their treatment and reduce traumatic experience caused by disruptions to the treatment process. Engaging all members of the ITA system in trainings and education will assist in creating a more seamless approach to the changes caused by the 120-hour detentions.

The work group recommends that:

1. DCRs and involuntary inpatient treatment facility staff be trained in and practice Motivational Interviewing to encourage patient "buy-in," participation, and empowerment.
2. Trauma Informed Care (TIC) training be expanded throughout the ITA process, including mandated TIC training for Emergency Department personnel and ITA court personnel.
3. To create trauma informed environments for people experiencing behavioral health crises as well as for trauma survivors, the state explores the need for a panel to address changes to the ITA court process, increasing accessibility and providing TIC training to all participants (judges, attorneys, bailiffs). The work group recommends basing this training on SAMHSA recommendations, and engaging peers and programs such as NAMI to provide training.
4. HCA continues to educate communities about behavioral health legislation, including website updates and identifying personnel who are available to answer questions.
5. Provide support for the access portal from HB 1800 that passed in 2022 through education and information for families and other community partners who are supporting their loved ones in navigating the ITA system. Review opportunities to expand the portal to support families of transition aged adults of 18 to 25 years.

The work group recognizes the need for strengthening coordination between behavioral health providers and streamlined processes to facilitate discharge planning and encourage warm hand-offs between inpatient and outpatient behavioral health providers.

To accomplish this, the work group recommends:

1. Expanding peer support services and/or case management to all individuals, including those with private insurance.

2. The state explores ways for insurance companies to offer different approaches based on individual needs.
3. Make peer services, both the peer bridge and peer navigator models, available at Evaluation and Treatment (E&T) facilities, Single Bed Certification (SBC) facilities, and Secure Withdrawal Management and Stabilization (SWMS) facilities, to coordinate care with individuals and their families/caregivers before and after discharge.
4. Employ peer counselors in emergency departments so that individuals in crisis have access to initial support and engagement while waiting for assessment and/or involuntary placement. Example models for this recommendation include Screening Brief Intervention and Referral to Treatment (SBIRT).
5. Increase crisis and diversion resources as well as transitional care programs, and assure facilities have awareness of these programs and are connecting individuals to them prior to discharge.

Reimbursement

The work group recognizes that it is empowering and effective to transition persons to voluntary care expeditiously. Payment structure should align to encourage the utilization of the LRA treatment options as a person is ready and willing. A Designated Crisis Responder may find that a person meets criteria for detention under ITA, but an LRA is available because the person is willing and appropriate for voluntary hospitalization. However, a Designated Crisis Responder may be unable to locate a facility that accepts the person's insurance for a voluntary admission and therefore must detain the person to receive appropriate treatment.

The work group recommends:

1. The state study ways in which facilities may receive reimbursement for both involuntary and voluntary inpatient treatment, assuring decisions regarding level of care can be made efficiently and in the best interest of the individual and their rights regardless of insurance type.
2. The state considers a system in which voluntary admission is paid regardless of insurance type when a DCR finds that a person meets ITA criteria however is willing and appropriate for a voluntary admission as an LRA option.
3. Collect data on and report the number of ITA service days reimbursed by private insurance. This is to ensure individuals' treatment are being financially supported without interruption.

Improve quality of behavioral health inpatient care

The work group recognizes when individuals receive high quality care at an inpatient facility, it increases the likelihood they may choose voluntary admission should they need extra support in the future. The work group discussed from their varied perspectives and experiences both successful inpatient treatments, as well as room for improvements and expansion of the availability of services.

The work group recommends:

1. Forming a task force made up of individuals with lived experience and their families to pursue improved quality care at inpatient facilities, to build on what is already working at some facilities.

2. Increase future work group opportunities on how to improve the ITA system by purposefully including more persons who have lived experience being involuntarily detained.
3. Specifically increasing bed capacity for individuals with complex needs, such as those with medical comorbidities, cognitive impairments, and/or with a history or current presentation of violent behavior or changes to RCW regarding acceptance and denial criteria for involuntary inpatient treatment facilities.
4. Track placement denial reasons specific to BH and medical acuity for the purpose of identifying areas to increase or decrease the bed capacity for individuals with complex needs.
5. Exploring opportunities to address inpatient workforce shortages (more funding, education, pay, incentives, hazard pay) to ensure facilities can hire, train, and retain the most qualified and dedicated workforce.

Housing after discharge

The availability of appropriate and safe housing options upon discharge from inpatient hospitalization are crucial to expedient and successful discharges. Increasing the number and type of housing options sets individuals up for success. Barriers include community stigma surrounding persons with behavioral health disorders.

The work group recommends:

1. The state explores ways to fund and maintain more permanent supported housing programs (such as combining Housing First and AOT), and other transitional housing, including group homes for youth to support safe and efficient discharges from inpatient care to the community.
2. The state considers ways to review and address zoning laws which present as a barrier to establishing community housing for persons with behavioral health disorders.

   The state track data regarding private insurance reimbursements for inpatient stays to determine if requirements for inpatient treatment are being paid for by private insurance.

Appendix A ITA work group data

Table 1: ITA investigations by calendar year

RSA_BHO	Calendar Year											
	2016		2017		2018		2019		2020		2021	
	clients	events	clients	events	clients	events	clients	events	clients	events	clients	events
GREAT RIVERS	2,233	2,294	1,581	1,591	989	1,375	1,108	1,678	1,166	1,696	980	**1,512**
GREATER COLUMBIA	536	617	902	1,104	1,141	1,527	1,287	1,934	1,137	1,499	1,053	**1,331**
KING	4,358	6,362	4,719	6,859	4,867	7,168	4,785	7,020	4,981	6,983	4,048	**5,777**
NORTH CENTRAL	509	728	288	377	330	442	236	287	490	755	306	**442**
NORTH SOUND	2,770	4,218	2,222	3,322	1,870	2,604	2,412	5,004	2,750	5,259	2,671	**4,254**
PIERCE	1,123	1,578	1,312	1,902	1,529	2,210	1,681	2,562	1,590	2,279	1,429	**2,016**
SALISH	1,205	1,771	1,160	1,667	1,038	1,498	817	1,188	853	1,328	745	**1,090**
SOUTHWEST	691	1,672	643	924	505	650	687	975	729	964	550	**706**
SPOKANE	2,490	3,709	2,510	3,727	2,248	3,334	2,525	3,800	2,529	3,789	2,613	**3,988**
THURSTON-MASON	1,097	1,486	1,309	1,893	1,423	2,075	1,706	2,734	1,708	2,815	1,427	**2,580**
Total Statewide	**16,384**	**24,435**	**15,979**	**23,366**	**15,171**	**22,883**	**16,370**	**27,182**	**16,902**	**27,367**	**14,900**	**23,696**

Note: Statewide totals are counts of individuals, whereas regional counts are the number of incidents.

Table 2: Statewide ITA investigation outcome by Calendar Year

Statewide Investigation Outcome		Calendar Year					
		2016	2017	2018	2019	2020	2021
Detentions and Commitments	Initial Detention to MH Facility	9,069	10,077	9,915	12,016	12,518	10,790
	Non-Emergent Detention Petition Filed	17	12	237	369	346	343
	Referred for Hold Under RCW 71.05	-	-	21	84	125	66
	Petition Filed for MH Outpatient Evaluation	-	-	-	-	-	-
	Returned to Inpatient Facility/Filed Revocation	1,266	938	1,266	1,294	1,296	1,041
	Initial Detention to Secure Detox Facility	23	-	279	539	653	625
	Subtotal	10,376	11,028	11,818	14,302	14,940	12,867
Voluntary MH Treatment	Referred to Voluntary Outpatient MH Services	5,869	5,689	4,599	5,102	4,620	3,854
	Referred to Voluntary Inpatient MH Services	1,250	965	1,015	1,314	1,346	987
	Subtotal	7,119	6,654	5,614	6,416	5,966	4,841
No Detention Due to Issues	No Detention-ET Acceptance Not Within Timeframes	86	45	151	295	279	311
	No Detention-Unresolved Medical Issues	35	28	42	103	149	272
	No Detention-SUD Acceptance Not Within Timeframe	-	-	18	34	36	68
	Subtotal	121	73	211	432	464	651
Less Restrictive Options SUD	Referred to Acute Detox	15	11	11	28	27	33
	Referred to Sub-Acute Detox	41	96	14	22	22	19
	Referred to Sobering Unit	33	22	15	14	16	13
	Referred to Crisis Triage	194	114	241	257	297	256
	Referred to SUD Intensive Outpatient Program	37	32	66	64	120	86
	Referred to SUD Inpatient Program	41	35	44	53	54	64
	Referred to SUD Residential Program	-	-	-	-	14	19
	Subtotal	369	315	393	447	550	490
Less Restrictive Options MH	Did Not Require MH or SUD Services	60	29	1,280	1,941	2,039	1,722
	Filed Petition Recommending AOT Extension	-	-	-	-	-	20
	Filed Petition Recommending LRA Extension	350	298	217	172	166	138
	Subtotal	410	327	1,498	2,118	2,246	1,880
Other	Referred to Non-Mental Health Community Resources	624	707	705	676	520	310
	Other	5,416	4,262	2,644	2,791	2,681	2,657
	Subtotal	6,040	4,969	3,349	3,467	3,201	2,967
Statewide Grand Total		24,435	23,366	22,883	27,182	27,367	23,696

Table 3: ITA detention by calendar year, unduplicated statewide

RSA_BHO	Calendar Year											
	2016		2017		2018		2019		2020		2021	
	clients	events	clients	events	clients	events	clients	events	clients	events	clients	events
GREAT RIVERS	169	172	110	110	368	463	484	657	545	709	499	**639**
GREATER COLUMBIA	455	516	801	952	1,090	1,440	1,244	1,838	1,108	1,449	1,021	**1,276**
KING	3,028	4,091	3,377	4,540	3,386	4,613	3,385	4,555	3,600	4,650	2,861	**3,803**
NORTH CENTRAL	185	236	117	134	123	145	153	176	161	207	119	**165**
NORTH SOUND	1,372	1,861	1,337	1,724	1,102	1,382	1,226	2,241	1,572	2,515	1,415	**1,905**
PIERCE	619	791	719	943	810	1,076	861	1,169	869	1,125	786	**991**
SALISH	410	546	349	472	417	570	373	505	418	588	370	**475**
SOUTHWEST	216	467	241	282	250	304	382	497	375	457	278	**326**
SPOKANE	1,009	1,269	1,058	1,358	998	1,274	1,255	1,716	1,611	2,241	1,761	**2,469**
THURSTON-MASON	345	427	410	513	439	551	636	948	731	997	638	**816**
Total Statewide	**7,584**	**10,376**	**8,237**	**11,028**	**8,650**	**11,818**	**9,613**	**14,302**	**10,512**	**14,938**	**9,320**	**12,865**

Note: Statewide totals are counts of individuals, whereas regional counts are the number of incidents.

Table 4: ITA hearing by calendar year

RSA_BHO	Calendar Year											
	2016		2017		2018		2019		2020		2021	
	clients	events	clients	events	clients	events	clients	events	clients	events	clients	events
GREAT RIVERS	133	260	92	166	131	193	169	193	118	127	215	**244**
GREATER COLUMBIA	862	1,180	870	1,393	911	1,467	862	1,500	913	1,606	842	**1,242**
KING	2,882	5,324	2,539	4,655	3,214	6,155	3,026	5,609	2,512	4,239	1,822	**2,902**
NORTH CENTRAL	18	18	11	11		13						
NORTH SOUND	1,038	1,648	890	1,327	1,467	2,455	962	1,389	372	532	178	**221**
PIERCE	139	160	661	1,172	681	1,185	723	1,305	574	813	784	**1,076**
SALISH	230	407	195	426	220	482	241	500	196	399	169	**333**
SOUTHWEST	178	287	148	226	152	210	210	343	122	176	98	**138**
SPOKANE	843	1,870	964	2,066	1,040	2,164	1,432	2,937	1,761	3,875	1,830	**3,739**
THURSTON-MASON	142	249	109	183	159	232	343	645	295	507	241	**396**
Total Statewide	**6,183**	**11,403**	**6,192**	**11,625**	**7,383**	**14,556**	**7,451**	**14,426**	**6,541**	**12,278**	**5,865**	**10,291**

Note: Statewide totals are counts of individuals, whereas regional counts are the number of incidents.

Table 5: Statewide ITA hearing outcomes

Statewide ITA Hearing Outcome		Calendar Year					
		2016	2017	2018	2019	2020	2021
		N	N	N	N	N	N
Acute Orders	14 Day MH Commitment	3,373	5,060	5,324	4,996	3,551	2,638
	14 Day SUD Commitment	-	-	-	19	20	61
	5 Day Commitment under Joel's Law	-	-	-	-	-	-
	Subtotal	3,374	5,068	5,336	5,018	3,573	2,705
Long Term Orders	90 Day SUD Commitment	-	-	-	-	-	-
	90 Day MH Commitment	769	1,212	1,215	1,226	820	701
	180 Day MH Commitment	147	169	212	208	199	128
	Revoked LRA	1,886	541	828	760	619	479
	Subtotal	2,802	1,923	2,258	2,199	21,639	1,309
Less Restrictive Agreement Orders	Dismissed	-	-	-	-	-	-
	90 Day SUD Revocation	-	-	-	-	-	-
	180 Day SUD Revocation	-	-	-	-	-	-
	90 Day SUD LRA	-	-	-	25	14	24
	180 Day SUD LRA	-	-	-	-	-	-
	180 Day MH LRA Extension	-	-	-	-	-	-
	90 Day MH LRA	2,827	2,816	3,249	3,007	3,093	2,506
	180 Day MH LRA	455	326	475	407	433	321
	Reinstate LRA	282	159	349	328	383	363
	Subtotal	3,564	3,301	4,076	3,778	3,928	3,217
Other	Dismissed	1,616	1,292	2,868	3,408	3,129	3,050
	Dismissal of Petition Filed under Joel's Law	-	-	-	11	-	-
	Outpatient Eval. Within 72 hrs for Assisted OT	-	-	-	-	-	-
	90 Day Assisted Outpatient Treatment Order	-	-	-	-	-	-
	Agreed to Voluntary Treatment	46	39	-	11	-	-
	Subtotal	1,662	1,333	2,886	3,431	3,138	3,060
Statewide Grand Total		11,403	11,625	14,556	14,426	12,278	10,291

Table 6: Investigation clients with at least one later investigation event

Calendar Year	Repeaters	Events	All Clients	Events	% Repeaters	% Events
2016	4,536	12,587	16,384	24,435	27.7%	**51.5%**
2017	4,103	11,490	15,979	23,366	25.7%	**49.2%**
2018	4,158	11,870	15,171	22,883	27.4%	**51.9%**
2019	5,668	16,480	16,370	27,182	34.6%	**60.6%**
2020	**5,542**	**16,007**	**16,902**	**27,367**	**32.8%**	**58.5%**

Table 7: Detention clients with at least one later detention event

Calendar Year	Repeaters	Events	All Clients	Events	% Repeaters	% Events
2016	1,824	4,616	7,584	10,376	24.1%	**44.5%**
2017	1,806	4,597	8,237	11,028	21.9%	**41.7%**
2018	1,967	5,135	8,650	11,818	22.7%	**43.5%**
2019	2,891	7,580	9,613	14,302	30.1%	**53.0%**
2020	**2,777**	**7,203**	**10,512**	**14,938**	**26.4%**	**48.2%**

Table 8: Hearing clients with at least one later hearing event

Calendar Year	Repeaters	Events	All Clients	Events	% Repeaters	% Events
2016	1,622	3,693	3,537	5,822	45.9%	**63.4%**
2017	1,690	3,891	6,121	11,247	27.6%	**34.6%**
2018	2,143	5,120	6,795	13,284	31.5%	**38.5%**
2019	2,122	5,252	7,535	14,649	28.2%	**35.9%**
2020	**1,799**	**4,560**	**6,847**	**12,908**	**26.3%**	**35.3%**

Table 9: Statewide detainees cohorts by calendar year

Calendar Year	2018 Detainees	Detention	2019 Detainees	Detention	2020 Detainees	Detention
2018Q1	2,711	2,808				
2018Q2	2,921	3,041				
2018Q3	2,909	3,019				
2018Q4	2,696	2,807				
2019Q1	935	983	2,915	3,051		
2019Q2	805	847	3,046	3,151		
2019Q3	809	852	3,301	3,453		
2019Q4	781	838	3,359	3,537		
2020Q1	654	694	1,035	1,090	3,192	3,342
2020Q2	726	781	993	1,068	3,523	3,712
2020Q3	700	752	1,004	1,072	3,665	3,862
2020Q4	621	667	839	889	3,422	3,571
2021Q1	647	698	831	888	1,297	1,385
2021Q2	631	683	754	808	1,106	1,194
2021Q3	438	472	582	621	789	828
2021Q4	480	505	549	576	755	786

Data note: this table shows how many 2018 cohort clients had repeated events in later follow up years. For example,there are 935 clients in the original 2018 cohort who were detained again in the first Quarter of 2019. And so on.

Graph 1: 2018, 2019, 2020 detainees cohorts

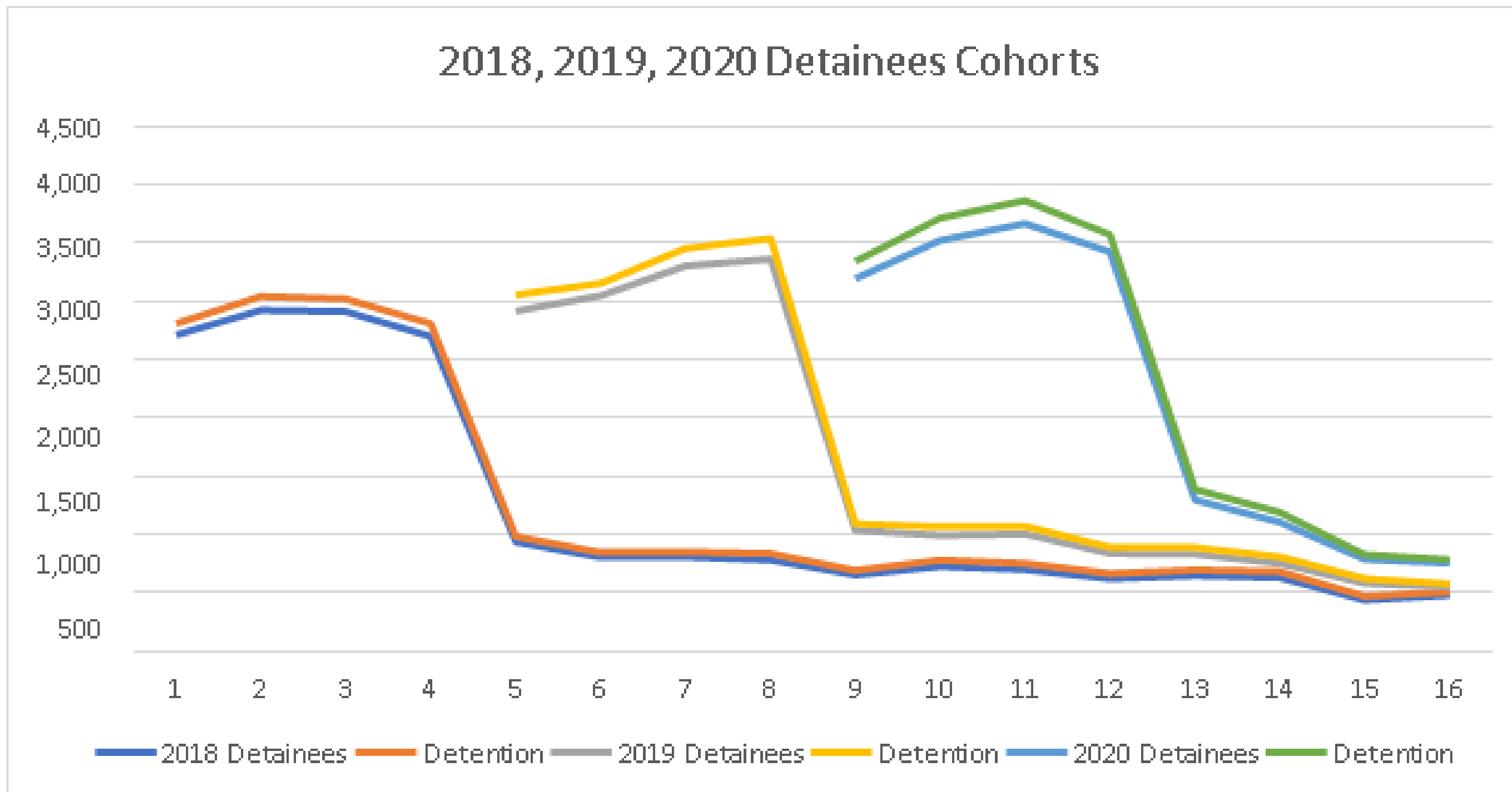


Table 10: All clients with one or more 14-day commitment

Calendar Year	2018 Cohort	Event	2019 Cohort	Event	2020 Cohort	Event
2018Q1	1636	1783				
2018Q2	1587	1754				
2018Q3	1570	1751				
2018Q4	1495	1655				
2019Q1	535	592	1460	1629		
2019Q2	399	435	1564	1701		
2019Q3	370	421	1478	1656		
2019Q4	320	359	1329	1510		
2020Q1	179	200	354	401	913	1012
2020Q2	190	213	263	293	1034	1141
2020Q3	207	232	284	316	1111	1222
2020Q4	201	231	286	332	1109	1242
2021Q1	181	202	222	247	289	324
2021Q2	163	175	188	213	257	288
2021Q3	96	108	113	126	148	170
2021Q4	81	98	102	121	124	141
2022Q1	121	133	115	132	135	151

Table 11: Percent of clients with one or more 14-day commitment

Calendar Year	2018 Cohort	Event	2019 Cohort	Event	2020 Cohort	Event
2018 Cohort	2018=100%	2018=100%				
2019Q1	34.0%	34.1%				
2019Q2	25.4%	25.1%				
2019Q3	23.5%	24.3%				
2019Q4	20.4%	20.7%	2019=100%	2019=100%		
2020Q1	11.4%	11.5%	24.3%	24.7%		
2020Q2	12.1%	12.3%	18.0%	18.0%		
2020Q3	13.2%	13.4%	19.5%	19.5%		
2020Q4	12.8%	13.3%	19.6%	20.4%	2020=100%	2020=100%
2021Q1	11.5%	11.6%	15.2%	15.2%	27.7%	28.1%
2021Q2	10.4%	10.1%	12.9%	13.1%	24.7%	25.0%
2021Q3	6.1%	6.2%	7.8%	7.8%	14.2%	14.7%
2021Q4	5.2%	5.6%	7.0%	7.5%	11.9%	12.2%
2022Q1	7.7%	7.7%	7.9%	8.1%	13.0%	13.1%

Data note: this table shows how many 2018 cohort clients had repeated events in later follow up years. For example, there are 535 clients (34%) in the original 2018 cohort who received commitment orders of any length again in the first Quarter of 2019. And so on. Most of the 2018 cohort did not came back in the follow-up years.

Graph 2: 2018 and 2019 14-day clients with any commitment order

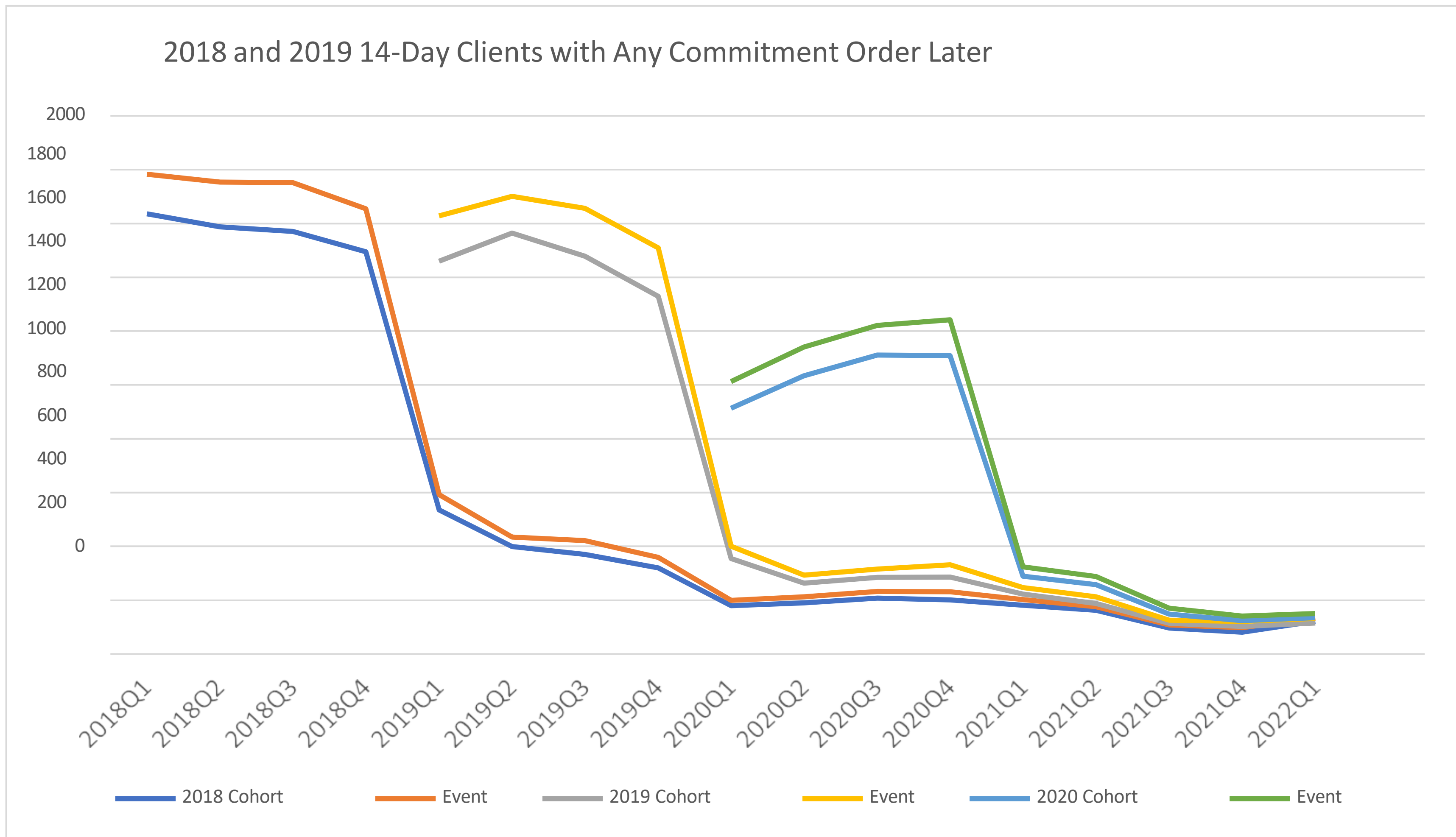
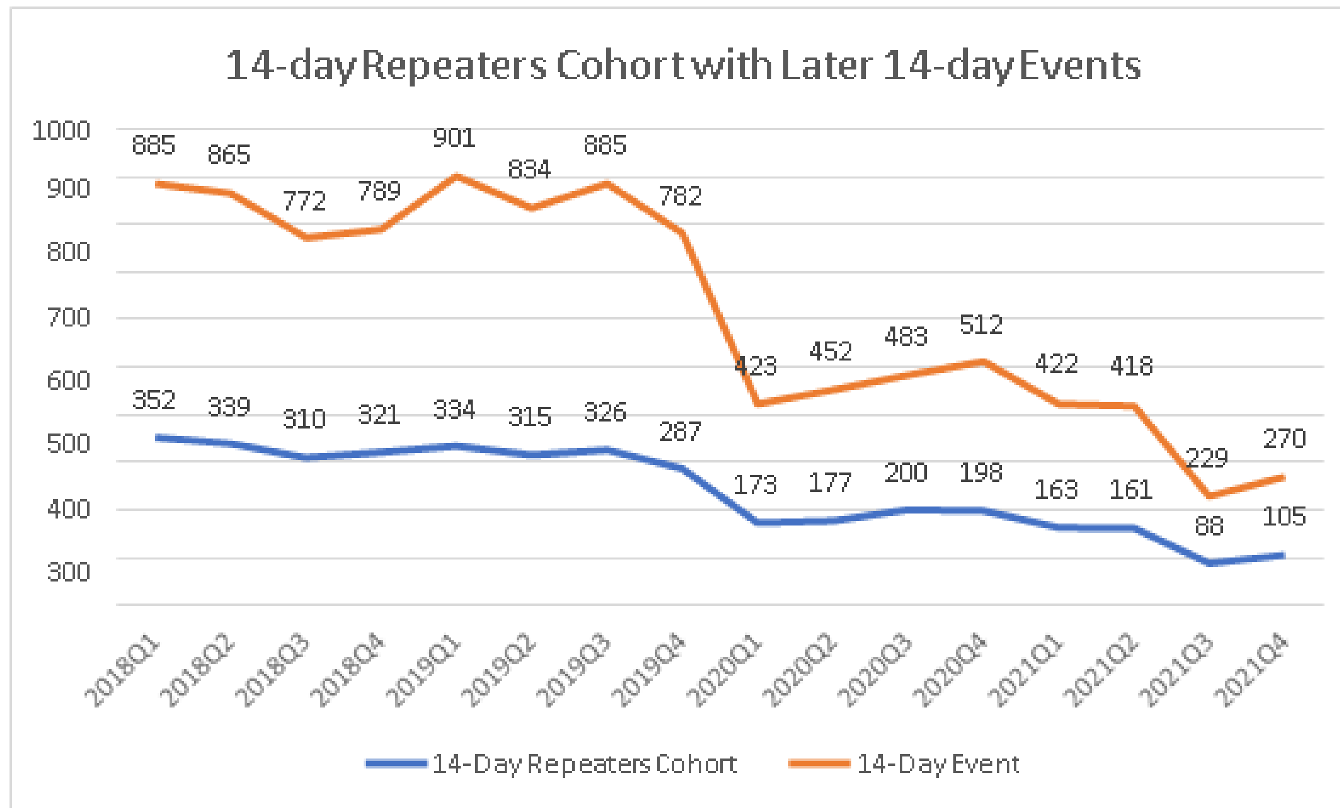


Table 12: 14-day Repeaters Cohort with more than one 14-day commitment

Calendar Year	14-Day Repeaters Cohort	14-Day Event	14-Day Repeaters Cohort	14-Day Event
2018Q1	352	885		
2018Q2	339	865		
2018Q3	310	772		
2018Q4	321	789	2018=100%	2018=100%
2019Q1	334	901	100.0%	100.0%
2019Q2	315	834	95.3%	100.0%
2019Q3	326	885	98.6%	100.0%
2019Q4	287	782	86.8%	94.5%
2020Q1	173	423	52.3%	51.1%
2020Q2	177	452	53.6%	54.6%
2020Q3	200	483	60.5%	58.4%
2020Q4	198	512	59.9%	61.9%
2021Q1	163	422	49.3%	51.0%
2021Q2	161	418	48.7%	50.5%
2021Q3	88	229	26.6%	27.7%
2021Q4	105	270	31.8%	32.6%

Graph 3: 14-day Repeaters Cohort with later 14-day events



Data note: We cannot analyze the data exactly as requested. Instead of basing the time event on Commitment Date, we used Hearing Date for approximation. BHDS does not collect the Commitment Date. Be aware that the Hearing Date is not Commitment Date. Many clients usually do not begin their commitment on the Hearing Date, so the real picture is somewhat different from the illustration above, even if we have perfect Hearing data for this analysis. And the difference may lead to different policy conclusions. In the following example, Client #1121, randomly picked, had a 14-day commitment, followed by a 90-day. However, when did the person actually start and end the 90 days in commitment is unknown because it was followed up with three Revoked LRA. This means there should be a LRA before April 3. What this tells us is that we are missing a lot of Hearing data. Therefore, the analysis results here must be used with caution. Note that SB 5071 passed in 2021 requires the clerk of the court to share hearing outcomes in all hearings under the ITA chapter with local BHASOs, including cases in which the DCR investigation occurred outside the region. This change should improve the data on hearing outcomes that HCA will receive.

Table 13: Single Bed Certification (SBC) annual report: Certificate and unique person count

Year	All Clients	Events	Repeaters	Events	% Repeaters	% Events
2006	658	844	121	307	18.4%	36.4%
2007	1,062	1,342	197	477	18.5%	35.5%
2008	1,644	2,288	389	1,033	23.7%	45.1%
2009	1,276	1,594	230	548	18.0%	34.4%
2010	1,338	1,648	237	547	17.7%	33.2%
2011	1,712	2,174	319	781	18.6%	35.9%
2012	2,359	3,060	446	1,147	18.9%	37.5%
2013	2,848	3,735	575	1,462	20.2%	39.1%
2014	3,706	5,094	887	2,275	23.9%	44.7%
2015	3,516	5,107	927	2,518	26.4%	49.3%
2016	4,474	6,908	1,292	3,726	28.9%	53.9%
2017	4,859	7,491	1,414	4,046	29.1%	54.0%
2018	6,097	9,843	1,798	5,544	29.5%	56.3%
2019	6,707	10,150	1,746	5,189	26.0%	51.1%
2020	7,351	10,941	1,876	5,466	25.5%	50.0%
2021	7,375	10,592	1,789	5,006	24.3%	47.3%
2022	2,052	2,397	284	629	13.8%	26.2%

Data note: SBC data for years prior to 2006 may not be as reliable. SBC data in 2022 ends in May 31, 2022.

Table 14: Annual counts of DMHP reports of no available E&T beds (no bed reports) and of (unduplicated) clients with no bed reports statewide (January 2019 to December 2021)

Calendar Year	No Bed Reports	Clients
2019	771	435
2020	711	517
2021	867	626

Data source: No bed report, submittals by designated mental health professionals within submitting entities.

Data analysis: CQCT/DATA/EARR-BH-Ted Lamb

Date of report: 5/10/2022

Analytic code: No bed report annual counts