


KING COUNTY AUDITOR'S OFFICE

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Involuntary Treatment Act Court: Reentry and Court Outcomes

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Executive Summary

This report expands the County's knowledge of the people who go through the involuntary treatment process, what factors determine whether they return to the system, and what factors determine the outcomes they receive in court. In 2017, the court responded to more than 3,000 people's mental health crises across more than 4,700 cases. The way King County approaches this process has the potential to impact the mental health of thousands of vulnerable people every year. To better understand the factors that the County can influence and inform upcoming system improvement efforts, we evaluated what factors may contribute to a person's likelihood of having subsequent Involuntary Treatment Act Court cases and what factors contribute to different court outcomes. The things that were consistently related to people returning to the system included the person's case history, race, and housing status, as well the final court order in their case, and the type of hospital that treated them.

King County

Involuntary Treatment Act Court: Reentry and Court Outcomes

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WHY THIS ANALYSIS MATTERS

The Involuntary Treatment Act (ITA) Court system helps ensure the safety of people experiencing mental health crises as well as the King County community at large. If a person is experiencing a mental health crisis, the ITA system must decide whether the person is a danger to themself or others. This is in addition to balancing individual rights and determining if involuntary detention and treatment is justified.

How King County approaches this process has the potential to significantly impact the mental health of thousands of vulnerable people every year. In 2017, the ITA system served over 3,000 people across nearly 4,700 court cases. Overall, the number of ITA cases increased more than 20 percent between 2014 and 2017. This vital service impacts an increasing number of county residents during an extremely difficult time in their lives. This report expands the County's knowledge of the people who go through the involuntary treatment process, what factors determine whether they return to the ITA system, and what factors determine the outcomes they receive in court. This report is meant to complement other ongoing County improvement efforts relating to ITA Court so that stakeholders can make informed and effective decisions as they make changes to the ITA system.

Our analysis connected Department of Judicial Administration data from over 17,000 cases filed between January 1, 2014 and October 31, 2018, with Department of Community and Human Services (DCHS) data on demographics, and from hospitals stays, for over 11,000 different anonymized people who have been in the ITA system. By connecting multiple distinct data sources, we were able to analyze the factors that contribute to court outcomes and a person's likelihood of returning to the ITA system. These factors included: personal characteristics such as prior case history and housing instability; hospital-level factors such as length of hospital stay and the hospital the person was held in; and court-level factors such as final court outcome and the use of case continuances. Connecting these data sources allowed us to assess not only who goes through the ITA system, but also who would be most likely to return to the ITA system in the future.

Throughout this report we include quotes from people who have interacted with the ITA system by having a family member go through the process—sometimes multiple times. These quotes often align with the data, and we include them to highlight the deeply personal experiences that people have within the ITA system.

INTRODUCTION TO THE ITA PROCESS

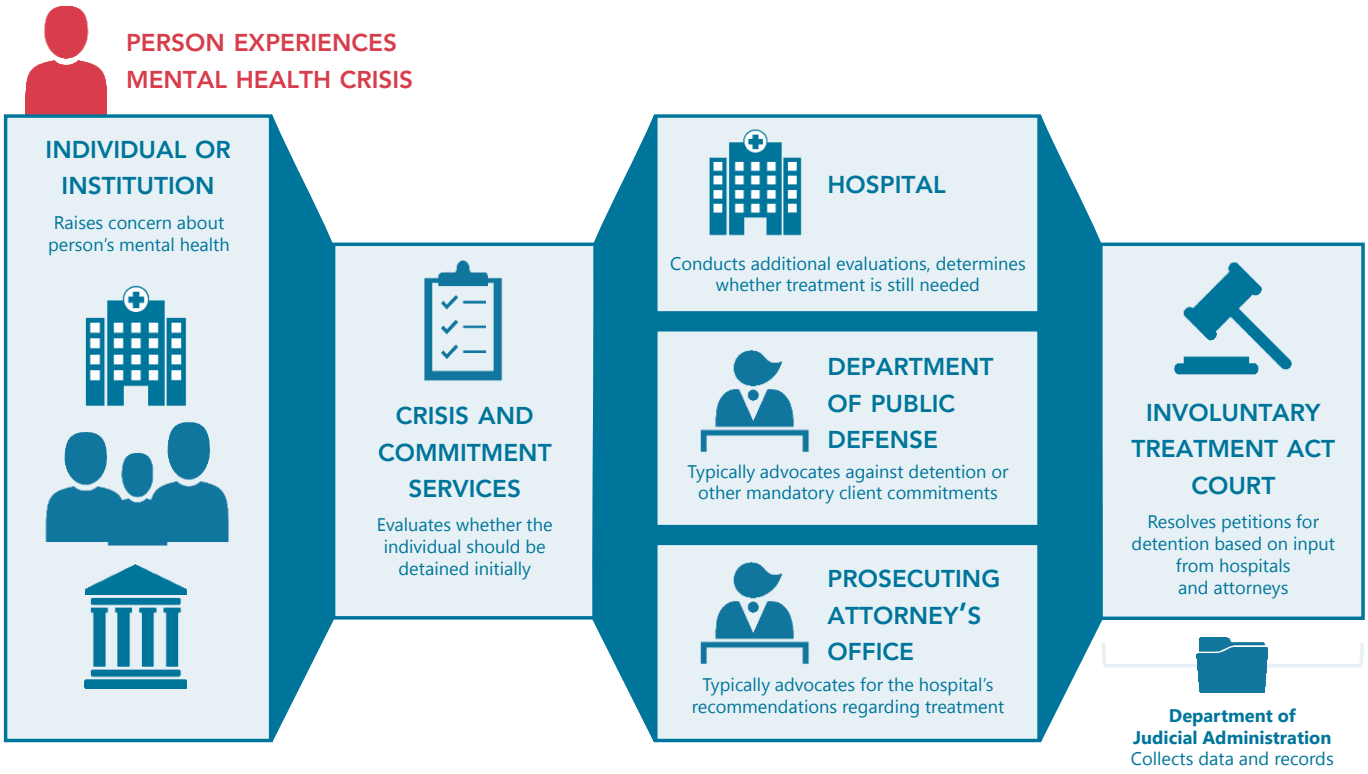
The ITA system addresses a person's mental health crisis when they present a harm to themself or others, or are in danger because of being gravely disabled and are unwilling to

seek appropriate voluntary treatment.[1] These parameters are defined under Revised Code of Washington (RCW) 71.05. The legislative intent of the ITA system is to:

a. protect the health and safety of persons with mental disorders and substance use disorders
b. protect public safety
c. prevent inappropriate and indefinite commitment
d. provide prompt evaluation and timely and appropriate treatment
e. safeguard individual rights
f. provide continuity of care.

The involuntary treatment system includes stakeholders from across the county, some with competing goals and priorities. While the person receiving treatment (and often their family) is the most direct stakeholder in this process, there are also a variety of institutional stakeholders. These stakeholders and their roles are described in Exhibit A and the text below.

EXHIBIT A: The ITA process and relevant stakeholders



Source: King County Auditor's Office summary based on interviews with system stakeholders and review of the Washington State Involuntary Treatment Act

[1] A person experiencing a mental health crisis is considered "gravely disabled" under RCW 71.05.020 if the person: "(a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety".

- **Crisis and Commitment Services**
  After someone reports what they perceive as a person's mental health crisis, designated crisis responders within Crisis and Commitment Services (CCS) evaluate whether the person meets the standard for involuntary treatment. The crisis responders base their final decision on whether the person they are evaluating presents a likelihood of serious harm to themself or others, or whether they are gravely disabled because of a mental disorder. The crisis responders also consider whether the person will voluntarily seek appropriate treatment. While the crisis responders' primary role is to determine if initial detention and treatment is necessary, they sometimes testify in ITA Court hearings and compile important information that other stakeholders use to argue the case in court.

- **Hospitals**
  If a crisis responder determines that the person is experiencing a mental health crisis and needs involuntary treatment, they transfer treatment responsibility for the person to a hospital. Court evaluators at the hospital conduct evaluations and determine whether the person needs additional involuntary treatment beyond the initial 72 hours set out by the court and designated crisis responder. If the court evaluator determines treatment is not necessary or justified, the hospital may release the person at this stage. If the court evaluator determines that additional involuntary treatment is necessary, the hospital can petition the court for it. Hospitals play an important role in both providing treatment and justifying the need for this treatment in ITA Court.[2]

  Evaluation and treatment (E&T) centers are designed for involuntary treatment and specialize in addressing severe psychiatric concerns. When space is not available in an E&T, people receiving involuntary treatment are held in other hospitals.[3] There are more than 17 hospitals in King County that provide mental health care for the ITA system, although the majority of ITA patients are treated by Navos Psychiatric Hospital, Harborview Medical Center, Fairfax Hospital, and Cascade Behavioral Health.

- **The Department of Public Defense**
  While private defense attorneys represent some people in the ITA system, Department of Public Defense (DPD) attorneys are appointed for all people in the ITA system in King County. DPD attorneys describe their role as representing the stated interests of their client in court, which in most cases is to advocate against involuntary detention and treatment or other mandatory client commitments. These other commitments could include required treatment outside a hospital setting, such as visits with a psychiatric provider and/or case manager. DPD attorneys become involved in the case once the designated crisis responder has initiated detention for the person they believe is experiencing a mental health crisis.

- **The Prosecuting Attorney's Office**
  Prosecuting Attorney's Office (PAO) attorneys describe their role as representing the interests of the public and the hospitals, which typically takes the form of advocating for the hospital's recommendations regarding involuntary treatment. PAO attorneys become involved in the case

[2] A person may be held at multiple hospital throughout their involuntary treatment period. Not all hospitals are certified for certain detention lengths.
[3] In these instances, the hospital is certified to provide treatment to this specific person, referred to as a "single bed certification."

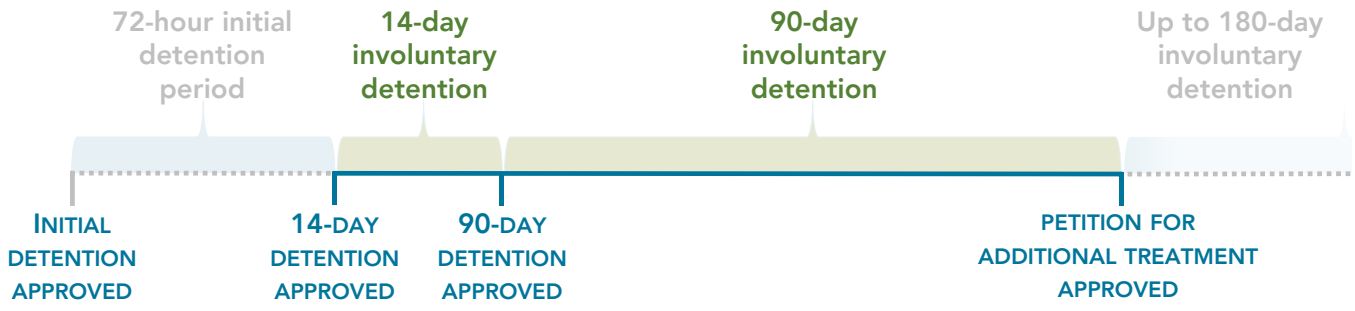
once the designated crisis responder has initiated detention for the person whom they believe is experiencing a mental health crisis and meets criteria for detention.

- **Involuntary Treatment Act Court**
  Petitions for involuntary detention and treatment are resolved within ITA Court—a function of the Superior Court system—either through agreement between the prosecuting attorney and the person's defense attorney (which ends in a court order), or through an order of the court in a hearing. The court is ultimately responsible for determining whether involuntary detention and/or treatment is justified, whether a less restrictive alternative treatment would be sufficient and possible, or whether petitions should be dismissed.[4]

- **The Department of Judicial Administration**
  The Department of Judicial Administration (DJA) is the custodian of Superior Court records and provides records access and customer service related to those records. DJA also acts as a banker for financial matters such as fees, fines, and trust management in Superior Court cases. Given their role as record keeper, DJA plays a key role in the collection and maintenance of data on ITA Court activities and decisions.

A person may initially be detained for 72 hours upon the order of a designated crisis responder or a judicial officer. The hospital must file a petition for treatment in order for the prosecuting attorney to make a case for the court to approve a longer detention. We denote the different case phases in Exhibit B, and in the text below, by the length of each potential detention period. Our analysis focused on the 14- and 90-day detention petition phases due to the limited data on the initial phase of detention and because there were significantly fewer cases that had petitions for 180 days of detention.

EXHIBIT B: The outcome analysis in this report focuses on 14 and 90-day detention petitions



Source: King County Auditor's Office summary of elements of the Washington State Involuntary Treatment Act

[4] ITA Court is distinct from other courts that address mental illness such as the Mental Health Courts, which adopt a therapeutic model and handle criminal cases. ITA Court is organized under an adversarial model, and only addresses civil commitments and related actions.

1. **Initial Detention Petition**
   The first detention phase is the period from when someone raises a concern about a person potentially experiencing a mental health crisis to when the person is initially detained. The designated crisis responder within CCS determines whether initial detention is necessary and legally justified based on their assessment of the person's likelihood of serious harm to self or others and a willingness to seek appropriate treatment. If the crisis responder determines the person meets the involuntary treatment criteria, responsibility for the person is transferred to a hospital. If medical professionals at the hospital determine that involuntary treatment is not needed or legally defensible, they may release the person at any time.

2. **14-Day Detention Petition**
   If medical professionals at the hospital where the person is held determine that additional detention and treatment is necessary beyond the initial 72 hours, they can work with the prosecuting attorney to petition for up to 14 additional days of involuntary detention and treatment. At this point, the court can make an order for 14 days of involuntary detention and treatment, 90 days of a less restrictive alternative treatment that occurs outside of a hospital, or for the petition to be dismissed. [5]

3. **90-Day Detention Petition**
   If medical professionals at the hospital where the person has been held determine that additional treatment beyond 14 days is necessary, they can work with the prosecuting attorney to petition for an additional 90 days of involuntary treatment. At this point, the court can make an order for 90 days of involuntary detention and treatment, 90 days of a less restrictive alternative treatment that occurs outside of a hospital, or for the petition to be dismissed.[6]

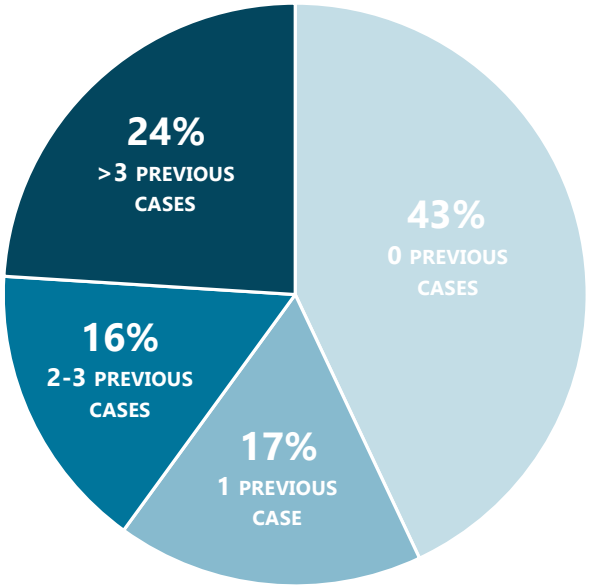
4. **180-Day Detention Petition**
   If medical professionals at the hospital where the person has been held determine that additional treatment beyond 90 days is necessary, they can work with the prosecuting attorney to petition for an additional 180 days of involuntary treatment. At this point, the court can make an order for up to 180 days of involuntary detention and treatment, 180 days of a less restrictive alternative treatment that occurs outside of a hospital, or for the petition to be dismissed.

[5] If the person violates the terms of their less restrictive alternative order, shows substantial deterioration in their functioning, or poses a likelihood of serious harm a designated crisis responder may petition for a revocation of the less restrictive alternative treatment. In this case, another court hearing may occur to determine whether to revoke the less restrictive treatment and involuntarily detain the person in a facility.
[6] While this length of detention is intended to occur at a state hospital, bed limitations at these hospitals have led to clients being held in local facilities not initially intended to treat this population on a single bed certification basis.

WHO GOES THROUGH THE ITA SYSTEM?

The majority of ITA cases involve people who have been through the ITA system before. In 2017, 57 percent of ITA court cases involved people who had prior ITA court cases. Of these cases, 24 percent involved people who had already been in more than three prior cases, and seven percent involved people who had been through the system at least 10 times before. Exhibit C, below, displays the percentage of cases in which the person had previously been in 0, 1, 2 or 3, or more than 3 cases.

EXHIBIT C: More than half of ITA court cases involved people who had a prior ITA case (for 2017 cases)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2017 to 12/31/2017

People in the ITA system are disproportionately likely to experience housing instability, particularly if they have a history of prior ITA cases. According to DCHS data, 28 percent of people with cases filed in ITA Court between January 1, 2014 and October 31, 2018, were experiencing housing instability, compared to less than one percent of King County residents overall.[7] Housing instability among people in the ITA system has trended upward since 2014, with people in nearly 31 percent of cases in 2017 experiencing housing instability.

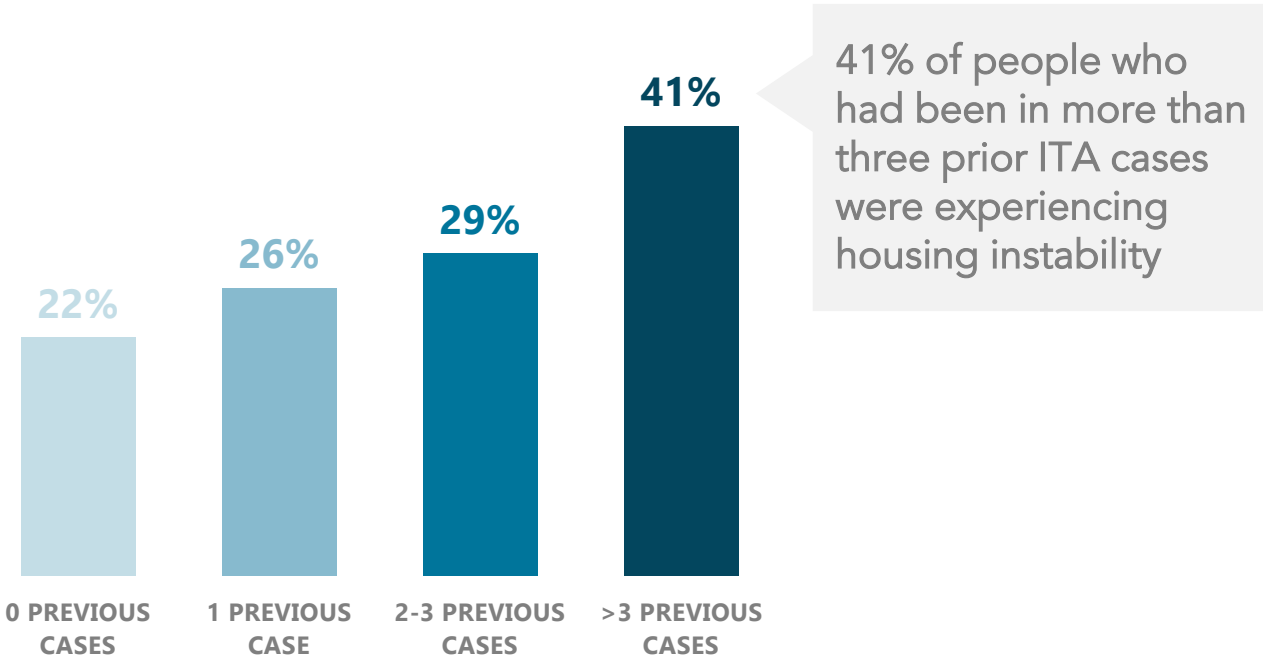
This difference is even more dramatic when looking at people with a history of prior cases. In 41 percent of cases involving a person who had been in more than three prior

Before he was arrested and "met criteria" [my son] was in a state of delusion/hallucination/psychosis…He was homeless because the hospital discharged him to the streets, unwell and unwelcome anywhere in the city.

[7] For the purposes of the analysis, a person was considered to be experiencing housing instability if the person's most recent (or last known) housing status in the Behavioral Health and Recovery Division (BHRD) information system was recorded as homeless or living in temporary housing at the time of referral to CCS.

ITA cases[8], the person was also experiencing housing instability. Exhibit D, below, shows the percentage of cases in which DCHS recorded the person as experiencing housing instability, categorized by their prior case history.

EXHIBIT D: People experiencing housing instability were more likely to have multiple prior ITA cases than people who were not experiencing housing instability (for cases from 2014 through 2018)

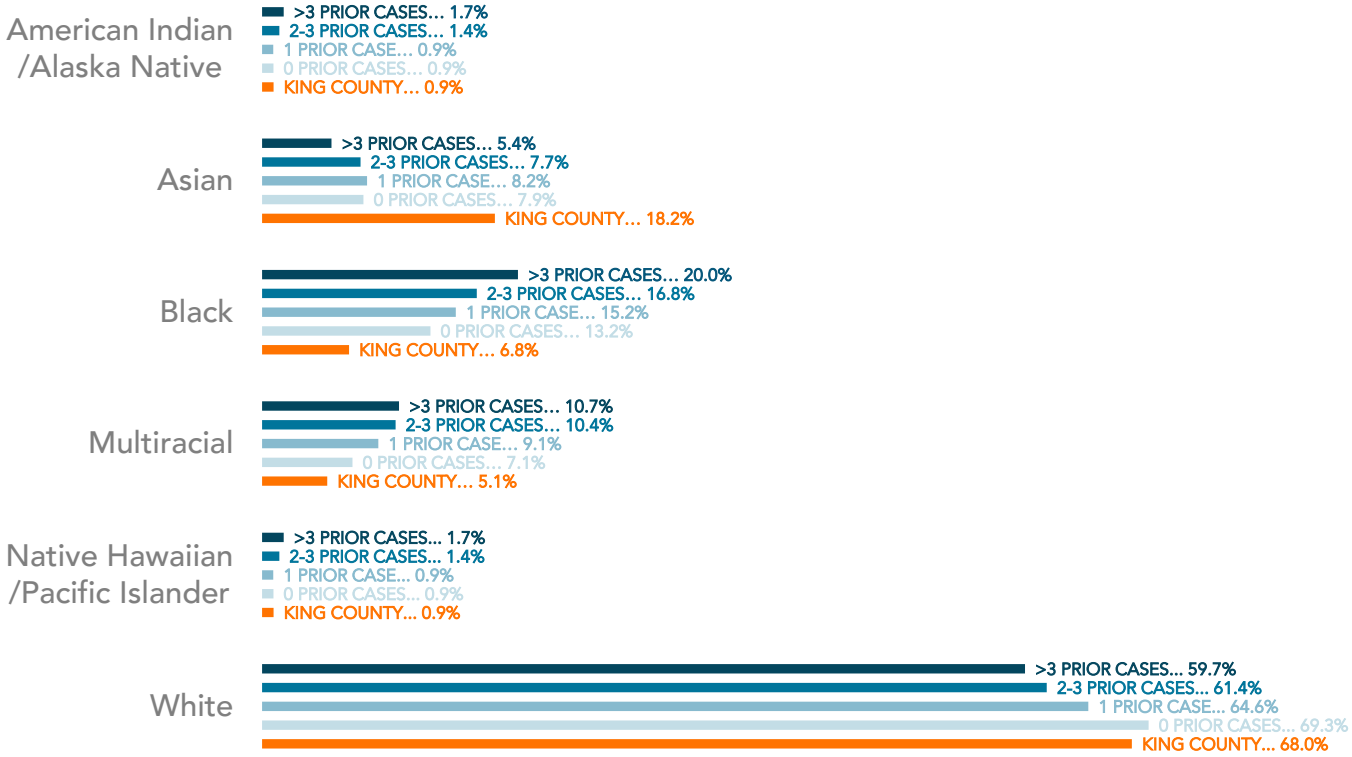


Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

People in the ITA system are disproportionately likely to be black, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, or multiracial, particularly if they have a history of prior ITA cases. People DCHS identified as white have gradually decreased as a percentage of the total ITA case population since 2014. People DCHS identified as black made up 14.8 percent of all ITA cases. When a person had more than three prior ITA cases, people identified as black made up 20 percent—this is despite being seven percent of King County's general population. We saw this same pattern with people DCHS recorded as other races that were not white or Asian. People DCHS identified as white made up 63 percent of all ITA cases and 60 percent of all cases for those who had been through ITA Court more than three times in the past; however, people DCHS identified as white make up 68 percent of King County's general population (see Exhibit E).[9]

[8] The data we used in this analysis only includes information on cases that occurred within King County ITA Court. ITA cases that occurred outside of King County are not included in this case history.
[9] For data limitations relating to race and other demographic, see the data limitations section on page 14.

EXHIBIT E: People who DCHS recorded as black, multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander were more likely to have prior case histories than people DCHS recorded as white or Asian (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and demographic data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018 for ITA population; United States Census for King County population

People in the ITA system are disproportionately likely to be male. DCHS recorded the majority (57 percent) of people in ITA cases as male, meaning that males are overrepresented in the ITA system compared to their percentage of the general population.

It is unclear whether people who identify as gender nonbinary are disproportionately represented in the ITA system. There are not clear statistics on the percentage of people who identify as gender nonbinary in King County, and DCHS recorded people as gender nonbinary in 0.9 percent of ITA cases.

A NOTE ON METHODOLOGY

The core questions of our analysis were:

1. What factors predict whether a person will have a future ITA case after leaving the ITA court system?
2. What factors predict ITA court outcomes?[10]

To answer these questions, we conducted statistical analyses using multiple sets of logistic regressions. One outcome we assessed was whether the person in the case had a future ITA case after leaving the court system. The other outcome we assessed was how ITA detention petitions were resolved. Appendices 1 and 3 list the potential contributors to these outcomes that we included in our regression analyses. By using this form of analysis, we were able to control for the distinct impacts of the factors included in the regressions. For example, if we found that there was a statistically significant correlation (relationship) between housing instability and a person's likelihood of having a future ITA case, we can be confident that this effect was not because of some other variable that was included in the regression (such as the person's history of prior cases). This was a useful form of analysis because it allowed us to isolate the impact of individual factors, rather than simpy making comparisons across groups.

In addition to these basic regressions, the team conducted regression analyses that considered the interactions between certain factors and categorized some groups in different ways (such as hospitals by whether they were E&Ts or not). When the variables used to test the interactions between variables were statistically significant, this meant that the effect of one of the variables was different depending on the value of the other variable.

In this report we draw comparisons between variables by directly comparing groups of cases or detention petitions. For example, we look at how often people return to the ITA system by how many prior ITA cases they were involved in. We present the results of our analysis as comparative percentages so that it is easier to interpret. Unless otherwise noted, we found variables discussed in the report body to be statistically significant contributors to the outcome being discussed in logistic regressions. These regressions controlled for other variables in the analysis, meaning we isolated the effects of the factors included in the analysis. By controlling for other variables, this allowed us to characterize the effects of single variables in situations where there are, in reality, many interacting factors. We included the results of these statistical tests, along with a more detailed explanation of how to interpret our results, in appendices 2 and 4.

Of note, when assessing court outcomes we only assessed the outcomes of 14- and 90-day detention petitions. This means that the people in these groups had already been involuntarily detained for up to an initial three days. CCS, therefore, initially determined that the people in these cases met the standards for involuntary treatment. We did not assess initial petitions for 72-hour holds due to data limitations, and we did not assess 180-day detention petitions due to their relatively small numbers.

[10] There are many possible outcomes for an ITA Court case. For instance, a case could result in an order for involuntary detention, a less restrictive form of treatment, a case dismissal, or a patient release with no court order.

Factors Associated with Returns to the ITA System

SECTION INTRODUCTION

In this section, we discuss how often people come back through the ITA system after finishing treatment at a hospital, and what factors are associated with their return to the ITA system. Key goals of the Involuntary Treatment Act are to provide appropriate treatment to people experiencing mental health crises, to safeguard individual rights, and to protect public safety. Stakeholders repeatedly raised concerns about aspects of the system that they believed limit how well it addresses underlying mental health challenges. Data on the status of a person's mental health is limited once they leave the ITA system. One can partly understand whether the treatment a person received addressed their mental health crisis however, by assessing whether they eventually have a subsequent ITA case after concluding treatment for the current case.

> *"…my younger brother went through the [ITA] process a few years back after an [emergency room] visit to Evergreen Hospital…The argument that he has the right to not get help is so upside down. His mind is what is broken; how can he possibly be able to be competent to decide? I have seen my brother in a stable state when he is off drugs and on his medication, and he is a productive member of society. But, he was just sent out and the crazy cycle just started all over again. Off and on the streets, more [emergency room] visits, jail time, and chronic stress and worry for my parents who love their son. The cost my brother has created in jail visits, court appearances, [emergency room] visits, not to mention the theft from stores must be pretty astronomical."*

In this analysis, we treat returns to the ITA system as an indicator of decompensation or worsening of symptoms, but it is important to note that returning to the ITA system could in some cases be positive. [11] If the system responds to a person's mental health crisis when they are a danger to themself or others, it is functioning as intended. Some returns to the ITA system may be due to a person's decompensation being noticed and addressed. Ideally, voluntary treatment is the first line of defense for addressing mental health concerns. Frequent returns to the ITA system may indicate that the person experiencing a mental health concern is not receiving sufficient treatment before they meet the criteria for involuntary treatment. Stakeholders also note that going through the ITA system can be traumatizing since it involves taking away a person's rights and sometimes physically restraining them.

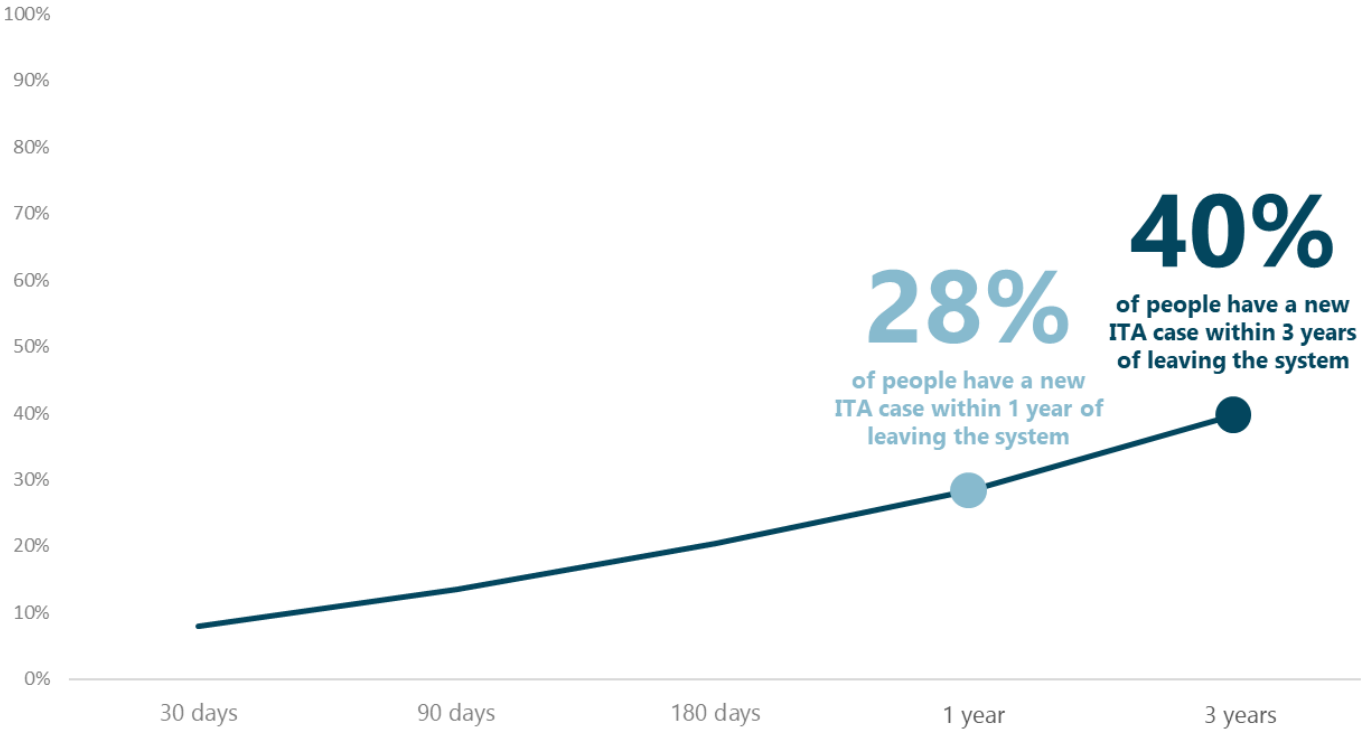
Nearly 30 percent of people who have an ITA case have a new case within one year of leaving a hospital, with almost 40 percent of people having a new case within three years of leaving a hospital. [12] Due to the chronic nature of many mental illnesses, it is likely that some people will return to the ITA system. It is

[11] Decompensation is a term used by mental health providers to describe the deterioration of the mental health of a person who, up until that point, was maintaining his or her mental health.

[12] This number excludes clients who may have decompensated outside of King County, or who decompensate and do not have a new ITA case. As such, this is likely an underestimate of how many people decompensate after leaving the ITA system.

unclear to what extent the current rate of return is positive or negative. Exhibit F, below, shows rates of return to the ITA system, indicating the percent of people who have a new case after 30, 90, 180, 365 (one year), or 1,095 days (three years) of leaving a hospital.

EXHIBIT F: 40 percent of people had a new ITA case within three years of leaving the ITA system (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

Stakeholders in the ITA system have theorized about what may lead people to return to the ITA system. They raised concerns about a variety of factors that may lead to a person not receiving the treatment they need and a subsequent increase in mental health symptoms. Factors they mentioned ranged from the hospital that treats the person to how many continuances are used in a case. To better understand which factors contribute to increases in mental health symptoms and subsequent returns to the ITA system, we included the ideas that stakeholders raised, plus other potentially relevant variables, in a series of regressions. These regressions tested the likelihood of a person having a new ITA case within 30, 90, 180, 365 (one year), and 1,095 days (three years) of leaving a hospital. This analysis was at the case level (rather than person level), therefore some people appear in the data multiple times.

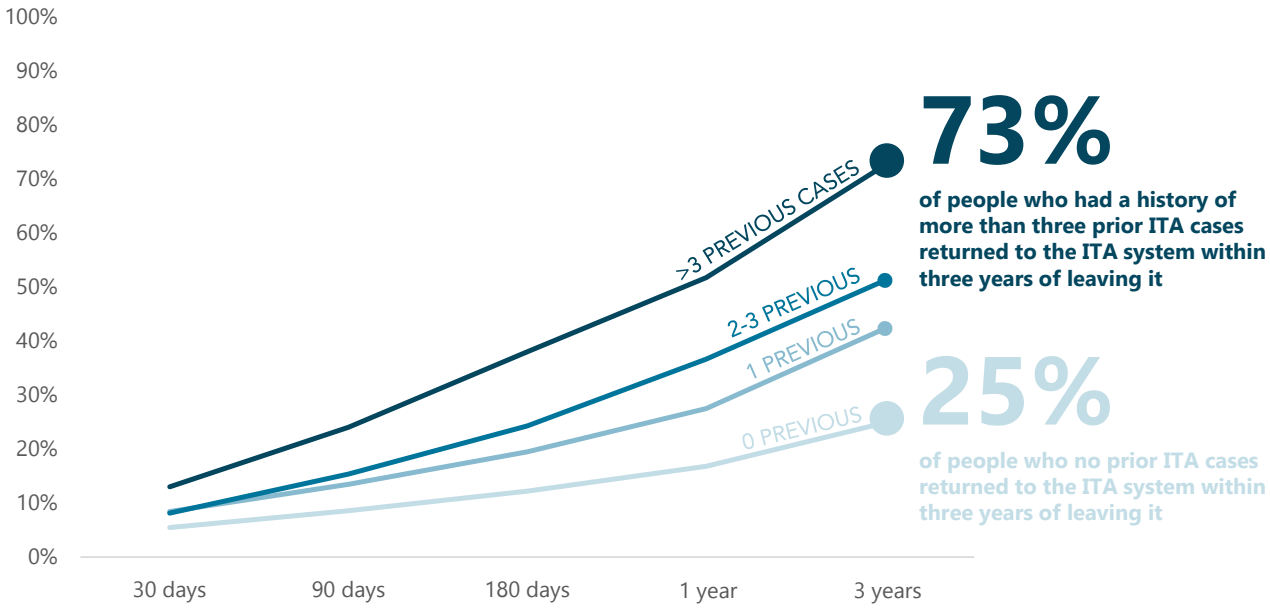
Personal Characteristics Associated with Returns to the ITA System

Stakeholders raised concerns about some people frequently returning to the ITA system, noting that these people repeatedly cycle through ITA Court without receiving treatment that would reduce their likelihood of having a new case. To better understand these concerns, we evaluated differences in people's rates of return to the ITA system related to a variety of personal characteristics, including prior case history, housing instability, and other demographic factors.

What personal characteristics were most associated with people's returns to the ITA system?

People who had prior ITA cases were more likely to return to the ITA system. Of people with more than three prior ITA cases, 73 percent returned to the ITA system within three years of leaving it. This compares to 25 percent of people who had no prior case history. Of the factors included in our analysis, prior case history was associated with the largest increase in people's likelihood of returning to the ITA system (for details, see Appendix 2). Exhibit G, below, describes the percentage of people that had a new case within 30, 90, 180, 365 (one year), and 1,095 days (three years) of leaving a hospital, grouped by the number of prior cases the person had. This shows that the likelihood of returning to the ITA system consistently increased based on the number of prior ITA cases the person had.[13]

EXHIBIT G: Nearly three quarters of people with more than three prior ITA cases had a new case within three years of leaving the ITA system (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

[13] Because this analysis is at the case-level, a person could have different case histories depending on which case is being assessed. As such, in their first case they would be in the 0 previous cases group, in their second case they would be in the one previous case group, etc.

People who were gender nonbinary were more likely to return to the ITA system. Of the people DCHS recorded as gender nonbinary, 73 percent returned to the ITA system within three years of leaving it. This compares to 39 percent of people recorded as male or female. People who were gender nonbinary were statistically more likely to return to the ITA system within 90 days, and three years. The fact that people who are gender nonbinary are not statistically significantly more likely to return to the system within other timeframes may be due to the relatively small number people DCHS recorded as gender nonbinary in the timeframe we assessed. (There were 154 cases out of a total of 17,431 cases with gender data). [14]

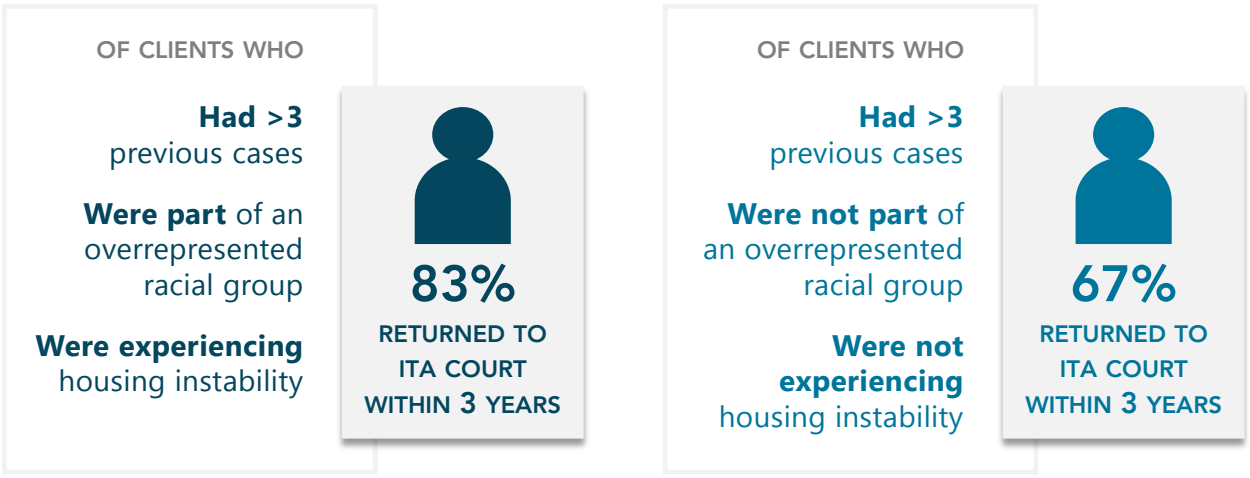
People experiencing housing instability are more likely to return to the ITA system. Of the people DCHS recorded as experiencing housing instability at the time of case intake, 52 percent returned to the ITA system within three years of leaving it. This compares to 36 percent of people who were not recorded as experiencing housing instability. The impact of housing instability on returns to ITA Court is statistically significant at all timeframes tested.[15]

People who are American Indian or Alaska Native, black, Native Hawaiian or Pacific Islander, or multiracial are more likely to return to the ITA system than people who are white or Asian. Of the people DCHS recorded as American Indian or Alaska Native, black, Native Hawaiian or Pacific Islander, or multiracial, 50 percent returned to the ITA system within three years of leaving it. This compares to 36 percent of people DCHS recorded as white. When people in a racial group overrepresented in the ITA system were considered together in the ITA system, we found that people that fell within that combined category were statistically more likely to return to ITA Court within 90 and 180 days, as well as after one and three years, than people who were recorded as white or Asian.

People in an overrepresented racial group or who are experiencing housing instability are more likely to return to the ITA system, even when considering generally longer case histories in these groups. This means that even when comparing two people who have both had more than three prior ITA cases, if one of the people was experiencing housing instability and the other was not, the person experiencing housing instability would be more likely to have a subsequent ITA case (see Exhibit H). For example, a person who was white and housed would be less likely to return to the ITA system than someone who was American Indian and experiencing housing instability.

[14] For data limitations relating to gender and other demographic, see the data limitations section on page 14.
[15] For data limitations relating to housing instability, see the data limitations section on page 14.

EXHIBIT H: People who were part of an overrepresented racial group or experiencing housing instability were more likely to have subsequent ITA cases, even when considering their higher likelihood of having a prior case history (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and demographic data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

NOTABLE DATA LIMITATIONS

Some race data is not self-reported, and it is not clear when this is the case. Data on race and gender in this data set is collected in multiple ways:

1. CCS evaluators fill out intake forms when initially evaluating a person in which they record the person's race and gender. In these instances, the data may be based on the direct observation and judgment of the evaluator or interviews with other involved people, rather than the person's disclosure.
2. If the person uses other DCHS services such as outpatient community mental health treatment, their race and gender data may be recorded or updated through another approach, such as self-report by the person in the case.

DCHS representatives explain that the data does not distinguish which source this demographic information came from within the data system. The fact that the data is sometimes based on the evaluator's observation may result in some entries that do not match how people self-identify.

Housing instability could be the result of decompensation. It's worth noting that housing instability could contribute to returns to the ITA system, but the decompensation associated with returns to the ITA system could also contribute to homelessness. As with many variables in this analysis, we cannot fully conclude that housing instability is the cause of the outcomes we're assessing.

NEXT STEPS

Disproportionality in the ITA system may reflect larger societal disparities in access to health care and other services. Some research suggests that discrimination, social stigma, and geographic and financial barriers inhibit access to the use of mental health services for people from certain racial groups. This could prevent some mental health concerns from being addressed prior to reaching the ITA system. Racial disparities in ITA Court entry are also similar to that of the criminal justice system, with people who are black and American Indian/Alaska Native being overrepresented in both ITA Court and King County jail bookings, as well as referrals to the ITA system from the criminal justice system. Understanding the reason for this disproportionality may offer an opportunity to further county goals by allowing the County to better address the needs of these populations.

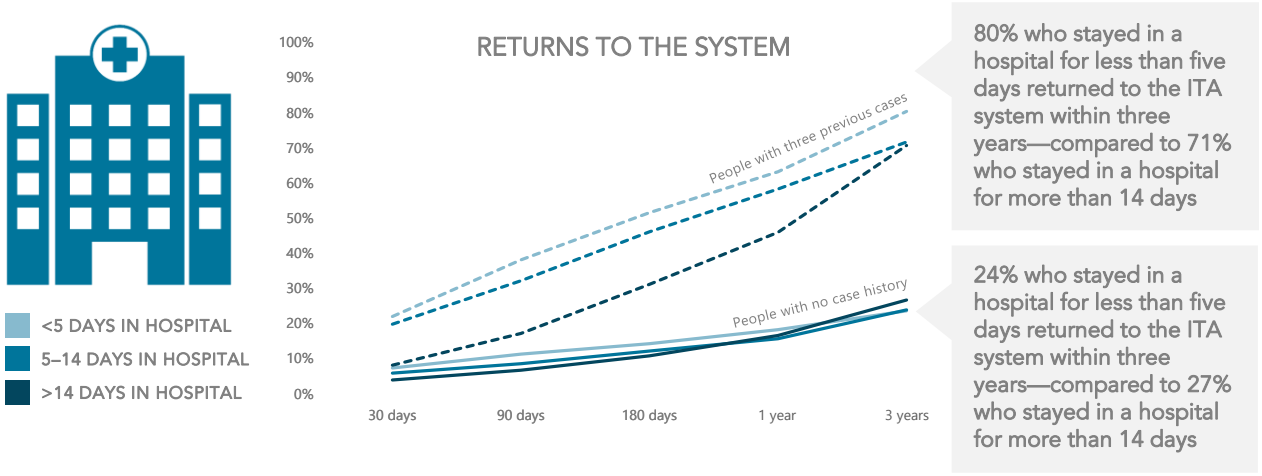
Hospital-Level Factors Associated with Returns to the ITA System

Stakeholders raised concerns about the level of care at some hospitals, noting that some hospitals may do a better job of addressing people's mental health concerns and preparing them to reenter the community than others. To better understand these issues, we evaluated differences in people's likelihood of returning to the ITA system related to how long they were held in a hospital, as well as related to the specific hospital where they received treatment. We also assessed differences in the characteristics of people treated by separate hospitals to explore stakeholder concerns that some hospitals systemically refuse certain patient populations.

Does the length of time a person spends in a hospital impact their likelihood of returning to the ITA system?

People who spend more time in a hospital were less likely to return to the ITA system if they had a prior ITA case history, but not if it was in their first case. The time a person spends in a hospital can vary depending on whether they receive involuntary treatment and detention, or whether the hospital chooses to discharge the person without a court order. While more time in a hospital does not appear to help people with no prior case history, it is associated with a lower likelihood of returning to the ITA system for people with more than three prior cases. Notably, the largest initial reduction in people's likelihood of returning to the ITA system occurs when the person is held for more than 14 days in a hospital. Of people with more than three prior cases who are held in a hospital for fewer than five days, 22 percent return to the ITA system within thirty days. This compares to four percent of people with more than three prior cases who are held in a hospital for more than 14 days (see Exhibit I).

EXHIBIT I: People who had a history of prior ITA cases and spent more time in a hospital were less likely to return to the ITA system (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

Does being treated by certain hospitals impact people's likelihood of returning to the ITA system?

People treated by some hospitals were more likely to return to the ITA system, but possible differences in the populations that hospitals serve makes this finding difficult to interpret. People whose primary treatment facility was Harborview Maleng (which serves people with co-occurring serious medical concerns) or Multicare Evaluation and Treatment Center (Multicare E&T) were more likely to return to the ITA system.[16] Of people whose primary hospital was Harborview Maleng and Multicare E&T, 36 and 41 percent respectively, returned to the ITA system within one year. This compared to 28 percent of people returning to the ITA system on average across all the hospitals.

While these relationships are statistically significant, independent of any influence by the other factors in our analysis, they should be interpreted with caution. Harborview Maleng primarily serves people with other serious physical health concerns, which are not accounted for in our analysis. People's higher likelihood of returning to the ITA system when they are treated by this hospital may be due to differences in the populations this hospital serves, rather than the level of care it provides. The reason that people treated by Multicare E&T are more likely to return to the ITA system is unclear, although it is worth noting that Multicare E&T was the primary hospital in a relatively small number of cases during our analysis period (fewer than 300 cases out of over 17,000 cases). Other than these two facilities, we saw no consistently statistically significant difference in people's likelihood of returning to the ITA system across the hospitals where they were treated.[17]

[16] These were in comparison to other Harborview Medical Center facilities.
[17] For data limitations relating to hospital comparisons, see the data limitations section on page 20.

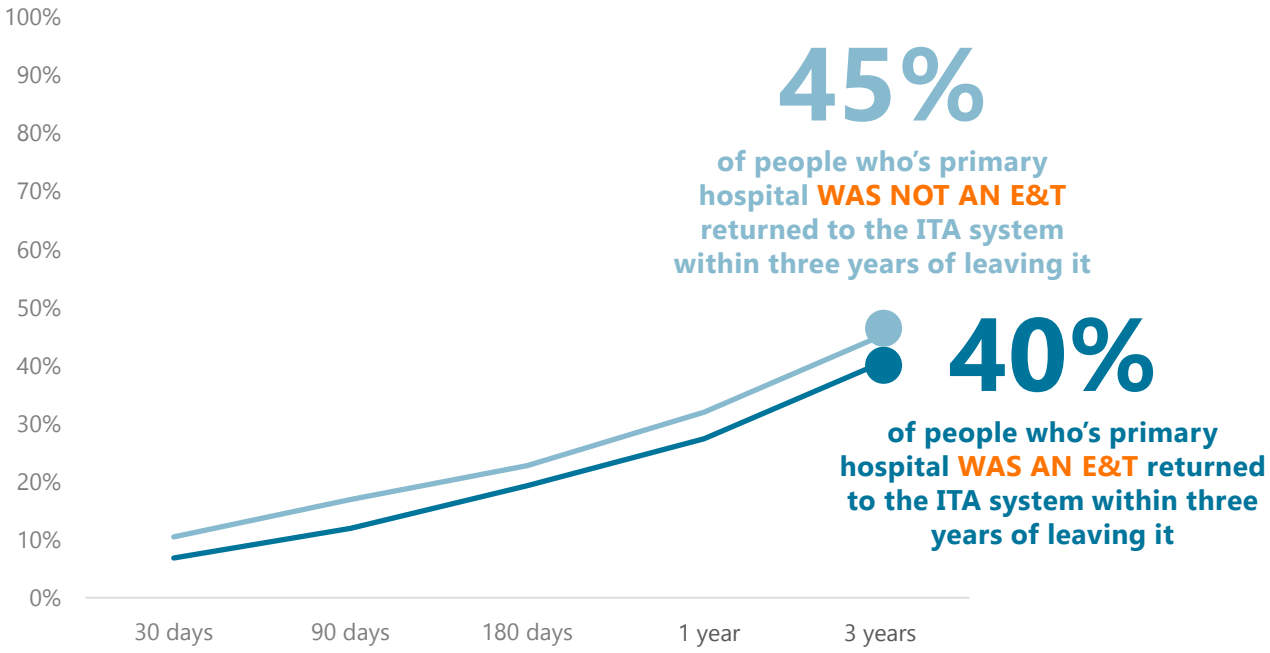
People treated by hospitals that specialize in serving ITA patients are less likely to return to the ITA system. Stakeholders noted that hospitals can contribute to lower rates of return to the ITA system by improving the mental health of their patients. They explained that some hospitals may provide higher levels of care after discharge or may better prepare their patients to reenter the community after discharge. E&Ts are the primary facilities designed to serve people experiencing mental health crises. Other hospitals do not necessarily specialize in serving this population.

People were less likely to return to the ITA system if their primary treatment facility was an E&T rather than a non-E&T, although the difference is relatively small.[18] Of people whose primary treatment facility was an E&T, 27 percent returned to the ITA system within a year, and 40 percent returned within three years. This compares to 32 percent and 45 percent for people whose primary hospital was not an E&T (for more details, see Exhibit J). People treated by hospitals that take fewer ITA cases[19] were also more likely to return to the ITA system compared to those treated by hospitals with larger caseloads within one year,[20] although the difference was not as large or consistent across time periods in this instance.

"Going through four hospitalizations in four different facilities, it is clear the level of care and treatment has significant variation [between hospitals]. Harborview appeared to have structure, capability to diagnose, strict guidelines on access to technology, therapy groups and a caring staff our son admired. The most recent [involuntary hospital stay]…he was in a new-to-him facility where he was medicated, given access to a computer with Internet (thereby feeding his delusions), allowed to stay up all night, and lived in an environment without a treatment plan. He was released yesterday with a 90-day least restrictive order. No appointments with case manager or a therapist, no meds, and no insurance."

[18] This difference was statistically significant for returns within every time period tested aside from 180 days.
[19] This group included all hospitals that each took less than five percent of ITA cases between 1/1/2014 and 10/31/2018 that did not specialize in serving a specific client population (i.e. Northwest Geropsychiatric Center, Seattle Children's Hospital, and the Veterans Affairs hospital were excluded from these groups).
[20] This group consisted of Navos Psychiatric Hospital, Harborview Medical Center, Fairfax Hospital, and Cascade Behavioral Health.

EXHIBIT J: People held in E&Ts were less likely to return to the ITA system than those held in non-E&T hospitals (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

Stakeholders expressed concerns about the level of care at private hospitals, but we did not find clear differences in rates of return to the ITA system between private and not-for-profit hospitals. People treated by private and not-for-profit hospitals were similarly likely to return to the ITA system, even when accounting for the impact of the personal characteristics and court factors included in our analysis. Of the people treated in not-for-profit hospitals, 42 percent returned to the ITA system within three years of leaving it, compared to 39 percent of people treated in private hospitals.[21]

Do private hospitals systemically avoid treating certain types of clients?

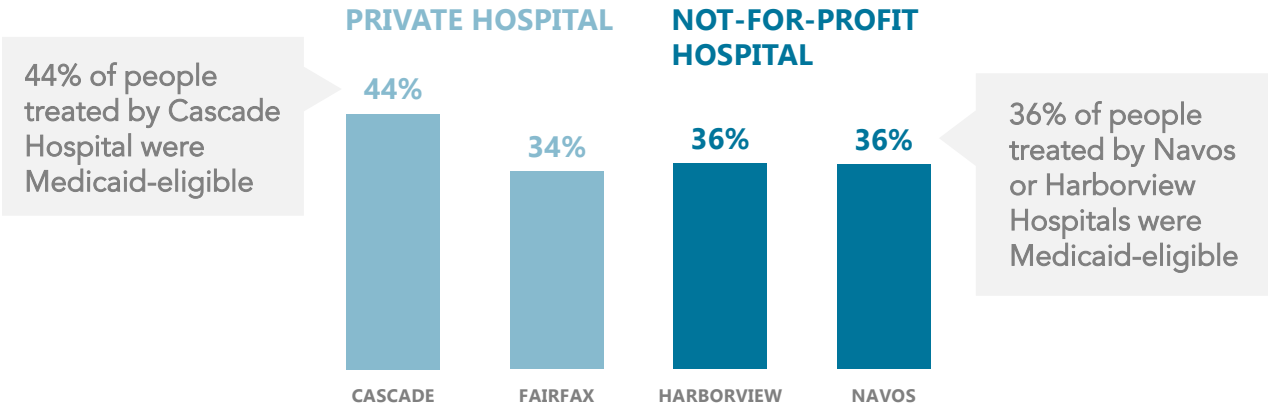
Stakeholders expressed concern that private hospitals would be less likely to accept Medicaid-eligible patients for treatment based on profit motive, but our analysis found that private hospitals were more likely to have ITA patients that were eligible for Medicaid than not-for-profit hospitals. Stakeholders were concerned about private hospitals refusing to treat people on Medicaid, given that the hospital would receive lower payments for the person's stay than if they had other forms of insurance. We found the opposite relationship; Private hospitals served more Medicaid-eligible ITA patients at the time of the 14-day petition than not-for-profit

[21] Government-run and nonprofit hospitals were categorized as "not-for-profit" for the purpose of this analysis, while hospitals described as proprietary by the Washington State Department of Health were categorized as "private." Hospitals that serve specialized populations, such as Northwest Geropsychiatric Center, Seattle Children's Hospital, and the Veterans Affairs hospital were excluded from these two groups.

hospitals did. This difference was largely driven by Cascade Behavioral Health Hospital, which had a notably higher percentage of Medicaid-eligible ITA patients than other hospitals. Of note, our analysis did not distinguish between people who were privately insured and people who were uninsured.[22]

Exhibit K, below, presents the percentage of cases in which the person was eligible for Medicaid at their initial intake with CCS, categorized by the hospital they were receiving treatment from at the time of the 14-day petition. This exhibit includes the four hospitals that took the majority of ITA cases from January 1, 2014 through October 31, 2018.

EXHIBIT K: Private hospitals generally, and Cascade in particular, had more cases in which the person was Medicaid-eligible (for cases from 2014 through 2018)



Source: King County Auditor's Office summary of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

People treated by not-for-profit hospitals were slightly more likely to be experiencing housing instability. This difference was relatively small, with 31 percent of people treated by not-for-profit hospitals experiencing housing instability at the time of their initial CCS evaluation, compared to 27 percent of people treated by private hospitals.

While not-for-profit hospitals are similarly likely to pursue a case to the point of a court order whether or not the person is Medicaid-eligible, private hospitals are actually more likely to pursue the case if the person is Medicaid-eligible. Even if a hospital initially accepts a person for treatment, the hospital and prosecuting attorney can choose to release the person rather than taking the case to court. When a hospital chooses to release the person it is treating, the petition for detention is closed without a court order. In these instances, the hospital files a notice of release. If private hospitals preferred not to pursue cases for Medicaid-eligible people, one would expect them to have more petitions that end without a court order for people who are Medicaid-eligible. The opposite was true; Private hospitals were more likely to pursue 14-day petitions when the person they were treating was Medicaid-eligible than not-for-profit hospitals. If a person was being treated by a not-for-profit hospital, they were similarly likely to have their

[22] For data limitations relating to insurance coverage, see the data limitations section on page 20.

14-day petition close without a court order regardless of whether that person had Medicaid. The difference between the two hospital types was not statistically significant for 90-day petitions.

For not-for-profit hospitals, 11 percent of 14-day petitions ended in a case closure without an order when the person was Medicaid-eligible, as compared to 13 percent when the person was not Medicaid-eligible. For private hospitals, 10 percent of 14-day petitions ended in a case closure without an order when the person was Medicaid-eligible, as compared to 17 percent when the person was not Medicaid-eligible. For more discussion on hospital decisions related to personal traits, see next steps, below.

NOTABLE DATA LIMITATIONS

Available data used does not contain information on people's medical conditions. Our analysis accounted for some factors that could indicate ITA case severity, such as a person's history of prior cases, but it does not include detailed information about people's medical conditions. Therefore, differences in people's likelihood of returning to the ITA system based on their primary hospital should be interpreted with caution. These could indicate differences in the levels of care across hospitals, differences in the people that hospitals accept for treatment, or some combination of the two. This also limits how much we can address differences in which people hospitals choose to treat. There are a variety of factors that could influence who hospitals treat that are not included in the data.

Some cases had to be excluded from the hospital analyses when discussing returns to the ITA system. When assessing returns to the ITA system, we defined the primary hospital for a case as the hospital in which the person was held for five days or more. We defined the variable this way because we needed mutually exclusive hospital categories for the regression analyses. A person could be held in multiple hospitals, or none, for five or more days.[23] In these instances, we could not assess the association between the specific hospitals where people were treated and their likelihood of returning to the ITA system. Results for these additional categories (people held in multiple hospitals for more than five days, or no hospital for five days) are available in Appendix 2. This limitation does not apply to the analysis of case acceptances or case pursuits by hospitals, as this used the charging hospital at the time of the 14-day detention petition (rather than the primary hospital in the case).

NEXT STEPS

- As noted above, while our analysis shows differences in people's likelihood of returning to the ITA system based on which hospital treats them, it is not clear what accounts for these differences. Some hospitals may treat fundamentally different populations, which could lead to

[23] In some cases, people may not be held in any one hospital for more than five days. This can occur if the hospital releases them voluntarily before five days have passed, or if the person was held in multiple hospitals at different times, but none for more than five days.

differing rates of return to the ITA system based on patient traits. Others may have different treatment standards and protocols for the release of patients. Further research on the conditions at hospitals that are associated with both high and low likelihoods of people returning to the ITA system, as well differences in the patients that they serve, could yield further insight on how levels of care impact personal health and returns to the system.

- As noted above, while our analysis shows differences in which people hospitals treat, and which cases the hospitals pursue based on people's traits, it does not identify the reasons for these differences. It also does not comprehensively test all relevant personal traits, such as severity of health concern, due to data limitations. Nevertheless, there are clear differences across hospitals in the people they serve and their likelihood of pursuing a case based on some personal characteristics. If hospitals systemically choose to release some people for reasons unrelated to their need for treatment, this could negatively affect these people and stand opposed to the ITA system's goal of providing appropriate treatment. More research on the reasons for these discrepancies could further stakeholder understanding of whether hospitals are accepting and pursuing cases differently based on people's traits, and whether these differences are justified.

Court-Level Factors Associated with Returns to the ITA System

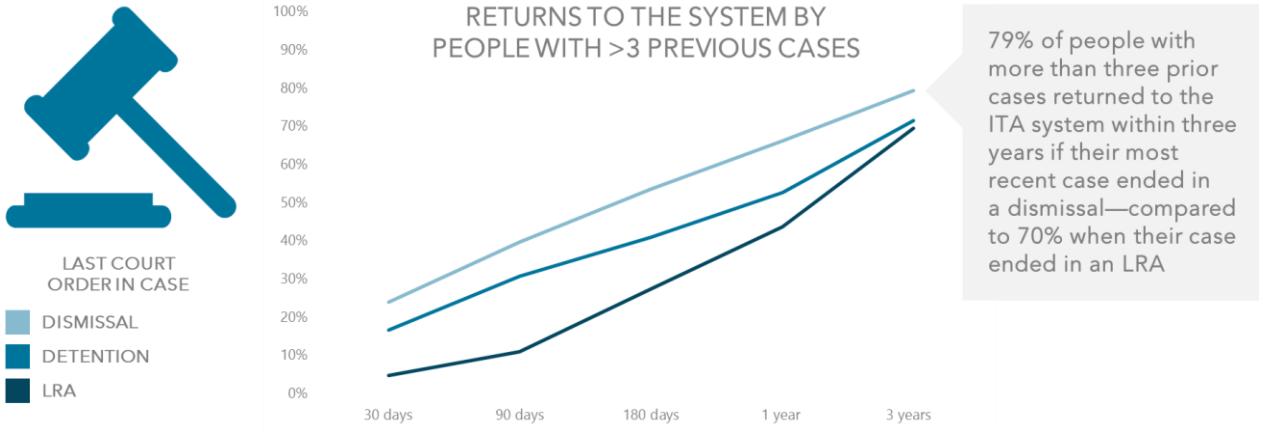
Given the impact that court decisions have on the treatment that people receive, court-level factors have the potential to influence people's long-term health outcomes. Court orders can require a person to be detained in a hospital for treatment, to receive a less restrictive alternative (LRA) form of treatment outside of a hospital, or to be released through a dismissal. Stakeholders raised concerns that some people may not receive the level of care they need if their case is dismissed early on. They noted that it was not uncommon for people to have their case dismissed due to a legal technicality, only to quickly return to the ITA system because their underlying mental health concern was not addressed. To explore these stakeholder comments, we evaluated whether people were more likely to return to the ITA system if they had certain court outcomes.

Does a person's final court outcome impact their likelihood of returning to the ITA system?

People whose case ended with a dismissal were more likely to return to the ITA system, regardless of their prior case history. This is counterintuitive given that one would assume case dismissals occur when a person does not need involuntary treatment. Stakeholders explained, however, that dismissals can also occur due to technicalities, or the hospital or prosecuting attorney not having sufficient evidence to advocate for the person's treatment. This suggests that if a petition is being filed for a person's 14-day detention and treatment, it is likely that the person's symptoms are severe enough to meet the standard for involuntary treatment, even if the petition is dismissed. Exhibit L shows how often people returned to the ITA system over time by

their final court outcome both for people who had more than three prior cases and for people who had no prior case history. [24]

EXHIBIT L: Case dismissals are associated with higher rates of subsequent ITA cases than other final court orders (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

We assessed whether the impact of dismissals varied depending on whether the person with the case dismissal was treated by a certain hospital, spent more than 14-days in a hospital, had more than three prior ITA cases, was a member of a racial group overrepresented in the ITA system, or was experiencing housing instability. Housing instability and case history were the only factors that had statistically significant differences on the impact of dismissals on a person's likelihood of reentering the ITA system for any of the timeframes tested. These differences were limited to only a few timeframes however, and are therefore difficult to interpret.[25]

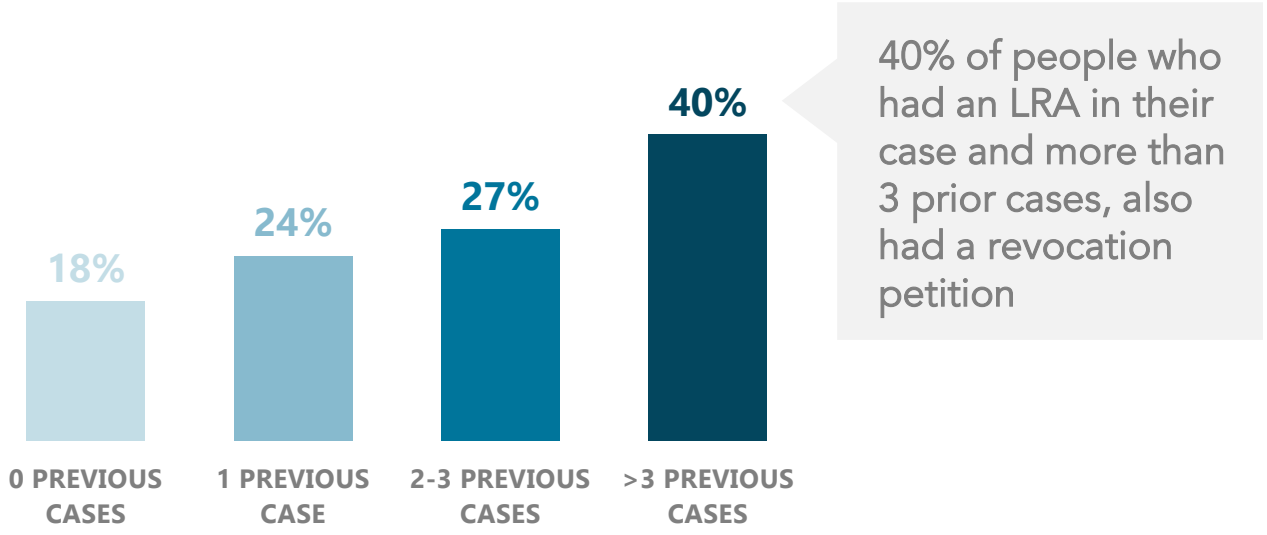
In the long run, people who had a final court order for an LRA treatment were similarly likely to return to the ITA system compared to people whose final order was for involuntary inpatient treatment, but revocation petitions within the cases with LRAs are common. The designated crisis responder may file a revocation petition if a person is violating the required treatment terms of their LRA or if the person's mental health significantly declines while they are receiving LRA treatment. If the revocation petition is successful, the person may then be required to receive treatment in an inpatient facility.

People were similarly likely to return to the ITA system in the long run if their final court order was for an LRA or for a detention, regardless of the person's case history.[26] People with extensive case histories were more likely to have a petition to revoke an LRA, however. Of people with more than

[24] For data limitations relating to court outcomes, see the data limitations section on page 23.
[25] Our analysis indicated that dismissals were less likely to contribute to a person's likelihood of returning to the ITA system within 30 or 90 days if they were experiencing housing instability than if they were not experiencing housing instability. Our analysis indicated that dismissals were more likely to contribute to a person's likelihood of returning to the ITA system within 365 days if they had more than three prior cases than if they had no prior cases.
[26] While people were less likely to have new ITA cases within 30 days to one year of leaving a hospital if their final court order was for an LRA, much of this difference is likely due to the fact that if they decompensated they would have a revocation under the current case (rather than having a new case).

three ITA cases before their current case, 40 percent who had an LRA also had a petition for revocation at some point in the case (see Exhibit M).

EXHIBIT M: Less restrictive alternative revocation petitions were more common when the person had a prior case history (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

NOTABLE DATA LIMITATIONS

The only court order this analysis considers is the last court order on the case. We assessed the association between the last court outcome in a person's likelihood of returning to the ITA system but did not assess the impact of other court orders within a case. For example, initially having a detention order for a 14-day petition, and subsequently having an LRA for a 90-day petition, could result in different outcomes than simply having an LRA for the initial 14-day petition. Due to the many combinations of outcomes that could occur depending on how many petitions there could be in a case, our analysis focused on only the last court outcome in the case. However, it is possible that the use of court orders at different phases in the case may have different impacts on a person's likelihood of returning to the ITA system than the final court order in a case.

Court data does not identify when the prosecuting attorney requested a dismissal. Stakeholders noted that the nature of dismissals is fundamentally different when the prosecuting attorney voluntarily dismisses a petition than when the judicial officer on the case orders the dismissal without such a request. Prosecutors may voluntarily dismiss a petition for treatment prior to a court hearing when they assess a case and determine that they do not have the evidence needed to proceed. A judicial officer may also dismiss a petition for treatment due to findings related to a motion to dismiss, or if the judicial officer determines the prosecutor did not

meet his or her burden of proof. The data used in this analysis does not distinguish between these two types of dismissals. This prevents us from assessing the differences in a person's likelihood of returning to the ITA system based on which type of order for dismissal they received.

NEXT STEPS

- While the association between case dismissals and a person's likelihood of returning to the ITA system could be due to a variety of factors, the relationship supports some concerns that stakeholders raised. Stakeholders noted that dismissals are sometimes due to technicalities or a lack of court actor preparation to argue for treatment, rather than a lack of need for treatment, and that this leads to the person reentering the system soon after their case is dismissed. If this were true, one would expect to see a high percentage of people reentering the ITA system immediately following the closure of the case. The fact that people who received dismissal orders were more likely to return to the ITA system within 30 days of leaving it supports this hypothesis. To understand more about the nature of these dismissals, however, and whether they were due to technicalities, would require more related details about the reason for the dismissal to be recorded in the case data.
- Our analysis shows generally positive long-term outcomes when the final court order on a case is an LRA (regardless of the person's case history), but high revocation petition rates for people with extensive case histories. While this suggests that ITA stakeholders' emphasis on the use of LRAs instead of more restrictive detentions, when reasonable, may be positive, there are large percentages of people for which an LRA may not be appropriate. Understanding more about when LRAs help a person, and when they do not, could allow for increasingly effective use of this practice.

Factors Associated with Court Outcomes

SECTION INTRODUCTION

The court plays a major role in shaping people's treatment by determining whether they will be involuntarily detained and treated, whether they will receive less restrictive forms of treatment, or whether they will not receive any form of involuntary treatment. As discussed in the previous section, the court outcome a person receives may play a significant role in that person's likelihood of returning to the ITA system, with people who receive orders for dismissal being more likely to return. Multiple stakeholders also emphasized the use of LRAs as a preferable alternative to involuntary detention and treatment, when it is appropriate for the person. Under an LRA, people receive treatment outside of an inpatient setting, and the specific requirements of this treatment are determined by their mental health provider. LRAs, therefore, allow people to maintain more personal rights compared to when they are involuntarily detained. Using LRAs also reduces the demands for a limited supply of ITA treatment beds.

Stakeholders we spoke with raised concerns about the potential for a variety of factors to influence orders for LRAs and dismissals. Factors mentioned ranged from how effectively hospital evaluators advocate for involuntary treatment to a person's eligibility for Medicaid.[27] To better understand what contributes to different court outcomes, we included these and other potentially relevant variables in a series of regressions, testing the likelihood that a petition would end in either an LRA or a dismissal.[28] Our analysis was at the petition level (rather than case level), because, as discussed in the introduction, multiple petitions and outcomes can occur within a case. For example, in a single case a person could have a 14-day petition that ends in involuntary detention, and a 90-day petition that ends in an LRA. Therefore, a single case could appear in the data multiple times. Our analysis focused on the outcomes of 14-day petitions and 90-day petitions, excluding initial petitions and 180-day petitions. This section explores the prevalence of different court outcomes and the major contributors to them.

NOTABLE DATA LIMITATIONS

ITA Court data does not explicitly match specific petitions with specific outcomes, which prevented us from assessing some outcomes. The data we used to assess petition outcomes does not explicitly identify which court outcomes are associated with which petitions. To perform our analysis, we needed to identify which court outcomes were connected to each petition by assessing when they occurred relative to each other. We treated the cases first court outcome after the petition as that petition's outcome. Unfortunately, even when considering identifiable

[27] Stakeholders noted that Medicaid recipients are typically more likely to have access to a care coordinator who can monitor them under the LRA, due to their membership in a managed care organization. They explained that private insurance often does not cover these services, and that other people often do not have a psychiatrist already available to monitor them.

[28] For a full list of variables included, see Appendix 3.

duplicates, it was not possible to identify the court outcome associated with every petition due to discrepancies in the data. We ultimately identified 18,367 14-day petitions and 7,441 90-day petitions for analysis, out of 18,513 14-day petitions and 7,717 90-day petitions we determined were not duplicates. This means that while the analysis described in this section includes 99 percent and 96 percent respectively of 14-day and 90-day petitions, there are a small number of petitions that are excluded because a petition-to-outcome link could not be made.

NEXT STEPS

ITA cases often have multiple distinct phases in which there is a new petition and associated outcome, as opposed to most court cases which typically have one final outcome. If a person is found guilty of a crime, they will have a specific sentence for this crime. Current King County court data systems are not designed with this unique trait of the ITA system in mind, and as such, do not identify which ITA outcomes are associated with which petition. Given this limitation, stakeholders may want to consider changes to the court data system that identify which ITA court outcomes are associated with which petition. This would allow them to assess petition outcomes without excluding relevant data.

Personal Characteristics Associated with Court Outcomes

Stakeholders emphasized the use of LRAs as a preferred alternative to involuntary detention in many cases but raised concerns that LRAs may not be viable in some cases due to certain personal characteristics. If a person receives an order for an LRA, a mental health service provider determines the specific parameters of the treatment, but some general requirements must be met for an LRA to be used. These include having a designated care coordinator, to work with outside of involuntary inpatient treatment, and a schedule of regular contacts between the person and their mental health provider. Stakeholders cited difficulties in establishing an appropriate LRA plan unless the person is already part of a state-run managed care organization.[29] Given that a person must be on Medicaid to be part of a state-run managed care organization, stakeholders were concerned that a patient not being on Medicaid would be a barrier to LRA use. To explore this concern, we analyzed differences in case outcomes associated with personal characteristics, particularly the impact of Medicaid on the likelihood of a person receiving an LRA.

[29] A person needs to be on Medicaid to be part of a state-run managed care organization. State-run managed care organizations are prepaid systems of health care delivery which includes preventive, primary, and other health services.

Is a person less likely to receive an LRA if they are not Medicaid-eligible?

A person cannot be treated using an LRA unless they have a mental health provider to work with outside of involuntary detention. Because an external mental health provider is required for a less restrictive form of treatment to be viable, stakeholders note that it is very difficult to treat a person through an LRA unless this provider-to-patient relationship is already established. They explain that many providers are unwilling to provide this kind of service, but that Medicaid recipients are more likely to be able to arrange this due to their membership in state-run managed care organizations. Stakeholders noted that they would therefore expect Medicaid recipients to be more likely to receive an LRA than people with either private or no insurance. The comparisons below are between cases where the person had Medicaid, and cases in which the person either had private or no insurance. [30]

People who were Medicaid-eligible were more likely to have orders for LRAs for both 14-day and 90-day petitions, but many people who are not Medicaid-eligible still have orders for LRAs in their case. If a person had Medicaid at the time they were initially held, they were more likely to later have an LRA. When a person was Medicaid-eligible, 43 percent of cases had an LRA, as compared to 26 percent when the person was not Medicaid-eligible. It appears that while having Medicaid helps facilitate orders for LRAs, the absence of Medicaid does not entirely prevent this form of treatment. In fact, in 55 percent of cases in which the client had an LRA, the person did not have Medicaid at the time of their initial detention.

People who had Medicaid at the time they were initially detained were also less likely to have their cases dismissed compared to those without Medicaid, although the difference is not as large.

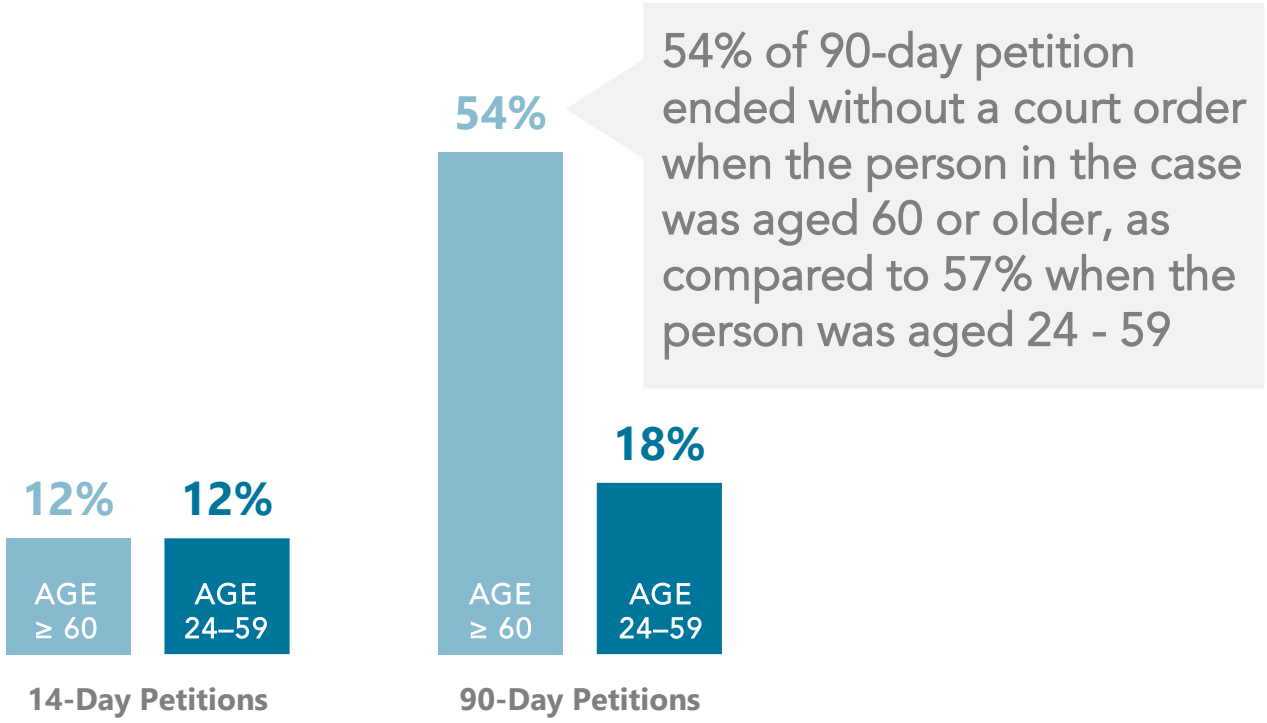
What other personal characteristics are strongly associated with orders for LRAs or other outcomes?

People who were 60 years or older were less likely to receive an LRA for both 14-day and 90-day petitions. Overall, four percent of 14-day petition orders, and 41 percent of 90-day petition orders were for LRAs for this group, compared to 13 percent and 63 percent for people 24 to 59 years old. People under the age of 18 were also less likely to receive an LRA order for 14-day petitions.

People who were 60 years or older were more likely to have 90-day petitions closed without a court order than people aged 24-59. Despite being statistically significant, differences were negligible for 14-day petitions. 54 percent of 90-day petitions involving a person 60 years or older were closed without a court order, however, as opposed to 18 percent for people aged 24 to 59 (see Exhibit N). This indicates that hospitals and/or the prosecuting attorney may be less likely to pursue cases in the long-term when the person is older.

[30] For data limitations relating to insurance coverage, see the data limitations section on page 28.

EXHIBIT N: 90-day petitions were more likely to be resolved without a court order when the person in the case was aged 60 or older (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and demographic data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

NOTABLE DATA LIMITATIONS

Available data does not distinguish between uninsured and privately insured people. While the data provided by DCHS indicates who is Medicaid-eligible, it does not indicate whether people who are not Medicaid-eligible have private insurance or no insurance. While stakeholders believed that it would be difficult to treat people through LRAs even when people have private insurance, we cannot fully confirm this in our analysis. While we can say that having Medicaid is associated with a higher likelihood of a person having an LRA, we cannot say whether this is relative to having private insurance or whether this is relative to having no insurance. We can only say that having Medicaid is associated with a higher likelihood of having an LRA relative to having either private insurance or no insurance (as a group).

Multiple stakeholders stated that finding that people who were not Medicaid-eligible were often treated through LRAs was counterintuitive to their experience. DCHS explained that the Medicaid information used in this analysis comes from the Washington State Health Care Authority however, and should accurately reflect individual's Medicaid eligibility status at the point of the referral to CCS.

NEXT STEPS

- Given that the data does not indicate whether a person has private insurance or no insurance, it is not possible to assess the impacts of these levels of insurance on court outcomes or a person's likelihood of returning to the ITA system. This also means that Medicaid comparisons can only be made to these two separate groups as one larger group. By including information on whether a person has private insurance or no insurance in their data, DCHS could better understand the impact of different insurance arrangements on the use of LRAs and outcomes.
- If LRAs are an appropriate form of treatment for more people than are currently receiving them, factors that limit treatment opportunities could lead to fewer people being treated through LRAs than is ideal. This could result in more restrictive limitations on some people's rights and may strain the limited supply of treatment beds. Efforts to increase the rate of Medicaid registration for people who are likely to engage with the ITA system could potentially increase the use of LRAs in cases, as would efforts that make LRAs easier to use when a person has either private insurance or no insurance. If the primary barrier to LRA use is a lack of connections with treatment providers, stakeholders may benefit from facilitating these connections more broadly.
- Stakeholders noted that the ITA system may not appropriately serve certain populations, such as people experiencing dementia. In these cases, the person is experiencing a decompensated state that is not possible to reverse; instead, the person's psychological decline may be permanent. While the data does not describe why petitions are not pursued to the point of a court order for older people, the fact that 90-day petitions involving people 60 years of age or older were much less likely to be pursued raises questions about the appropriateness of the ITA system in treating this population. Specifically, this lower likelihood of having their case pursued could reflect that, in many cases, hospitals do not believe that involuntary treatment is appropriate for people experiencing dementia, particularly in the long-term. Other types of interventions may be needed to serve the needs of people experiencing more permanent forms of decompensation. Given data limitations on relevant details, and the fact that a goal of the ITA system is to provide appropriate treatment, stakeholders may want to track the reasons cases are not pursued by hospitals to identify populations for which the ITA system may not be providing appropriate treatment.

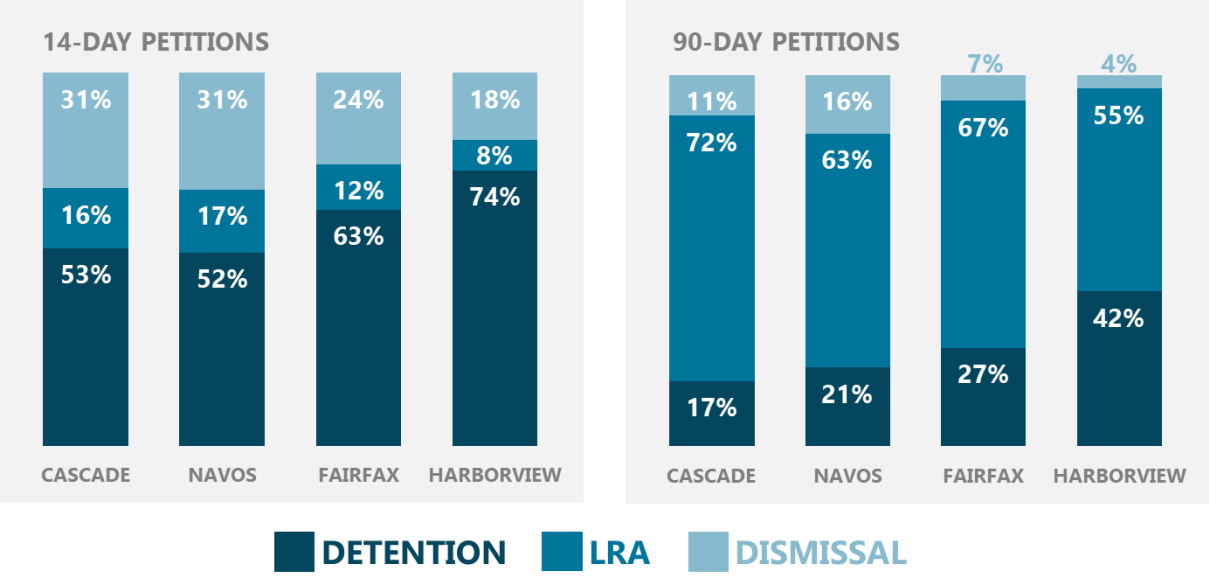
Hospital-Level Factors Associated with Court Outcomes

When a hospital treats a person in an ITA case, providing effective medical care is only one part of the hospital's responsibilities. Hospitals also play a major role in determining whether a petition should be filed for further treatment, and for building a case for involuntary treatment. Stakeholders raised concerns that some hospitals may advocate more effectively for medical treatment than others due how well they prepare for ITA court cases. While our analysis does not determine the underlying reason for differences across facilities, we address which facilities and facility types see different court outcomes independent of the influence of other variables (listed in Appendix 3).

Do people treated by the major ITA hospitals have different court outcomes?

Among the hospitals that serve the most ITA patients, people treated by Harborview were the most likely to be detained and the least likely have an LRA or case dismissal.[31] This statistically significant difference is consistent even when Harborview Maleng (which serves people with co-occurring serious medical concerns) is considered separately and when removing the influence of other factors in our analysis. Exhibit O, below, shows the percentage of petitions that ended in a dismissal, LRA, or detention, grouped by the charging hospital and petition type.

EXHIBIT O: People treated by Harborview were the most likely to be detained, and the least likely to receive an LRA among the hospitals that take most ITA cases (for cases from 2014 through 2018)



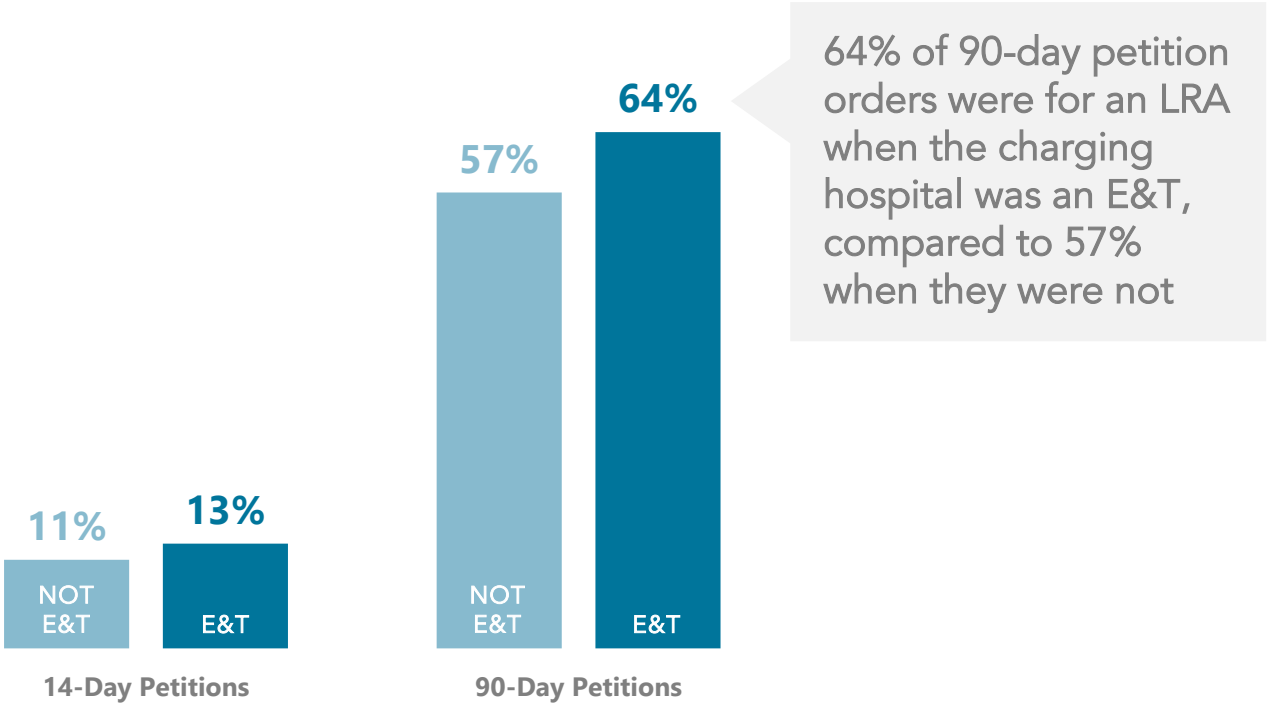
Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

[31] These comparisons focus on the hospitals that take the largest number of clients. Differences across hospitals that take fewer patients are unclear due to small sample sizes, and the impact of differences across larger hospitals are much larger in terms of total people affected.

Do people treated by certain types of facilities have different court outcomes?

People treated by E&Ts were more likely to receive LRAs than people treated by non-E&T hospitals.[32] E&Ts are facilities designed to serve people experiencing a mental health crisis. While there was only a two percent difference in how often people received LRAs for 14-day petitions, which is not statistically significant, the difference was larger and statistically significant for 90-day petitions. When the person was treated by an E&T, 64 percent of court orders for 90-day petitions were for LRAs, as compared to 57 percent when the hospital was not an E&T (see Exhibit P). We did not find, however, any statistically significant differences in the rate of dismissals between E&T and non-E&T hospitals.[33]

EXHIBIT P: People treated by Evaluation and Treatment Centers (E&Ts) were more likely to receive an order for an LRA than people treated by non-E&T hospitals (for cases from 2014 through 2018)



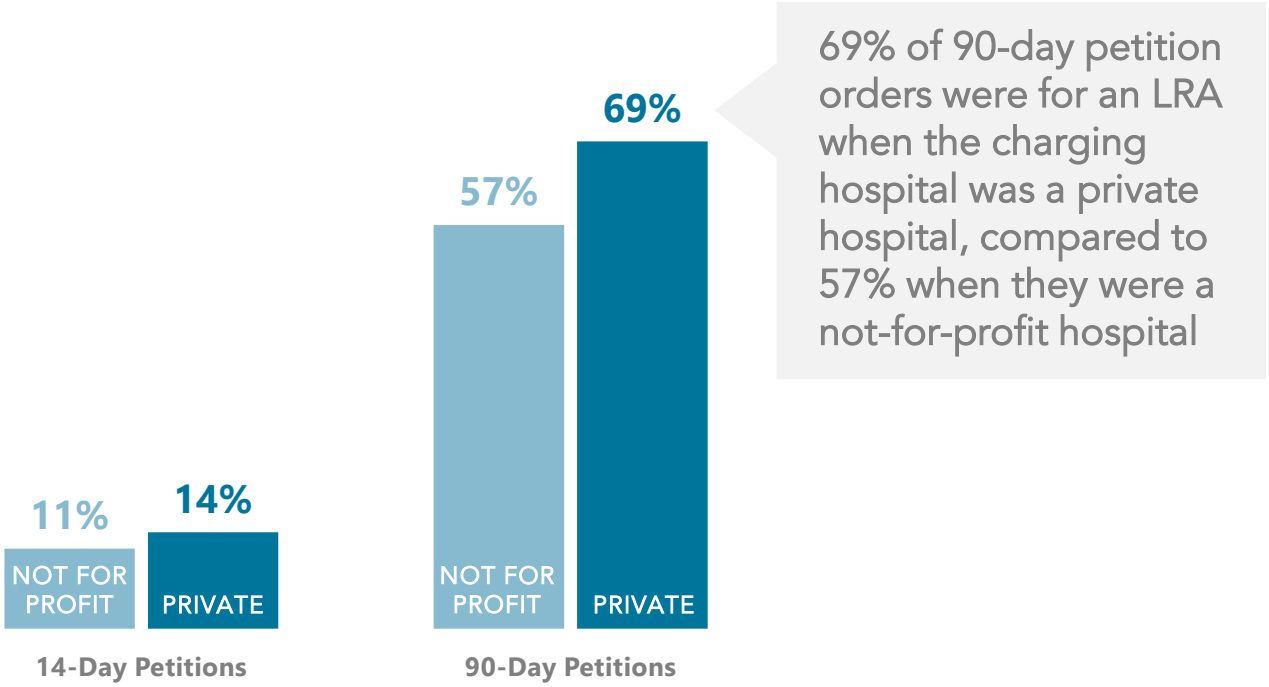
Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

People treated by private hospitals were more likely to receive LRAs than people treated by not-for-profit hospitals.[34] The difference was not statistically significant for 14-day petitions, but it was statistically significant for 90-day petitions. When the person was treated by a private hospital, 69 percent of 90-day petition court orders were for an LRA, as compared to 57 percent in not-for-profit

[32] Hospitals that serve specialized populations, such as Northwest Geropsychiatric Center, Seattle Children's Hospital, and the Veterans Affairs hospital were excluded from these groups for this analysis.
[33] For data limitations relating to hospital comparisons, see the data limitations section on page 33.
[34] Hospitals that serve specialized populations, such as Northwest Geropsychiatric Center, Seattle Children's Hospital, and the Veterans Affairs hospital were excluded from these groups for this analysis.

hospitals (see Exhibit Q). Private and not-for-profit hospitals did not have statistical differences in the rate of dismissals.

EXHIBIT Q: People treated by private hospitals were more likely to receive an LRA than people held in not-for-profit hospitals (for cases from 2014 through 2018)

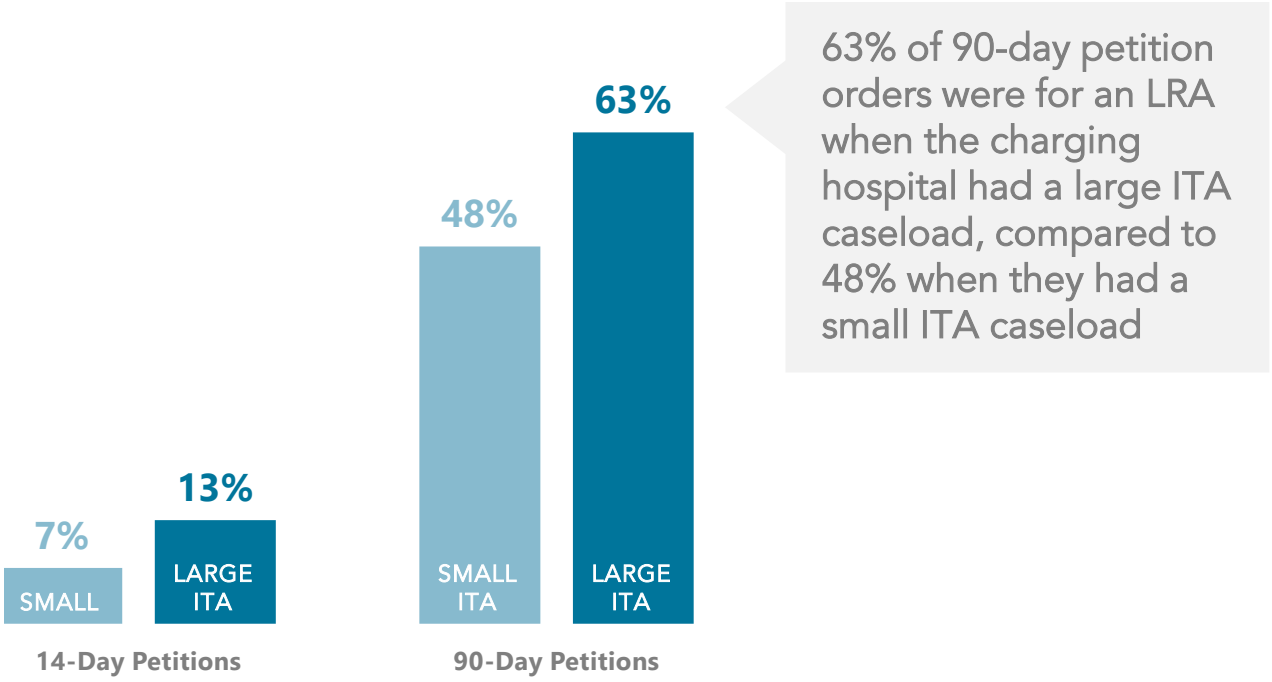


Source: King County Auditor's Office analysis of case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

People treated by hospitals with smaller ITA caseloads were less likely to receive LRAs, and somewhat less likely to have their cases dismissed than people whose petitions originated in the hospitals that took the majority of ITA cases. When the person was treated by a hospital with a small ITA caseload, seven percent of 14-day and 48 percent of 90-day petition orders were LRAs.[35] This compares to 13 percent and 63 percent for people treated in a hospital with large ITA caseloads (see Exhibit R).[36] People treated by hospitals with small ITA caseloads were somewhat less likely to have 14-day petition orders for dismissals, but more likely to have their petition closed without a court order for both 14-day and 90-day petitions. People who are released without a court order leave the hospital without a mandatory treatment plan.

[35] This group included all hospitals that each took fewer than five percent of ITA cases between 1/1/2014 and 10/31/2018, that did not specialize in serving a specific client population (i.e., Northwest Geropsychiatric Center, Seattle Children's Hospital, and the Veterans Affairs hospital were excluded from these groups).
[36] This group consisted of Navos Psychiatric Hospital, Harborview Medical Center, Fairfax Hospital, and Cascade Behavioral Health.

EXHIBIT R: People treated by hospitals that had more than 300 ITA cases were more likely to receive an LRA than people treated by hospitals that had fewer than 300 ITA cases (from 2014 through 2018)



Source: King County Auditor's Office analysis of Superior Court case data provided by DJA and DCHS and hospitalization data provided by DCHS, closed cases with file dates from 1/1/2014 to 10/31/2018

NOTABLE DATA LIMITATIONS

The reasons for the observed differences across hospitals are unclear. When discussing differences in outcomes across hospitals, it is difficult to determine how much these differences are driven by variations in populations served rather than the hospital's approach to the case. There are a variety of factors with no available data (such as indicators of case severity). As such, the best we can say is that there are some differences across hospitals in what case outcomes people in the ITA system are receiving when controlling for observable factors such as Medicaid eligibility, case history, or housing instability.

NEXT STEPS

Hospitals play a major role in influencing the court outcomes of people in the ITA system, both in determining the appropriate course of treatment, as well as for helping to build an effective case for treatment in court. Court outcomes could vary based on how effectively hospitals fulfill this role, or due to outside factors such as differences in the severity of mental health concerns of those who they serve. This analysis identifies statistically significant differences in court outcomes

by hospital but does not identify the source of these differences. Depending on priorities and preferred outcomes, stakeholders may want to further investigate the reasons for differences in court outcomes and whether any raise concerns or provide insight for system changes.

Court-Level Factors Associated with Court Outcomes

Multiple stakeholders we spoke with raised concerns about the use of continuances in ITA court cases. A continuance is the postponement of a hearing or other scheduled court proceeding. The prosecuting attorney and defense attorney can request case continuances to delay hearings and court orders. Either attorney may do this for a variety of reasons, including because they are not prepared to argue the case yet or because unique case circumstances make a delay necessary. Agreed case continuances may also be used strategically in some cases so that the person in the case has an opportunity to stabilize by the time of the next potential hearing. Stakeholders were concerned that excessive use of case continuances interrupt people's treatment and could result in premature case dismissals. Stakeholders noted that sometimes when a case is delayed, a person could stabilize enough to no longer appear to be a danger to themself or others, but not enough to be stabilized long-term. This would allow them to avoid involuntary treatment but could also contribute to later returns to the ITA system. To explore this concern, we evaluated whether differences in the use of case continuances were associated with different court outcomes.

To what extent do continuances impact people's court outcomes?

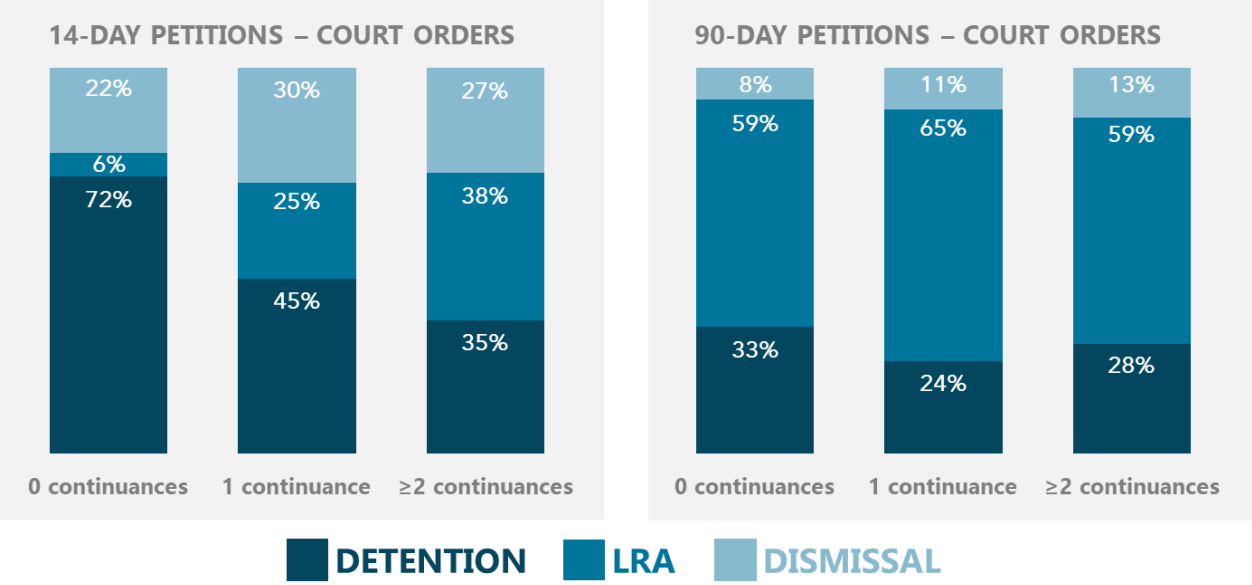
People whose attorneys successfully advocated for case continuances are significantly more likely to receive orders for LRAs and dismissal for 14-day petitions, but not for 90-day petitions. People who had one or more continuances before the conclusion of their 14-day petition were statistically more likely to receive an LRA rather than detention. Exhibit S, below, details the percentage of petitions that ended in dismissal, LRA, or detention, separated by how many continuances the case had between initial petition filing and that order.

Continuances are associated with far larger increases in LRA and dismissal rates for 14-day petitions than for 90-day petitions. This may be because the person can only be involuntarily

"My son was held and sent to Fairfax [hospital] in Kirkland. I was asked to testify to have him committed, which I agreed to without hesitation, since I knew his life was at stake. I was so impressed with the clerks and attorney in Seattle who contacted me to coordinate the court appearance. They called me periodically while the attorney assigned to my son continued to negotiate with him, asking him to agree to the commitment so that the court process of commitment would not have to occur…In the end, my son agreed to the commitment, was remanded under a less restrictive involuntary mental health treatment order for 90 days, and spent the next three weeks at Fairfax, where he finally got the counseling, psychiatric, and medication help he needed. Because he was held at Fairfax for that time, the medications he was required to take began to take effect, and for the first time in years he began to emerge from the darkness of his mental illness."

detained for 72 hours before the court determines the outcome of the 14-day petition, leaving little time to arrange LRAs. Lower rates of inpatient detention may also be driven by the fact that the person has more time to stabilize when there are case continuances. Prior to filing a 90-day petition, the hospital and attorneys already have about 11 days of the court-ordered detention to make arrangements for an LRA and for the person to stabilize because the person has already received an order for up to 14 days of detention (assuming they did not initially receive an order for an LRA).[37] This longer period of time may limit the relative impact of continuances. In the long run, people who had a final court order for an LRA were similarly likely to return to the ITA system compared to people whose final order was for involuntary inpatient treatment, but revocation petitions within the cases with LRAs are common.

EXHIBIT S: People whose cases were continued were more likely to receive orders for LRAs for 14-day petitions (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of Superior Court case data provided by DJA, closed cases with file dates from 1/1/2014 to 10/31/2018

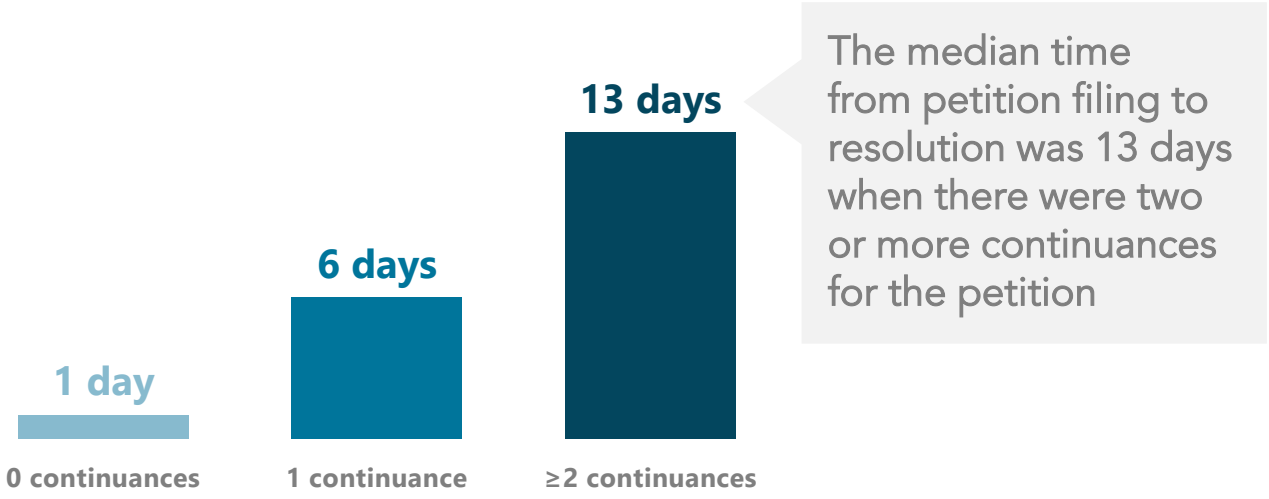
The more agreed continuances there are following a person's detention petition, the less likely it is that the hospital and prosecuting attorney will choose to pursue an order for involuntary treatment. Of 14-day petitions with two or more continuances, 35 percent were closed without a court order (meaning the person was released without a mandatory treatment commitment), compared to three percent of 14-day petitions with no continuances. While stakeholders raised concerns about some people returning to the ITA system when their cases were dropped early on, people whose cases ended without a court order returned to the ITA system at similar rates to people whose cases ended in involuntary treatment and detention.

Using case continuances may ultimately result in the person being involuntarily detained for less time. The time from when a petition is filed to the final petition outcome is longer when

[37] The 90-day petition must be filed with three days before the 14-day hold expires, which is why the hospital and attorneys have 11, rather than 14 days, to make these arrangements

there are case continuances. However, given that the use of continuances was associated with higher rates of LRA orders, continuances may lead to people spending less total time in a hospital. More than half of all 14-day petitions that had one continuance were resolved in six days or fewer, and more than half of petitions with two or more continuances were resolved in 13 days or fewer (see Exhibit T). In both scenarios, when a person received an LRA, rather than a 14-day detention, they usually spent less time in a hospital involuntarily than if they had initially been detained for 14 days with no case continuances.

EXHIBIT T: People whose petitions were continued one or more times and received an LRA usually spent less time in a hospital than they would have if they were detained for 14 days (for cases from 2014 through 2018)



Source: King County Auditor's Office analysis of Superior Court case data provided by DJA, closed cases with file dates from 1/1/2014 to 10/31/2018

NOTABLE DATA LIMITATIONS

The impact of continuances on outcomes may not be causal. We were able to determine that continuances are associated with the prosecuting attorney and hospital choosing not to seek a 14-day order for involuntary treatment, as well as with a higher likelihood that the person in the case will receive an LRA. Stakeholders indicated that this may be because the person in the case is willing to voluntarily remain in treatment at the time of the continuance. It is unclear the extent to which continuances are the cause of this association however, as we could not control for some variables. Multiple continuances can be the result of an agreement between the relevant parties, reflecting that the person in the case is willing to stay in treatment for the duration of the continuance. If this were true, these cases may consistently have different outcomes regardless of use of continuances. So, the extent to which continuances are a causal factor in the outcomes described above is unclear.

NEXT STEPS

- Involuntary detention can impact personal rights, such as the loss of the right to possess a firearm. Given that one of the primary goals of the Washington state ITA law is to safeguard personal rights, a strategy such as the use of case continuances that prevents detention when reasonable and lessens time involuntarily held may be in line with this objective, particularly if it does not result in differences in a person's likelihood of returning to the ITA system. Our analysis shows that early on in a case (during the 14-day petition period), continuances are associated with an increase in LRA use. They are also associated with case dismissals and decisions to not pursue involuntary treatment further. The reason for this higher rate of dismissals and lower rate of case pursuits could be due to the person stabilizing during this time and no longer needing treatment. If stakeholder concerns are correct however, it could be due to the hospital and/or prosecuting attorney choosing not to pursue cases because they no longer believe they can successfully argue the case. Stakeholders noted that this may occur when the person has stabilized enough to no longer meet the standards for involuntary detention and treatment, making it difficult to argue for treatment in court, but has not stabilized to a point where their recovery is sustainable. In these cases, it is possible that the hospital and prosecuting attorney may choose not to pursue the case, regardless of whether they believe treatment is still appropriate. By further investigating the reasons hospitals and attorneys request case continuances, stakeholders can better understand whether the continuances are the cause of the differences we found in this analysis.
- It is difficult to evaluate whether people are receiving adequate treatment, but people released from hospitals without a court order—and therefore without a mandatory treatment plan—did not return to the ITA system more frequently than those with an order for detention. This is true even when only looking at cases in which the person was released prior to a 14-day petition order, and in which multiple continuances were used. This suggests that the increase in the rate of release without a court order due to continuances may not be negative for personal health, but this should be interpreted with caution. To better understand whether this is truly the case, stakeholders would need to understand more about the hospital and prosecuting attorney's involuntary treatment decision process and under what circumstances the hospital and prosecuting attorney believe decisions not to pursue a case go against the person's interest.

Conclusion

The ITA system is highly complex, involving a wide range of functions and stakeholders, often with competing roles and priorities. The system does have several primary goals: to provide appropriate treatment to people experiencing mental health crises, to safeguard personal rights, and to protect public safety. The findings in this report are meant to assist ITA system actors in moving forward as they fulfill these goals. By better understanding what contributes to returns to the ITA system, stakeholders can work to create a system that addresses these contributing factors and works to avoid repeated cycling through the system. By understanding what contributes to court outcomes, stakeholders can ensure that people have access to the most appropriate treatment for their needs by removing barriers to their use. Given upcoming improvement efforts, we hope that ITA system actors use this and other information to effectively serve the vulnerable people who go through ITA Court and ensure that they continue to have their rights respected while receiving treatment.

Appendix 1: Variables Included in Logistic Regressions for Returns to the ITA System

PEOPLE'S CHARACTERISTICS

Prior ITA court cases

- 0 Prior Cases
- 1 Prior Case
- 2–3 Prior Cases
- >3 Prior Cases

Race

- American Indian/Alaska Native (AIAN)
- Asian
- Black
- Native Hawaiian/Pacific Islander (NHPI)
- White
- Multiracial
- Other

Race (overrepresented)

- Underrepresented racial group (white or Asian)
- Overrepresented racial group (AIAN, black, NHPI, multiracial)

Ethnicity - Hispanic

Age

- <18
- 18–23
- 24–59
- ≥60

Gender

- Female
- Male
- Nonbinary

Medicaid Eligibility (at intake)

Disability

Housing Instability

Non-English Speaker

HOSPITAL-LEVEL FACTORS

Primary Hospital – Specific Hospital

- Navos
- Fairfax
- Cascade
- Harborview – Psych Wards
- Harborview – Maleng
- NW Geropsychiatric Center
- NW – Other
- Swedish
- Multicare – E&T
- Multicare – Other
- Telecare
- Veteran's
- Children's
- Overlake
- Evergreen
- Valley
- University
- Highline
- Virginia Mason
- Other
- Multiple Hospitals more than 5 days
- None (fewer than 5 day stay)

Primary Hospital (E&T vs. Not E&T)

- Evaluation and treatment center (E&T)
- Not E&T
- Specialized
- Multiple hospitals more than 5 days
- No hospital more than 5 days

Primary Hospital (Private vs. Not-For-Profit)

- Not-for-profit
- Private
- Specialized
- Multiple hospitals more than 5 days
- No hospital more than 5 days

Primary Hospital (Large vs. Small ITA Caseload)

- Large Caseload
- Small Caseload
- Specialized
- Multiple Hospitals more than 5 days
- No hospital more than 5 days

CASE-LEVEL FACTORS

Case Filing Year

- 2014
- 2015
- 2016
- 2017
- 2018

Case Continuances

- 0 Continuances
- 1 Continuance
- 2–4 Continuances
- >4 Continuances

Final Court-Ordered Outcome

- Dismissal
- Detention
- LRA
- None

Monthly Case Filings

Appendix 2: Returns to the ITA System Logistic Regression Results – Odds Ratios

Introduction to Approach

To assess the impact of a wide variety of variables on people's likelihoods of returning to the ITA system, we conducted multiple sets of logistic regression analyses. We used this approach so that we could assess the impacts of multiple variables relative to this outcome, while controlling for each variable's individual impact on people's likelihoods of returning to the ITA system. If for instance, people who were experiencing housing instability were more likely to have subsequent ITA cases than people that were not experiencing housing instability, but this was only because they are more likely have prior case histories, this form of analysis would account for this. In this instance, housing instability would not be found to be statistically significantly associated with people's likelihoods of returning to the ITA system, because it was really the history of prior cases that was associated with these returns. By testing all these variables together, we account for the differing impacts of all the variables included in the model and can better understand the relative impact of each variable. For the purposes of our analysis, we considered an association to be statistically significant if it had a p-value of lower than or equal to.05.

We treated a person's return to the ITA system as a binary outcome (yes or no) across multiple regressions, which is why we used logistic (rather than standard) regressions. To understand whether variables were associated with people's likelihoods of returning to the ITA system at different times, we ran multiple regressions with the same independent variables (listed in Appendix 1) but in which the dependent variable (the outcome) was whether the person returned to the ITA system within a certain timeframe. The timeframes tested were returns within 30, 90, 180, 365, and 1,095 days of leaving an ITA hospital. For the purposes of this analysis, the person being involved in a new filed case after they had left the hospital for a previous case was counted as a return to the ITA system. Cases were only included in the regression if the person in the case had been out of an ITA hospital as long as the timeframe being assessed. For example, if a person had only been out of a hospital for 200 days, they would be included in the regression testing returns within 180 days, but not in the regression testing returns within 365 days.

For some of our regressions we considered the same variables categorized different ways (people who were held in an evaluation and treatment center [E&T] for instance, rather than a specific hospital). In these instances, we conducted separate logistic regressions in which the relevant variables were categorized differently to avoid overlap. For example, we conducted individual regressions in which hospitals were categorized by the specific hospital, by whether they were an E&T or not, whether they were a private or not-for-profit hospital, and whether they were the primary hospital in more than 300 ITA cases between January 1, 2014 and October 31, 2018 or not.

Interpretation of Odds Ratios

Due to the nature of logistic regression analysis, statistical associations in the tables below are presented as 95% confidence intervals of odds ratios. An odds ratio is a way of describing the relative chance of the dependent variable being true for the variable being assessed (which we will refer to as the comparison category) relative to the reference category.

Odds

Odds are the probability of the dependent variable being true, over the probability of the dependent variable not being true given some circumstance. For example, if 20 percent of people who were over the age of sixty returned to the ITA system within one year, the odds of them returning to the ITA system within one year would be 0.25 (0.2/0.8).

Odds Ratio

The odds ratio is the odds of the dependent variable being true for the comparison category, over the odds of the dependent variable being true for the reference category. For example, if the odds of a person who was Medicaid-eligible returning to the ITA system within 90 days were 0.4, and the odds of a person who was not Medicaid-eligible returning to the ITA system within 90 days were 0.2, then the odds ratio for Medicaid-eligible person relative to non-Medicaid-eligible person would be 2 (0.4/0.2). This can be interpreted as "the odds that a person who is Medicaid-eligible will return to the ITA system within 90 days of leaving a hospital are two times as high as the odds that a person who is not Medicaid-eligible will return to the ITA system within 90 days of leaving a hospital". When there are multiple comparison categories (such as in the case of race or primary hospital), the odds ratio for each comparison category is relative to the odds for the reference category (listed above the table). While similar, it is important to note that odds are different from probability. Having an odds ratio of 1.5, does not mean that an outcome is 1.5 times more likely for the comparison category than for the reference category.

A Note on Results Display

To make the associations identified in our regression analysis easier to interpret, the results are color coded. Results coded in red or pink indicate that the comparison category is statistically significantly associated with a higher rate of reentry into the ITA system within the time period being referenced compared to the reference category. The results are:

- **highlighted in red if the lower bound of the confidence interval is 1.5 or above**
- **highlighted in pink if the lower bound of the confidence interval is between 1.0 and 1.5.**

Results coded in green or light green indicate that the comparison category is statistically significantly associated with a lower rate of reentry into the ITA system within the time period being referenced compared to the reference category. The results are:

- **highlighted in green if the upper bound of the confidence interval is 0.75 or below**
- **highlighted in light green if the upper bound of the confidence interval is between 0.75 and 1.0**

Exhibit 1: People's Characteristics—Race (Specific)

Reference Category: White															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
American Indian/ Alaska Native	0.78	1.77	0.43	1.14	2.15	0.01	1.23	2.16	0.00	1.01	1.81	0.04	0.87	2.26	0.17
Asian	0.72	1.20	0.58	0.76	1.16	0.56	0.80	1.16	0.73	0.94	1.32	0.23	0.90	1.45	0.28
Black	0.87	1.23	0.69	0.98	1.30	0.09	1.01	1.29	0.03	1.01	1.28	0.03	1.11	1.56	0.00
Native Hawaiian/ Pacific Islander	0.89	2.37	0.14	0.84	1.98	0.24	1.05	2.19	0.03	1.08	2.32	0.02	1.06	3.39	0.03
Multiracial	0.98	1.50	0.07	1.16	1.64	0.00	1.24	1.67	0.00	1.23	1.66	0.00	1.51	2.42	0.00
Other	0.83	1.58	0.41	0.81	1.40	0.66	0.87	1.42	0.38	0.96	1.53	0.11	0.84	1.64	0.35

Exhibit 2: People's Characteristics—Race (Overrepresented vs. Not Overrepresented)

Reference Category: Not Overrepresented															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Race - Overrepresented	0.98	1.29	0.08	1.12	1.40	0.00	1.16	1.41	0.00	1.13	1.36	0.00	1.28	1.69	0.00

Exhibit 3: People's Characteristics—Hispanic Ethnicity

Reference Category: Not Hispanic															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Hispanic	0.82	1.31	0.75	0.87	1.27	0.61	0.91	1.28	0.36	0.83	1.15	0.78	0.76	1.22	0.76

Exhibit 4: People's Characteristics—English Fluency

Reference Category: English Speaker															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Non-English Speaker	1.11	1.84	0.87	1.02	1.57	0.03	0.84	1.25	0.79	0.79	1.15	0.63	0.60	1.04	0.09

Exhibit 5: People's Characteristics—Medicaid Eligibility

Reference Category: Not Medicaid-Eligible at Intake															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Medicaid-eligible at Intake	0.95	1.24	0.25	0.98	1.22	0.10	0.99	1.19	0.09	1.02	1.23	0.02	0.97	1.30	0.11

Exhibit 6: People's Characteristics—Housing Instability

Reference Category: Not Experiencing Housing Instability at Intake															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Experiencing Housing Instability at Intake	1.10	1.45	0.00	1.15	1.43	0.00	1.15	1.40	0.00	1.10	1.33	0.00	1.17	1.56	0.00

Exhibit 7: People's Characteristics—Disability

Reference Category: Do Not Have a Disability															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Have a Disability	0.74	1.04	0.12	0.89	1.17	0.77	0.96	1.21	0.20	0.88	1.10	0.78	0.67	0.94	0.01

Exhibit 8: People's Characteristics—Gender

Reference Category: Male															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Female	0.90	1.15	0.82	0.91	1.11	0.90	0.89	1.07	0.59	0.92	1.08	0.93	0.87	1.10	0.73
Nonbinary	0.61	1.93	0.77	1.10	2.60	0.02	0.97	2.16	0.07	0.92	2.12	0.12	1.46	6.19	0.00

Exhibit 9: People's Characteristics—Age

Reference Category: 24-59 Years Old															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
<18 Years Old	0.79	2.16	0.30	0.73	1.70	0.63	0.59	1.32	0.55	0.64	1.32	0.64	0.43	1.13	0.15
18–23 Years Old	1.23	1.73	0.00	1.04	1.40	0.01	0.93	1.21	0.40	0.89	1.15	0.85	0.89	1.27	0.49
≥60 Years Old	0.94	1.40	0.17	0.85	1.18	0.97	0.84	1.12	0.67	0.69	0.92	0.00	0.69	1.02	0.09

Exhibit 10: People's Characteristics—Previous Cases

Reference Category: 0 Previous Cases															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
1 Previous Case	1.51	2.12	0.00	1.55	2.07	0.00	1.53	1.97	0.00	1.58	2.00	0.00	1.74	2.36	0.00
2–3 Previous Cases	1.48	2.15	0.00	1.87	2.52	0.00	2.03	2.62	0.00	2.35	2.99	0.00	2.32	3.22	0.00
>3 Previous Cases	2.86	4.00	0.00	3.68	4.85	0.00	4.00	5.09	0.00	4.33	5.47	0.00	5.72	8.29	0.00

Exhibit 11: Hospital Variable—Primary Hospital (Specific)

Reference Category: Harborview Psych Wards

	30 Day Returns			90-day Returns			180 Day Returns			365 Day Returns			3 Year Returns		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Fairfax	0.73	1.30	0.87	0.88	1.40	0.38	0.90	1.34	0.35	0.86	1.24	0.72	0.89	1.41	0.33
Cascade	0.85	1.59	0.36	0.99	1.66	0.06	0.92	1.43	0.22	0.88	1.34	0.44	0.71	1.69	0.68
Navos	0.67	1.20	0.46	0.80	1.28	0.91	0.81	1.19	0.89	0.86	1.22	0.80	0.87	1.38	0.42
Harborview – Maleng	1.14	2.22	0.01	1.16	2.01	0.00	1.07	1.72	0.01	1.12	1.77	0.00	1.13	2.14	0.01
Northwest – Geropsychiatric Center	0.59	1.37	0.61	0.65	1.32	0.68	0.62	1.15	0.28	0.66	1.18	0.39	0.69	1.41	0.96
Northwest – Other	0.21	2.35	0.57	0.26	1.85	0.47	0.36	1.79	0.59	0.43	2.02	0.86	0.71	5.17	0.20
Swedish	0.51	1.70	0.81	0.51	1.44	0.57	0.69	1.61	0.81	0.60	1.50	0.83	*Omitted – No Cases*		
Multicare – E&T	1.29	3.05	0.00	1.27	2.70	0.00	1.29	2.58	0.00	1.19	2.45	0.00	*Omitted – No Cases*		
Multicare – Other	0.70	3.43	0.28	0.66	2.86	0.39	0.74	2.78	0.29	0.80	3.08	0.19	0.33	5.27	0.70
Telecare	0.38	1.97	0.72	0.50	2.11	0.94	0.35	1.66	0.50	*Omitted – No Cases*			*Omitted – No Cases*		
Veterans	0.29	1.87	0.51	0.54	2.06	0.88	0.82	2.22	0.24	0.64	1.79	0.79	0.66	2.26	0.53
Seattle Children's	0.02	1.34	0.09	0.22	1.65	0.33	0.17	1.20	0.11	0.46	1.78	0.77	0.55	2.80	0.60
Overlake	0.65	3.16	0.37	0.75	2.87	0.26	0.45	1.75	0.72	0.67	2.39	0.47	0.45	2.73	0.83
Evergreen	0.51	2.99	0.65	0.67	2.87	0.38	0.68	2.53	0.41	0.70	2.66	0.36	0.36	3.69	0.80
Valley	0.90	4.44	0.09	0.93	3.80	0.08	0.64	2.59	0.48	0.56	2.51	0.66	0.33	2.66	0.91
University	0.04	2.05	0.21	0.02	1.26	0.08	0.05	0.91	0.04	0.23	1.65	0.33	0.87	5.17	0.10
Highline	0.38	3.32	0.83	0.68	3.53	0.29	0.60	2.68	0.53	0.58	2.54	0.61	0.57	3.67	0.44
Virginia Mason	0.14	2.61	0.50	0.37	2.79	0.97	0.46	2.72	0.81	0.49	2.85	0.71	0.53	7.75	0.30
Other	0.27	2.28	0.65	0.37	2.11	0.78	0.36	1.75	0.57	0.48	2.18	0.96	0.01	1.16	0.07
Multiple Hospitals	0.54	1.05	0.09	0.78	1.30	0.96	0.82	1.24	0.93	0.95	1.39	0.16	0.79	1.33	0.86
No Hospital >5 days	0.85	1.51	0.39	0.95	1.52	0.12	0.90	1.34	0.36	0.91	1.33	0.30	0.83	1.37	0.61

Exhibit 12: Hospital-Level Variable—Primary Hospital (E&T vs. Not E&T)

Reference Category: Evaluation and Treatment Centers															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Not E&T	1.11	1.69	0.00	1.08	1.53	0.01	0.99	1.35	0.07	1.11	1.51	0.00	1.10	1.73	0.01
Specialized Hospitals	0.57	1.14	0.22	0.64	1.12	0.25	0.66	1.07	0.17	0.71	1.11	0.30	0.74	1.29	0.90
Multiple Hospitals	0.58	0.95	0.02	0.76	1.10	0.35	0.82	1.10	0.52	0.97	1.26	0.15	0.77	1.15	0.58
No Hospital > 5 days	0.95	1.35	0.18	0.95	1.27	0.21	0.91	1.18	0.63	0.93	1.21	0.36	0.82	1.19	0.91

Exhibit 13: Hospital-Level Variable—Primary Hospital (Not-For-Profit vs. Private)

Reference Category: Not-For-Profit Hospitals (Government or Nonprofit Run)															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Private Hospital	0.82	1.13	0.64	0.91	1.19	0.56	0.93	1.16	0.53	0.86	1.07	0.44	0.84	1.15	0.82
Specialized Hospitals	0.52	1.03	0.08	0.61	1.07	0.13	0.65	1.05	0.12	0.66	1.03	0.09	0.70	1.21	0.55
Multiple Hospitals	0.54	0.89	0.00	0.74	1.08	0.24	0.81	1.10	0.48	0.91	1.21	0.49	0.74	1.11	0.34
No Hospital > 5 days	0.88	1.27	0.56	0.92	1.25	0.38	0.89	1.18	0.73	0.88	1.15	0.95	0.78	1.13	0.52

Exhibit 14: Hospital-Level Variable—Primary Hospital (Large vs. Small ITA Caseload)

Reference Category: Hospitals with Large ITA Caseloads															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Small Caseload Hospital	0.95	1.47	0.13	0.97	1.40	0.10	0.98	1.37	0.08	1.02	1.44	0.03	0.91	1.66	0.18
Specialized Hospitals	0.54	1.06	0.10	0.61	1.06	0.13	0.64	1.04	0.10	0.67	1.05	0.12	0.70	1.20	0.52
Multiple Hospitals	0.56	0.92	0.01	0.75	1.08	0.24	0.82	1.10	0.47	0.95	1.24	0.24	0.75	1.12	0.41
No Hospital > 5 days	0.92	1.31	0.29	0.93	1.25	0.30	0.90	1.18	0.63	0.92	1.19	0.49	0.80	1.15	0.66

Exhibit 15: Court-Level Variable—Final Court Order

Reference Category: Detention															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Dismissal	1.59	2.24	0.00	1.53	2.03	0.00	1.57	2.03	0.00	1.42	1.84	0.00	1.30	1.88	0.00
LRA	0.18	0.29	0.00	0.23	0.31	0.00	0.52	0.67	0.00	0.68	0.86	0.00	0.91	1.25	0.44
Hospital Release before 14-day Petition Conclusion	0.89	1.35	0.37	0.94	1.32	0.21	0.86	1.18	0.91	0.80	1.09	0.40	0.76	1.18	0.62

Exhibit 16: Court-Level Variable—Case Continuances

Reference Category: 0 Case Continuances in Case															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
1 Continuance	0.68	0.97	0.02	0.70	0.93	0.00	0.73	0.94	0.00	0.77	0.97	0.01	0.78	1.09	0.33
2–4 Continuances	0.71	1.03	0.10	0.71	0.97	0.02	0.77	1.00	0.05	0.86	1.10	0.68	0.91	1.28	0.39
≥5 Continuances	0.46	0.85	0.00	0.43	0.71	0.00	0.62	0.90	0.00	0.73	1.03	0.11	0.82	1.43	0.58

Exhibit 17: Court-Level Variable—Case Filings per Month

Reference Category: N/A – Continuous Variable															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Case Filings	1.00	1.00	0.82	1.00	1.00	0.64	1.00	1.00	0.60	1.00	1.00	0.15	1.00	1.00	0.39

Exhibit 18: Court-Level Variable—Filing Year of Case

Reference Category: 2014															
	30 Day Returns			**90-day Returns**			**180 Day Returns**			**365 Day Returns**			**3 Year Returns**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
2015	0.69	1.02	0.08	0.80	1.09	0.40	0.82	1.07	0.33	0.86	1.08	0.53	0.86	1.09	0.60
2016	0.74	1.09	0.28	0.78	1.08	0.30	0.77	1.02	0.09	0.83	1.06	0.28	*Omitted – No Cases*		
2017	0.86	1.36	0.52	0.99	1.45	0.06	0.96	1.34	0.13	0.96	1.31	0.16	*Omitted – No Cases*		
2018	0.61	1.07	0.13	0.64	1.02	0.07	0.84	1.28	0.75	*Omitted – No Cases*			*Omitted – No Cases*		

Appendix 3: Variables Included in Outcome Regressions

Client-level Factors

Prior ITA court cases

- 0 Prior Cases
- 1 Prior Case
- 2–3 Prior Cases
- >3 Prior Cases

Race

- American Indian/Alaska Native (AIAN)
- Asian
- Black
- Native Hawaiian/Pacific Islander (NHPI)
- White
- Multiracial
- Other

Race (overrepresented)

- Underrepresented racial group (white or Asian)
- Overrepresented racial group (AIAN, black, NHPI, multiracial)

Ethnicity - Hispanic

Age

- <18
- 18–23
- 24–59
- ≥60

Gender

- Female
- Male
- Nonbinary

Medicaid Eligibility (at intake)

Disability

Housing Instability

Non-English Speaker

Hospital-Level Factors

Charging Hospital – Specific Hospital

- Contract Group (Multicare, Telecare)
- Navos
- Cascade
- Fairfax
- Harborview – Psych Wards
- Harborview – Maleng
- NW Geropsychiatric Center
- Swedish
- Seattle Children's
- Evergreen
- Franciscan Health
- Overlake
- Veterans
- University
- Valley
- Virginia Mason

Charging Hospital (E&T vs. Not-E&T)

- Evaluation and treatment center (E&T)
- Not E&T
- Specialized Hospital

Charging Hospital (Not-For-Profit vs. Private)

- Not-for-profit Hospital
- Private Hospital
- Specialized Hospital

Charging Hospital (Large vs. Small Case Load)

- Large Caseload Hospital
- Small Caseload Hospital
- Specialized Hospital

Case-Level Factors

Case Filing Year

- 2014
- 2015
- 2016
- 2017
- 2018

Phase Continuances

- 0 Continuances
- 1 Continuance
- ≥2 Continuances

Filings per Month

Other

Referral Source (General)

- Emergency Room
- Court
- Community Mental Health Center
- Voluntary
- Jail
- Family
- Inpatient
- Other

Referral Source (Hospital)

- Harborview ER
- Harborview - Other
- Highline
- Northwest – ER
- Northwest – Other
- Valley
- Evergreen
- Multicare – Auburn
- Swedish – First Hill
- Swedish – Cherry
- Swedish – Ballard
- Swedish Issaquah
- Overlake
- University
- St. Francis
- Virginia Mason
- Fairfax
- Veterans
- Seattle Children's
- Other
- Not Hospital or Unknown

Appendix 4: Outcome Logistic Regression Results – Odds Ratios

Introduction to Approach

To assess the impact of a wide variety of variables on the likelihood of different court outcomes, we conducted multiple sets of logistic regression analyses. We used this approach so that we could assess the impacts of multiple variables relative to the outcome being assessed, while controlling for each variable's impact on that outcome's likelihood. For instance, if people who were experiencing housing instability were less likely to have their case dismissed than people that were not experiencing housing instability, but this was only because they are more likely have prior case histories, this form of analysis would account for this. In this instance, housing instability would not be found to be statistically significantly associated with dismissal orders, because it was really the history of prior cases that was associated with dismissal orders. By testing all these variables together, we account for the differing impacts of all variables included in the model and can better understand the relative impact of each variable. For the purposes of our analysis, we considered an association to be statistically significant if it had a p-value of lower than or equal to 0.05. Unlike the analysis discussed in Appendix 2, this analysis was at the petition level, rather than case level. Multiple petitions from one case could therefore be included in the analysis.

We treat outcomes as binary (yes or no) across multiple regressions, which is why we used logistic (rather than standard) regressions. To understand whether variables contribute to different outcomes, we ran multiple regressions with the same independent variables (listed in Appendix 3) but in which the dependent variable (the outcome) was either that the case petition ended in an LRA or ended in a dismissal. We tested these outcomes separately for 14-day and 90-day petitions. For the purposes of this analysis, LRAs as an outcome were only tested if the petition ended in treatment (testing whether an LRA was likely to occur instead of an alternative form of detention), while dismissal rates were tested for all petitions that had a court-ordered outcome (testing whether a dismissal was likely occur instead of any form of mandatory treatment).

For some of our regressions we considered the same independent variables categorized in different ways (petitions in which the charging hospital was an evaluation and treatment center [E&T] for instance, rather than a specific hospital). In these instances, we conducted individual logistic regressions in which the relevant variables were categorized differently to avoid overlap. For example, we conducted separate regressions in which hospitals were categorized by the specific hospital, by whether they were an E&T or not, whether they were a private or not-for-profit hospital, and whether they were the primary hospital in more than 300 ITA cases between January 1, 2014 and October 31, 2018 or not.

Interpretation of Odds Ratios

Due to the nature of logistic regression analysis, statistical associations in the tables below are presented as 95% confidence intervals of odds ratios. An odds ratio is a way of describing the relative chance of the dependent variable being true for the variable being assessed (which I will refer to as the comparison category) relative to the reference category.

Odds

Odds are the probability of the dependent variable being true, over the probability of the dependent variable not being true given some circumstance. For example, if 20 percent of petitions involving people who were over the age of sixty ended in dismissals, the odds of them having a dismissal relative to some other court-ordered outcome would be 0.25 (0.2/0.8).

Odds Ratio

The odds ratio is the odds of the dependent variable being true for the comparison category, over the odds of the dependent variable being true for the reference category. For example, if the odds of petition involving a person who was Medicaid-eligible ending in a dismissal were 0.4, and the odds of a petition involving a person who was not Medicaid-eligible ending in a dismissal were 0.2, then the odds ratio for Medicaid-eligible people relative to non-Medicaid-eligible people would be 2 (0.4/0.2). This can be interpreted as "the odds that petition involving a person who is Medicaid-eligible will end in a dismissal rather than a different court-ordered outcome are two times as high as the odds that a petition involving a person who is not Medicaid-eligible will end in a dismissal rather than a different court-ordered outcome". When there are multiple comparison categories (such as in the case of race or primary hospital), the odds ratio for each comparison category is relative to the odds for the reference category (listed above the table). While similar, it is important to note that odds are different from probability. Having an odds ratio of 1.5, does not mean that an outcome is 1.5 times more likely for the comparison category than for the reference category.

A Note on Results Display

To make the associations identified in our regression analysis easier to interpret, the results are color coded.

Results coded in red or pink indicate that the comparison category is statistically significantly associated with a higher likelihood of the outcome being referenced occurring compared to the reference category. The result is:

- **highlighted in red if the lower bound of the confidence interval is 1.5 or above**
- **highlighted in pink if the lower bound of the confidence interval is between 1.0 and 1.5.**

Results coded in green or light green indicate that the comparison category is statistically significantly associated with a lower likelihood of the outcome being referenced occurring compared to the reference category. The result is:

- **highlighted in green if the upper bound of the confidence interval is 0.75 or below**
- **highlighted in light green if the upper bound of the confidence interval is between 0.75 and 1.0.**

Exhibit 1: People's Characteristics—Race (Specific)

Reference Category: White																	
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
American Indian /Alaska Native	0.50	1.32	0.41	1.01	2.77	0.05	0.62	1.16	0.31	1.12	3.70	0.02	1.08	2.87	0.02	0.74	1.86	0.50
Asian	0.86	1.45	0.42	1.16	2.20	0.00	1.00	1.40	0.05	0.69	1.59	0.82	0.83	1.29	0.75	0.78	1.37	0.82
Black	1.08	1.53	0.00	0.93	1.38	0.21	1.00	1.27	0.05	0.91	1.61	0.20	1.04	1.47	0.02	0.91	1.35	0.29
Native Hawaiian /Pacific Islander	0.75	2.21	0.36	0.51	1.83	0.91	0.82	1.78	0.34	0.26	2.18	0.60	0.87	3.32	0.12	0.84	3.74	0.14
Multiracial	1.26	1.90	0.00	0.85	1.44	0.46	0.82	1.14	0.69	0.50	1.16	0.20	0.91	1.40	0.27	0.99	1.75	0.06
Other	0.74	1.48	0.80	0.85	1.94	0.24	0.84	1.35	0.59	0.50	1.59	0.70	0.85	1.55	0.38	0.71	1.52	0.86

Exhibit 2: People's Characteristics—Race (Overrepresented vs. Not Overrepresented)

Reference Category: Not Overrepresented																	
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Race – Overrepresented	1.13	1.48	0.00	0.91	1.26	0.40	0.93	1.13	0.57	0.88	1.40	0.37	1.08	1.42	0.00	1.01	1.38	0.04

Exhibit 3: People's Characteristics—Hispanic Ethnicity

Reference Category: Not Hispanic																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Hispanic	0.90	1.46	0.26	0.58	1.04	0.09	0.86	1.20	0.86	0.97	2.13	0.07	0.86	1.35	0.51	0.73	1.26	0.77

Exhibit 4: People's Characteristics—Medicaid Eligibility

Reference Category: Not Medicaid-Eligible at Intake																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Medicaid-eligible at Intake	1.40	1.82	0.00	1.30	1.77	0.00	0.76	0.92	0.00	0.55	0.88	0.00	1.01	1.31	0.03	1.23	1.68	0.00

Exhibit 5: People's Characteristics—Housing Instability

Reference Category: Not Experiencing Housing Instability at Initial Intake																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Experiencing Housing Instability at Intake	0.75	0.99	0.04	0.71	0.98	0.03	0.80	0.99	0.03	0.69	1.13	0.33	1.06	1.42	0.01	0.81	1.12	0.55

Exhibit 6: People's Characteristics—Disability

Reference Category: Do Not Have a Disability																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Have a Disability	0.82	1.13	0.64	0.68	0.96	0.02	0.59	0.76	0.00	0.44	0.82	0.00	0.79	1.10	0.39	0.92	1.30	0.34

Exhibit 7: People's Characteristics—English Fluency

Reference Category: English Speaker																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Non-English Speaker	0.62	1.08	0.15	0.62	1.19	0.36	0.66	0.98	0.03	0.73	1.80	0.54	0.96	1.54	0.11	1.04	1.97	0.03

Exhibit 8: People's Characteristics—Gender

Reference Category: Male																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
Female	0.78	1.01	0.08	0.83	1.12	0.62	1.11	1.32	0.00	1.19	1.81	0.00	1.02	1.28	0.02	0.71	0.92	0.00
Nonbinary	0.72	2.56	0.34	0.28	1.31	0.20	0.58	1.59	0.87	0.06	3.43	0.44	0.23	0.64	0.00	0.21	0.79	0.01

Exhibit 9: People's Characteristics—Age

Reference Category: 24–59 Years Old																	
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
<18 Years Old	0.26	0.85	0.01	0.02	6.36	0.48	0.48	1.05	0.09	*Omitted – No Petition*			0.69	1.53	0.89	0.19	41.26	0.45
18–23 Years Old	0.70	1.02	0.08	0.98	1.59	0.07	0.98	1.25	0.10	0.65	1.29	0.62	0.81	1.11	0.48	0.64	0.98	0.03
≥60 Years Old	0.34	0.57	0.00	0.47	0.75	0.00	0.58	0.79	0.00	1.00	1.93	0.05	1.19	1.73	0.00	0.58	0.87	0.00

Exhibit 10: People's Characteristics—Prior Cases

Reference Category: 0 Prior Cases																		
	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						**CASE DISMISSAL (VS. DETENTION OR LRA)**						**COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)**					
	14-DAY PETITIONS			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**			**14-DAY PETITIONS**			**90-DAY PETITIONS**		
	95% C.I.		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**	**95% C.I.**		**P >|Z|**
1 Prior Case	0.82	1.18	0.85	0.87	1.34	0.48	0.67	0.85	0.00	0.65	1.20	0.44	1.31	1.76	0.00	1.10	1.58	0.00
2–3 Prior Cases	0.93	1.34	0.23	0.78	1.18	0.67	0.57	0.73	0.00	0.75	1.37	0.95	2.06	2.98	0.00	1.27	1.85	0.00
>3 Prior Cases	0.85	1.19	0.97	0.91	1.34	0.33	0.40	0.52	0.00	0.64	1.14	0.29	2.97	4.47	0.00	1.62	2.37	0.00

Exhibit 11: Hospital-Level Variable—Charging Hospital (Specific)

Reference Category: Harborview – Psychology Wards

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Contract Group	0.97	2.08	0.07	0.86	1.87	0.22	0.94	1.65	0.13	1.94	7.41	0.00	1.08	1.94	0.01	0.48	0.99	0.04
Cascade	1.87	3.25	0.00	2.43	4.14	0.00	1.90	2.76	0.00	2.18	5.77	0.00	1.93	3.10	0.00	0.90	1.52	0.25
Fairfax	1.23	2.08	0.00	1.35	2.18	0.00	1.26	1.79	0.00	1.36	3.70	0.00	1.21	1.83	0.00	0.53	0.84	0.00
Navos	2.21	3.63	0.00	1.50	2.31	0.00	1.98	2.78	0.00	3.42	8.20	0.00	1.08	1.79	0.01	0.80	1.40	0.69
Harborview Maleng	0.88	1.61	0.25	0.69	1.15	0.36	1.09	1.64	0.01	0.65	2.22	0.57	1.68	2.56	0.00	0.99	1.56	0.06
Northwest Geropsychiatric Center	0.43	1.17	0.19	0.33	0.77	0.00	0.50	0.90	0.01	0.86	3.67	0.12	0.71	1.29	0.75	0.09	0.16	0.00
Swedish	0.70	1.74	0.68	0.49	1.39	0.47	1.23	2.15	0.00	0.82	6.27	0.12	0.70	1.31	0.79	0.42	1.14	0.15
Seattle Children's	0.24	2.07	0.53	0.06	4.29	0.55	0.01	0.44	0.01	*Omitted – No Petition*			0.63	2.19	0.61	0.10	2.33	0.36
Evergreen	0.08	0.90	0.03	0.04	0.92	0.04	0.82	1.97	0.28	*Omitted – No Petition*			1.84	6.62	0.00	0.22	1.43	0.22
Franciscan Health	0.34	1.07	0.08	0.27	2.19	0.63	1.01	1.93	0.04	1.62	23.72	0.01	1.52	3.73	0.00	0.19	0.87	0.02
Overlake	0.27	1.25	0.16	0.01	0.81	0.03	0.88	1.84	0.21	1.53	43.41	0.01	0.65	1.54	1.00	0.10	0.56	0.00
Veteran's	1.47	5.19	0.00	1.01	4.29	0.05	0.23	0.90	0.02	0.27	5.53	0.79	0.64	1.94	0.69	0.57	2.13	0.78
University	0.63	2.87	0.44	0.79	18.95	0.10	0.63	1.92	0.74	1.39	21.17	0.02	0.70	2.09	0.50	0.35	2.87	0.99
Valley	0.27	1.13	0.10	0.02	1.64	0.12	1.08	2.25	0.02	1.87	67.93	0.01	0.75	1.74	0.54	0.08	0.62	0.00
Virginia Mason	0.20	1.38	0.19	0.14	1.94	0.34	0.36	1.33	0.27	*Omitted – No Petition*			0.42	1.29	0.29	0.29	3.15	0.93

Exhibit 12: Hospital-Level Variable—Charging Hospital (E&T vs. Not-E&T)

Reference Category: Evaluation and Treatment Centers

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Not-E&T	0.79	1.03	0.11	0.65	0.89	0.00	0.93	1.11	0.67	0.96	1.50	0.11	0.97	1.24	0.15	0.92	1.25	0.40
Specialized Hospitals	0.45	0.91	0.01	0.34	0.69	0.00	0.30	0.48	0.00	0.38	1.22	0.20	0.57	0.90	0.00	0.14	0.22	0.00

Exhibit 13: Hospital-Level Variable—Charging Hospital (Not-For-Profit vs. Private)

Reference Category: Not-For-Profit Hospitals (Government or Nonprofit Run)

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Private Hospital	1.00	1.30	0.05	1.57	2.16	0.00	0.98	1.18	0.11	0.67	1.07	0.16	1.02	1.29	0.03	0.68	0.92	0.00
Specialized Hospitals	0.50	1.00	0.05	0.43	0.87	0.01	0.30	0.48	0.00	0.34	1.09	0.10	0.57	0.89	0.00	0.13	0.20	0.00

Exhibit 14: Hospital-Level Variable—Primary Hospital (Large vs. Small ITA Caseload)

Reference Category: Hospitals with Large ITA Caseloads

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Small Caseload Hospitals	0.40	0.59	0.00	0.45	0.76	0.00	0.67	0.86	0.00	0.81	1.81	0.35	0.68	0.91	0.00	0.49	0.77	0.00
Specialized Hospitals	0.40	0.81	0.00	0.35	0.72	0.00	0.27	0.44	0.00	0.36	1.16	0.14	0.50	0.79	0.00	0.12	0.19	0.00

Exhibit 15: Court-Level Variable—Case Continuances

Reference Category: 0 Case Continuances Following Petition

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
1 Continuance	5.87	7.88	0.00	1.33	1.95	0.00	1.34	1.67	0.00	0.90	1.53	0.24	0.07	0.09	0.00	0.80	1.11	0.47
≥2 Continuances	12.08	16.91	0.00	1.06	1.49	0.01	1.11	1.45	0.00	0.95	1.55	0.11	0.05	0.07	0.00	0.78	1.06	0.23

Exhibit 16: Court-Level Variable—Case Filings per Month

Reference Category: N/A – Continuous Variable

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Case Filings	1.00	1.00	0.58	1.00	1.00	0.40	1.00	1.00	0.96	1.00	1.00	0.96	1.00	1.00	0.93	1.00	1.00	0.43

Exhibit 17: Court-Level Variable—Filing Year of Case

Reference Category: 2014	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
2015	0.68	1.02	0.08	0.42	0.67	0.00	0.77	1.01	0.07	0.90	1.75	0.19	0.84	1.24	0.85	0.72	1.10	0.28
2016	0.53	0.82	0.00	0.35	0.57	0.00	0.83	1.09	0.48	0.86	1.70	0.29	0.81	1.20	0.90	0.82	1.26	0.88
2017	0.59	0.97	0.03	0.38	0.68	0.00	0.89	1.24	0.55	0.72	1.70	0.64	0.64	1.01	0.06	0.69	1.17	0.43
2018	0.58	1.03	0.08	0.41	0.80	0.00	0.55	0.82	0.00	0.43	1.22	0.23	0.36	0.59	0.00	0.61	1.11	0.21

Exhibit 18: Other Variable—Referral Source (General)

Reference Category: Emergency Room Referral	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Court Referral	0.65	1.34	0.72	0.47	0.97	0.03	1.09	1.74	0.01	0.88	2.27	0.15	1.63	4.79	0.00	1.03	2.46	0.04
Community Mental Health Center Referral	1.00	1.49	0.05	1.09	1.71	0.01	0.36	0.54	0.00	0.39	0.85	0.01	1.98	3.71	0.00	1.58	2.65	0.00
Voluntary Referral	0.89	1.80	0.19	0.34	0.80	0.00	0.53	0.88	0.00	0.15	1.15	0.09	0.72	1.24	0.69	0.81	1.74	0.39
Jail Referral	0.16	0.53	0.00	0.43	1.04	0.07	0.58	1.08	0.15	0.46	1.83	0.81	1.03	2.74	0.04	0.53	1.23	0.32
Family Referral	0.60	1.12	0.21	0.95	2.09	0.09	0.68	1.05	0.13	1.18	2.70	0.01	1.00	1.78	0.05	0.78	1.51	0.64
Inpatient Referral	0.45	0.86	0.00	0.41	0.73	0.00	0.62	0.90	0.00	0.57	1.49	0.74	0.75	1.14	0.47	0.82	1.34	0.70
Other Referral	0.55	0.93	0.01	0.94	1.67	0.12	0.66	0.93	0.01	1.19	2.31	0.00	1.28	2.13	0.00	1.02	1.69	0.03

Exhibit 19: Other Variable—Referral Source (Hospital)

Reference Category: Emergency Room Referral

	LESS RESTRICTIVE ALTERNATIVE (VS. DETENTION)						CASE DISMISSAL (VS. DETENTION OR LRA)						COURT ORDER (VS. RELEASE WITHOUT COURT ORDER)					
	14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS			14-DAY PETITIONS			90-DAY PETITIONS		
	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|	95% C.I.		P >|Z|
Harborview – Other	0.61	1.22	0.40	0.52	0.96	0.03	0.60	0.97	0.03	0.48	1.86	0.88	0.82	1.45	0.55	0.82	1.56	0.46
Overlake	0.70	1.39	0.94	0.49	1.17	0.21	0.97	1.51	0.09	0.82	2.74	0.19	0.51	0.89	0.01	0.45	0.91	0.01
Highline	0.76	1.46	0.75	0.96	2.16	0.08	0.89	1.39	0.33	0.54	1.75	0.92	0.79	1.50	0.61	0.77	1.60	0.57
Northwest – ER	0.61	1.37	0.65	0.78	1.94	0.38	0.72	1.25	0.71	0.34	1.62	0.46	0.71	1.41	0.99	0.59	1.22	0.38
Northwest – Other	0.09	1.84	0.25	0.25	2.23	0.61	0.44	1.67	0.66	0.21	4.75	0.99	0.41	1.51	0.47	0.38	1.55	0.45
Valley	0.65	1.29	0.61	0.68	1.53	0.93	0.73	1.18	0.55	0.51	1.77	0.87	0.60	1.10	0.18	0.87	1.88	0.22
Evergreen	0.63	1.41	0.78	0.64	1.88	0.73	0.95	1.56	0.12	1.29	4.66	0.01	0.45	0.84	0.00	0.45	1.01	0.05
Multicare – Auburn	0.83	1.78	0.32	0.64	1.65	0.91	0.71	1.25	0.68	0.77	2.81	0.24	0.71	1.47	0.91	0.84	2.02	0.23
Swedish – First Hill	0.45	1.01	0.06	0.62	1.59	0.97	0.71	1.24	0.64	0.71	2.86	0.32	0.66	1.35	0.75	0.61	1.46	0.80
Swedish – Cherry	0.45	1.22	0.24	0.73	2.46	0.35	0.77	1.46	0.73	0.73	3.39	0.25	0.59	1.40	0.65	0.64	1.96	0.69
Swedish – Ballard	0.53	1.41	0.56	0.45	1.39	0.42	0.81	1.52	0.53	0.65	3.25	0.37	0.69	1.61	0.80	0.54	1.54	0.73
Swedish – Issaquah	0.21	0.96	0.04	0.41	2.11	0.86	0.90	1.90	0.16	0.64	5.22	0.26	0.53	1.34	0.48	0.29	1.03	0.06
University	0.57	1.32	0.52	0.51	1.31	0.40	1.04	1.76	0.03	0.64	2.50	0.50	0.72	1.51	0.83	0.78	2.01	0.35
St. Francis	0.64	1.46	0.89	0.72	1.89	0.53	0.66	1.18	0.40	0.58	2.24	0.71	0.72	1.56	0.78	0.78	1.86	0.41
Virginia Mason	0.43	1.18	0.19	0.50	1.36	0.46	0.79	1.53	0.59	0.41	1.99	0.80	0.74	1.78	0.55	0.88	2.46	0.14
Fairfax	0.74	2.19	0.39	0.43	1.67	0.64	0.39	0.90	0.01	*Omitted – No Petition*			0.53	1.33	0.46	0.74	2.69	0.30
Veterans	0.36	3.85	0.78	0.55	8.57	0.27	0.18	2.20	0.47	*Omitted – No Petition*			0.17	1.84	0.34	0.16	2.39	0.49
Children's	0.13	2.58	0.47	0.22	95.01	0.33	0.30	4.03	0.88	*Omitted – No Petition*			0.44	2.77	0.83	0.14	6.54	0.97
Other Referral	0.51	1.62	0.74	0.46	2.07	0.94	0.93	1.88	0.12	0.45	3.40	0.69	0.40	0.91	0.02	0.62	2.32	0.58
None or Unknown	0.78	1.17	0.66	1.02	1.56	0.03	0.77	1.02	0.10	0.95	2.01	0.10	1.23	1.86	0.00	1.16	1.79	0.00

Statement of Compliance, Scope, Objective & Methodology

Statement of Compliance with Government Auditing Standards

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Scope of Work on Internal Controls

We assessed internal controls relevant to the audit objectives. This included interviews with knowledgeable staff both in and out of the King County government. This included staff within the Department of Community and Human Services (DCHS), the Department of Judicial Administration (DJA), the Department of Public Defense (DPD), the Prosecuting Attorney's Office (PAO), Superior Court, and several hospitals that serve Involuntary Treatment Act (ITA) Court patients. In performing our audit work, we identified issues relating to data availability and validity.

Scope

This performance audit examined involuntary treatment services conducted by King County and contributors to system challenges and patient outcomes for cases filed between January 1, 2014 to October 31, 2018.

Objectives

The objectives of this audit were:

1. What are the major contributors to ITA patient court outcomes and ITA patient reentry into the involuntary treatment system?
2. Of the major contributors identified in the first objective, what are the trends since 2010 and what are potential impacts?

Methodology

To understand the major contributors to different court outcomes and the likelihood of people returning to the ITA system, we conducted a series of logistic regressions using data from cases filed from January 1, 2014 to October 31, 2018 (for more details on our methodology for these regressions see appendices 1-4). These logistic regressions tested the association between a variety of independent variables (listed in Appendix 3) and the use of orders for less restrictive alternative treatments and the use of orders for dismissals. Another set of logistic regression tested the association between a variety of independent variables (listed in Appendix 1) and the likelihood of people returning to the ITA system (as defined by having a new ITA case) within either 30, 90, 180, 365, or 1,095 days. The results of these regressions are in appendices 2 and 4. We also compared differences in these outcomes by independent variable groups when the logistic regressions found these variables to be statistically significant and presented these comparisons in the text of the report.

To determine the independent variables to include in these regressions, we interviewed knowledgeable staff both in and out of the King County government. This included staff within the DCHS, DJA, DPD, PAO, Superior Court, and several hospitals that serve ITA patients. We also attended several ITA Court calendars and spoke to members of the East King County Affiliate of the National Alliance on Mental Illness. We assessed the context for, and limitations of, the variables included in this analysis through a series of meetings with representatives from the departments that provided this data (DCHS and DJA) and representatives from Superior Court. We also assessed the data for logical issues, such as new cases that start before previous cases end and excluded data entries and variables when these issues compromised the validity or reliability of the data.

In addition to this primary set of logistic regression analyses, we conducted supplemental analyses based on meetings with stakeholders in which we discussed interim findings. These included assessments of the traits of people who go through the ITA system, assessments of whether the effect of some independent variables changed depending on who they applied to, trends in demographics traits, and other statistics that are included in this report.

KING COUNTY AUDITOR'S OFFICE

Advancing Performance & Accountability

KYMBER WALTMUNSON, KING COUNTY AUDITOR

MISSION

Promote improved performance, accountability, and transparency in King County government through objective and independent audits and studies.

VALUES

INDEPENDENCE - CREDIBILITY - IMPACT

ABOUT US

The King County Auditor's Office was created by charter in 1969 as an independent agency within the legislative branch of county government. The office conducts oversight of county government through independent audits, capital projects oversight, and other studies. The results of this work are presented to the Metropolitan King County Council and are communicated to the King County Executive and the public. The King County Auditor's Office performs its work in accordance with Government Auditing Standards.

This audit product conforms to the GAGAS standards for independence, objectivity, and quality.