Stakeholder Report

Washington state Civil Discharge Settlement Agreement

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

Disability Rights WASHINGTON

Table of Contents

I. Background of the Settlement Agreement

The Washington State Civil Discharge Settlement Agreement was reached in December 2022, after over a year of negotiations between the Department of Social and Health Services (DSHS), the Health Care Authority (HCA) and Disability Rights Washington (DRW). It aims to improve discharge planning and outcomes for people civilly committed to Eastern and Western State Hospitals. The Settlement Agreement is focused on improving discharge planning for civil patients who are or will be committed to the state hospitals for a period of 90 days or more.

The Settlement Agreement emphasizes the expectations that 1) discharge planning at the state hospitals begins at admission; 2) sound discharge planning requires coordination, collaboration and accountability between the state hospitals and multiple entities; and 3) the patient must be at the center of every discharge and should be involved in the process. The goal of the Settlement Agreement is to implement changes in the discharge planning process to achieve quicker and more sustainable discharges. The state hospitals have written discharge policies and procedures that follow regulations established by the Center for Medicare and Medicaid Services (CMS), a regulatory entity that is part of the U.S. Department of Health and Human Services. CMS acknowledges that the state hospitals are not solely responsible for the success of a person's discharge back to the community, but they are required to implement a discharge planning process that focuses on improving quality of care for patients and reducing the chances of readmission.

DSHS and HCA are working together to implement the policy and performance goals from the Settlement Agreement, focusing on the following objectives:

- Avoid undue delays in discharge by ensuring timely discharge planning.
- Discharge patients to the most integrated setting that meets their needs.
- Connect patients to appropriate community services and supports before discharge, and as soon after admission as possible to achieve the first two objectives.

The term "integrated setting" comes out of the Integration Mandate in Title II of the Americans with Disabilities Act and is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[1] The Agreement includes a presumption that most people discharging from the state hospitals can live in their own homes with supports in place, or another setting of their choosing.

A crucial component to meeting the goals outlined in the Settlement Agreement is gathering feedback from Stakeholders, or those who are directly or indirectly impacted by the civil discharge planning process at the state hospitals. This report describes the stakeholder engagement conducted by DSHS, HCA, and DRW; summarizes key themes that emerged from the stakeholder feedback received; and provides recommendations for discharge planning policy and process changes based on the feedback received.

II. The Stakeholdering Process

In collaboration with DRW, the state used several methods to educate Stakeholder groups about the Settlement Agreement as well as obtain their input about the current state hospital discharge planning process and ways to improve it. Stakeholders identified were current and former patients of the state hospitals, family members and guardians of patients, and providers (state employees and community-based professionals working with patients and former patients).

[1] 28 C.F.R. pt. 35 app. A (2010)

A. Hospital Ward Meetings/Former Patient Outreach:

In January, February and March 2023, representatives from DRW and the state went to both Eastern and Western State Hospitals to meet with civil patients on their wards to inform them about the Settlement Agreement and discuss how the Settlement Agreement might impact them. After each presentation, patients were interviewed about their thoughts on the current discharge planning processes and ways discharge planning could be improved.[2] Questionnaires were used to guide the interviews and additional questionnaires were given to hospital staff to provide to patients who wished to complete it at a later time. In addition to the questionnaire, patients received a one-page document to use as a reference on key components of the Settlement Agreement. DRW and state representatives' contact information was also provided in case patients had additional questions or wanted to provide more feedback. Former patients of the state hospitals were also provided the one-page document and questionnaire via their community case managers. Questions were developed from the following topics:

- What information patients have received or would like to receive about being ready for discharge, discharge criteria, and available services or housing options after discharge
- When and whether patient preferences about where to live or what services to receive post-discharge were discussed and what would help patients engage in these conversations
- What, if any, barriers are there to living where patients want to live after being discharged, and how patients think these barriers could be resolved
- What post-discharge services are difficult to get, and what would make these easier to access
- What would help make discharge planning better

B. Outreach to Families/Guardians:

With patient consent, in March 2023 family members and guardians were provided a one-page document about the Settlement Agreement that was tailored to their role as support persons for state hospital patients. The one-page document provided a link to an online questionnaire.[3] The document was mailed via USPS to this group and was also available to family members/guardians when they arrived to visit a patient at the state hospitals. The questionnaire for this group focused on the following topics:

- What, if any, contact family members have had with treatment teams regarding discharge planning and what types of contact family members would like to have
- What discharge options have been discussed, and what other answers or information would be helpful to receive
- What opportunities have family members had to give input about discharge planning and what other kinds of opportunities should be available
- What are the barriers to family members participating in this process

C. Listening Sessions for Providers:

In January and February 2023, DRW and the state conducted listening sessions with state employees and those who provide community-based services and supports to civil patients at discharge. During the listening sessions, key components of the Settlement Agreement were discussed, and these Stakeholders were given an opportunity to share their immediate thoughts about the current civil discharge planning processes. Stakeholders were also informed they would be receiving a questionnaire to complete to capture their feedback in more detail.[3] The topics focused on for this group were as follows:

- What barriers to timely and appropriate discharge planning are a problem and how these barriers could be resolved
- What challenges to early engagement on discharge planning for patients cause delays in discharge planning and what practice changes would mitigate those challenges
- What discharge services are difficult to access for patients and what community Stakeholders think would help remove access barriers

[2] Patients were informed their participation was voluntary, would be anonymous, and that the discharge planning in their individual case, and any state benefits or services they were entitled to receive, would not be impacted.

[3] Family members/guardians and providers were informed their participation was voluntary and would be anonymous.

- Reasons why patients are not discharging to their own homes from WSH/ESH and what would help more patients do so

D. Stakeholder Participation:

Out of all the questionnaires provided to the different Stakeholder groups, 273 completed questionnaires were received as follows.

Current patients: 65 (ESH) and 139 (WSH)
Former patients: 13
Families/guardians: 14
State employees/community providers: 42

III. Feedback Received

Theme 1:

Lack of communication about discharge planning: Patients and families desire to be better informed about how the discharge planning process works, provided with updates on progress made toward discharge, and receive more information on community-based resources.

Many patients reported confusion about the discharge planning process. Several reported that better communication and more frequent meetings focused on discharge planning would be beneficial.

There are multiple systems of care that serve people with mental health challenges both inside and outside of the state hospitals. From the perspective of patients and family members/guardians who don't have professional knowledge about these systems of care, it can be difficult and overwhelming to understand all that's involved in safely transitioning a state hospital patient back to their community. Patients suggested "breaking down the process to make it easier to understand."

Patients would prefer more information about other aspects of the discharge planning process as well, including information on discharge criteria and discharge timelines. Patients reported not knowing "what it takes to be on the discharge list," or "what I need to do to get out of here." They requested better and clearer communication about goals they can work toward that will help them get back to their lives outside of the hospital. They want a "plan in place for me to work on" and "more info ahead of time so I will not be lost or stressed."

In addition, once they have met discharge criteria, patients want a "prediction about when I can leave" and believe that "a rough time frame would help reduce my anxiety around it." Even if the discharge plan isn't completely figured out, patients still reported wanting to have discussions about any progress made. One stated, "I want weekly updates on the status of my discharge. What's been done, what still needs to be done…"

Many current patients reported having little to no knowledge about community-based services and supports and some did not feel they had an active role in making decisions about discharge. Some family members/guardians reported no communication with discharge planners and said they were not aware of the community-based resources available to the person they were supporting in the hospital. Some family members reported experiencing a lack of being able to participate in discharge planning meetings and several cited geographical distance from the state hospital being the biggest barrier. Several former patients mentioned that more information prior to their discharge about discharge planning and discharge options would have been helpful.

Patient stakeholders reported that being an active participant in planning for a return to community life isn't always an option. One patient stated, "it feels like we aren't actually given a role [in discharge planning]. We have to wait for our treatment team to provide momentum." In order to actively participate in planning for their discharges, patients want to know about all the community-based services available to them to assist with continued stability, as noted by a former patient: "Maybe they could educate people like me on all of the options. I don't remember getting much of that." A family member reported that "providing a list of possible outside services would be greatly helpful."

Family members who reported not being able to participate in discharge planning said that geographical distance from the state hospitals was the biggest barrier. From comments such as "I can't make trips out to Eastern because it's too far to drive" and "distance is the only barrier. Funds are extremely tight…," it appears that in-person participation in discharge planning is preferred by these Stakeholders.

Theme 2:

Discharge delays: There are multiple barriers that interfere with the discharge timeline.

Multiple patients reported frustrations with discharge delays and slow progress with discharge planning efforts.

When asked what would make discharge planning better, one patient said, "speed up the process." Another patient noted that "delays are frustrating." There are a multitude of factors that affect how quickly a patient is released from the state hospitals. Lack of resources and systemic issues appear to be the barriers with the most impact on the discharge timeline, and the next several sections of this report discuss this in more detail.

Several patients reported a preference for independent living. The majority of providers noted there is a scarcity of affordable housing and lack of available services and supports. Many feel this significantly hinders some patients' ability to live independently when discharging directly from the state hospitals.

One patient said, "I would like options for living in my own home." Another reported that it helps him "to be alone. Group settings are hard." However, "real estate rental rates are beyond the budget of people living off of social security," said one provider. In fact, the vast majority of stakeholders in the provider group specifically pointed to a lack of independent living options for patients leaving the state hospitals as a primary barrier to more timely discharges. Providers also had recommendations for how to handle the lack of affordable housing, including "more master leases with landlords, [and] grants for building income-restricted housing."

In addition to a lack of affordable housing, many providers feel there is a lack of services available to support people to live in their own homes. Common sentiments from providers about the availability of community-based services and supports were highlighted by statements such as, "[there are] no section 8 vouchers," "more staff [are needed] for supported housing vendors," "there are not enough PACT teams in the state," "not enough peer bridgers for all the residents at the hospital," and "concern for readmission due to insufficient supports in place at discharge."

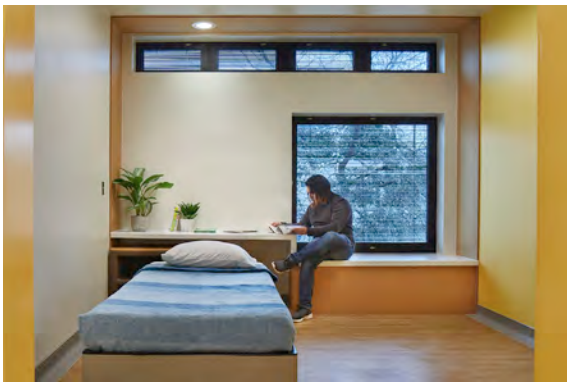
Many patients reported that their treatment teams were recommending discharge to residential settings.[4]

One community provider said, "I hear frequently that discharge planners are pushing LTC (long term care residential settings) because its 'faster' and more easily accessed…The notion that LTC is the fix … is absolutely not factual. It's important to find ways to support folks in their chosen environments." Another said, "many of WSH/ESH residents aiming to discharge are not wanting a LTC facility but are forced into it because of the discharge process. Remove barriers to independent housing for those who it's appropriate for." One patient stated they'd been told "it would take too long to set up independent living." On the other hand, others report that discharging to residential care settings isn't necessary a faster process. One family member reported, "the discharge process and paperwork for sending a patient to an adult family home takes at least 3 months, which makes the patient and family member hopeless to the discharge plan, and when the patient becomes hopeless, [they] may refuse taking [their] daily med." An interviewer speaking for a patient noted, "barriers to finding an adult family home is preventing discharge." In addition, there are some patients for whom structured care is the preferred option. One patient reported she preferred to live in a group home because she wants to "live with other people." Another reported, "I'm looking forward to three meals a day at a group home."

Some providers thought that transitional "step-down" options should be created for patients to increase chances of success at discharge.

For patients who desire to live independently, some providers commented that more needs to be done to prepare some of them so they can function well in that setting. One provider described this as "community readiness skill building" and believes that "having a step-down program where individuals are able to experience more independence prior to being housed in the community" would be useful. A state hospital social worker noted that "many of the patients I work with have come from living in structured care and have not lived independently for a long period of time, or have never lived independently. More patients could live in a supportive living setting where apartments have on-site mental health staff and supports." Another provider noted, "if a stepdown was an option, it would decrease failed community placements."

Lack of natural and/or family supports for those discharging is a huge barrier.



For multiple reasons, there are patients who don't have supportive family members or friends who are available to advocate on their behalf or provide them with a place to live. While some patients interviewed made comments such as, "I want to live with my mom, and the treatment team supports this decision," or "I have my own home and plan to go back and live with my wife," many others reported different experiences. One provider, said, "some of the clients have burned bridges with their family. Or a family member was a victim of assault by the client, making a home placement not recommended." Another reported, "family is burnt out and not wanting them back in the home." A third made the comment that, "behaviors can also be hard to manage for any untrained caregiver." These patients, then, are left relying solely on community providers for support.

[4] *Residential care settings* for Home and Community Services refers to long-term care provided to individuals who receive Long-Term Services and Supports in a setting other than a home. The provider is paid a daily rate and there is no lease in effect. Examples include assisted living facilities, adult family homes, and Enhanced Service Facilities. Settings such as Adult Residential Treatment Facilities and Intensive Behavioral Health Treatment Facilities are additional resources funded by the Managed Care Organizations.

Providers reported that the DDA discharge planning process slows down discharge and makes early engagement difficult or impossible.

Every administration within DSHS that works with the state hospitals to discharge patients has their own set of rules and guidelines that drives the work they do and when they do it. The Developmental Disabilities Administration (DDA) serves clients receiving treatment on the Habilitative Mental Health (HMH) wards. One provider remarked that the discharge process for patients on HMH "is presented as a DDA process." Other provider comments expressed concern that there is a delay in discharge planning for DDA clients that prevents early engagement. The DDA process was described as "long" and discharge planning for individuals on HMH is thought to be "limited to only DDA services. Other services are not considered until DDA resources are exhausted which can result in many months delay." Like many other community resources, providers noted there is also a "lack of DDA funded placements," and, "limited openings at DDA approved supported living agency homes," which also may delay the discharge process.

Several civilly committed patients housed on WSH CFE wards reported being told by staff that discharge planning will not begin until they are transferred to a civil ward.

Patients interviewed at Western State Hospital's Gage Center for Forensic Excellence commonly reported that they were told discharge planning wouldn't occur until they transferred to a civil ward. A person in the provider group indicated, "patients come over ready to go and extremely angry that they are still in the hospital when they were told they could discharge as soon as they come to civil." As a possible reason for why this might occur, one provider said "staffing and possibly changes in staff workload sometimes make for challenging discharge planning." Patients appear to share this belief with comments such as, "there is not enough time given to each person that needs to get out." Another noted, "they need additional people to help with discharge planning."

Multiple providers reported that the risk assessment process significantly delays discharge.

State law requires additional evaluations for persons with a history of violence. These evaluations are commonly referred to as the "6358" and they must be completed prior to discharge. There has been a significant increase in the number of patients requiring these evaluations, and they are to be requested when the treatment team feels the patient will soon be ready for discharge planning. Providers have noted there are "delays in getting the 6358 completed." One provider said that "often times, we are further along in discharge planning by the time the 6358 gets completed and the recommendations are out. Sometimes the recommended level of care in [the] 6358 is not in support of what the team has been working on (e.g., independent housing vs AFH [Adult Family Home]). That means the team and the client will need to start over on the discharge plan."

Many in the provider stakeholder group thought that residential care settings need more training and support to deal with people with significant behavioral challenges.

When patients are discharged to residential care settings, providers are often expected to assist patients in adhering to their medication regimen, attending their outpatient mental health appointments, and generally remaining psychiatrically stable. One provider, however, believes discharge planners have "unrealistic expectations for people with severe mental health issues to be supported in adult family homes." Another provider remarked, "one issue with appropriate discharge planning is the lack of appropriate and experienced placements in the community. I think there needs to be an enormous amount of training done." And another reported, "in the past I have been asked to find and place residents in

facilities who have little to no experience with patients with the high needs of those leaving the state hospitals. Then once in the community it's like 'hot potato' and no one really helps the resident or the provider and it turns into a failed placement, homelessness, etc." Another comment was, "when facilities have riskier residents, their insurance cost increases significantly, which deters them from considering." Another reported, "when patients are denied placement for requiring too much care, they often are stuck in the hospital system."

Many providers feel that criminal history/history of violence and chronic homelessness prior to hospitalization are significant barriers to independent living.

Finding independent housing options for patients who have a criminal history/history of violence can be problematic, as it is "hard for them to pass background checks to get into their own apartments," one provider indicated. This is especially true for patients with a history of sex offenses. Another challenge is having a history of housing instability. Assisting a patient with regaining stability and providing them with supports so they can return to the home they had prior to admission is much less complicated than discharging someone "when they don't have a home to return to," as one provider remarked.

Theme 3:

The importance of community-based services and supports: They are essential to a successful discharge plan and to patients' ongoing stability.

Former patients specifically mentioned that GOSH, Peer Bridgers, and behavioral health supports (including medication management), have been particularly helpful since their discharge from WSH/ESH. Many providers feel Peer Bridgers and other community-based housing and behavioral health supports are an integral part of the discharge process.

It is clear from stakeholder feedback that community-based services and supports, that are targeted to assist individuals leaving inpatient settings to discharge to the most integrated setting that meets their needs, are an invaluable resource. Lack of resources in this area is considered a significant problem. Some of these services are available long-term, following an individual back into an inpatient setting when needed, and then remaining ready to receive the individual into services when they discharge again. One patient remarked that he doesn't "want to lose GOSH and PACT if I agree to go to an adult family home. "

One former patient, when discussing the array of services they have access to in the community described it as being "a whole team. We work together. We get stuff done." When providers were asked their opinions on the most useful post-discharge services and supports, they often indicated that it wasn't just the services and supports themselves that were useful. It was the "wraparound" nature of all of the supports, working together with individuals and for individuals that proved most effective.

Theme 4:

Positive feedback about discharge planning was received.

Some family members/guardians reported having good and consistent communication with hospital staff. Most reported having had at least some contact with discharge planners.

While certain themes arose that call for changes in discharge planning at the state hospitals, it is important to note that some stakeholders had positive things to say about the discharge planning process and discharge planning staff. One family member indicated having had "extensive phone and video contact" with members of the treatment team. A guardian reported, "I am a guardian and have discharged several clients to successful community placements and have been very pleased with the profession-

alism of all involved, making these placements a success." When asked how often patients have had discharge planning meetings with their social worker or the treatment team, there were patients who made comments such as "regularly," "almost every day," and "they've immediately talked to me and helped." Another patient remarked that the social worker, "listens to what I have to say."

IV. Policy Recommendations Received from the Stakeholders

Based on the stakeholder feedback provided in this report, here is a list of recommendations to improve discharge planning and outcomes for state hospital patients:

- Create consistent policies that require regular person-centered discharge planning meetings for all civil patients at WSH and ESH, including civilly committed patients housed on forensic wards.
- Provide more frequent and earlier opportunities for ESH and WSH patients to learn about and connect with existing community-based supports, such as PACT, GOSH, HARPS, and Peer Bridger programs, and vocational supports during the course of their hospitalization.
- Continue to expand in-home support, including PACT, GOSH, HARPS, and Peer Bridger programs state-wide, as well as existing targeted rental subsidies, so that more patients discharging from WSH and ESH can have the option of living in their own homes with wrap-around supports, when clinically appropriate.
- Provide additional supports, including intensive behavioral health supports, peer supports, and crisis management supports to individuals discharging from WSH and ESH to residential care settings, and provide additional training for residential care providers on support needs and services available to assist residents following their discharge.
- Require DDA and BHA to work jointly to streamline and improve the discharge planning process for patients on the WSH and ESH Habilitative Mental Health Units.
- Provide targeted education and information to WSH and ESH patient families and guardians about community resources available to patients upon discharge.
- Streamline and/or start the statutorily required risk assessment process earlier.

V. Next steps

The Settlement Agreement obligates the state to "fully assess and strongly consider problems and barriers identified and the suggestions provided by stakeholders." The agreed upon stakeholder engagement plan further requires that the state "use its best judgment to implement changes that honor the experiences and wishes of patients as the most impacted stakeholders."

The state will consider the Stakeholder feedback and suggestions described herein and develop an action plan for implementing any changes to the process necessary to support the policy goals of the Settlement Agreement. The action plan and suggested changes will be completed in collaboration with DRW.

Dates of Stakeholder Engagement

January 9 and 10, 2023	Eastern State Hospital on-ward patient visits
January 30, 2023	Housing And Recovery through Peer Services (HARPS) provider meeting
January 31, 2023	Eastern State Hospital management meeting
February 1, 2023	Governor's Opportunity for Supportive Housing (GOSH) meeting
February 2, 2023	Western State Hospital management meeting
February 14, 2023	Multi-State agency meeting with Department of Social and Health Services (DSHS) staff; Department Of Corrections (DOC); The Health Care Authority (HCA) staff; Managed Care Organizations (MCO); and Behavioral Health Administrative Services Organizations (BH-ASO) hospital liaisons
February 15-17, 2023	Western State Hospital civil on-ward patient visits
February 27, 2023	Peer Bridger provider meeting
March 3, 2023	Program of Assertive Community Treatment (PACT) provider meeting
March 10, 2023	Family and/or guardian feedback was received
March 22 and 23, 2023	Western State Hospital's Gage Center on-ward patient visits

Supporting Documents

WSH & ESH Civil Discharge Settlement

Todd Carlisle & Chloe Merino
Staff Attorneys, Treatment Facilities Program
Disability Rights Washington

What is DRW?

- DRW is a private non-profit organization that protects the rights of people with disabilities statement
- DRW is not a state agency
- We are part of the federal protection and advocacy network, and Washington's mandated P&A agency
- Our mission is to advance the dignity, equality, and self-determination of people with disabilities, including people in facilities like ESH & WSH
- DRW investigates abuse and neglect and advocates for patient rights, sometimes via litigation

How did we get here?

- Investigation: The civil discharge case began with an extensive investigation into significant discharge delays of civilly committed people at ESH & WSH
- Negotiations: DRW entered into structured negotiations with DSHS and HCA rather than filing a complaint in court
- Settlement: On 12/2/2022, all parties reached a 3-year settlement agreement
  - The agreement settles DRW's claims against the HCA and DSHS regarding civil discharge delays and discharges to settings that are unnecessarily restrictive.
- Stakeholdering: The first thing step in settlement implementation → feedback, ideas, suggestions.
  - DSHS & HCA need your feedback on how to make the discharge process better

Civil Discharge Settlement: Goal #1

- Timely discharge planning & timely discharges
  - Goal is timely discharges w/ all necessary supports already in place once the treatment team determines that the patient is ready for discharge
- *What does timely mean?*
  - For example, referrals and transfers of case information to other discharge planning individuals and service providers will occur within seven business days of the event that made the referral or transfer appropriate
  - Other timeframes apply for things like financial assessments, discharge related visits, eligibility assessments, etc.

Civil Discharge Settlement: Goal #2

- Discharges to the patient's own home or "the most integrated setting appropriate."
  - New explicit goal of discharge planning is "to provide individuals with the option to live in their own homes or a setting that is the most integrated setting appropriate for their needs."
- The settlement defines "most integrated setting" as a setting that includes the following features:
  - Supports the individual's access to the greater community
  - In the individual's own home or is another setting selected by them
  - Ensures an individual's rights to privacy, dignity, respect, and freedom from coercion and restraint
  - It optimizes individual initiative, autonomy, and independence in making life choices
  - It facilitates individual choice regarding services and supports and who provides them

Civil Discharge Settlement: Goal #3

- Early Engagement
  - Information will be provided to patients and families earlier in commitment process
  - Patients will also be provided with earlier connections to supported housing providers and other community-based supports
    - I.e., GOSH, HARPS, PACT, Peer Bridgers, DVR

Civil Discharge Settlement: Commitment #1

- New DSHS & HCA policies and procedures to achieve more timely discharges
  - Uniform discharge planning policies & procedures for the state hospitals
    - Completed within 15 months
  - New "digital discharge planning system"
    - Goes live in 24 months; completed in 36 months
  - New requirements for "timely discharge planning" that mandates a 7 day deadline for many tasks

Civil Discharge Settlement: Commitment #2

- New presumption
  - Discharge planning at WSH & ESH will begin with the presumption that most people can live in their own home with supports in place
  - Everyone should be discharged to the most integrated adequately supported setting appropriate for their needs

Civil Discharge Settlement: Commitment #3

- New “in-reach” at WSH & ESH
  - Peer Bridgers for everyone assigned at admission
  - DVR liaisons at WSH & ESH
  - All patients will be “fully informed” about community-based behavioral health programs and services including PACT, supportive housing, Peer Bridgers, and vocational supports.

Stakeholder Input

- 3 months of stakeholder engagement to get input from:
  - Patients currently civilly committed at ESH/WSH
  - Former patients
  - Family members/those who support patients in the discharge process
  - Community providers
  - MCO & BHASO reps
  - BHA & HCA staff
- Please fill out our community provider questionnaire

Thank you!

Questions?

Chloe Merino,
Disability Rights Washington, 206-324-1521 ex.131, chloem@dr-wa.org

Todd Carlisle,
Disability Rights Washington, 206-324-1521 ex. 237, toddc@dr-wa.org

315 5th Ave S. Suite #850

Seattle, WA 98104

206.324.1521 or 800.562.2702 | fax: 206.957.0729

See https://www.disabilityrightswa.org/cases/civil-discharge-settlement/

Disability Rights WASHINGTON
Washington's protection and advocacy system

March 10, 2023

WSH & ESH Guardians and Family Members

Re: Civil Discharge Settlement Agreement – Request for Feedback

Dear Guardians and Family Members,

We are writing to ask for your help to improve civil discharge planning at Western State Hospital (WSH) and Eastern State Hospital (ESH).

The Washington State Department of Social and Health Services (DSHS) and Health Care Authority (HCA) recently entered into a settlement agreement with Disability Rights Washington (DRW) related to civil discharge planning at WSH & ESH. The settlement requires that WSH and ESH update and improve their discharge planning policies and procedures for civilly committed patients to achieve the following goals:

- Create discharge plans that recommend and facilitate timely discharge to the most integrated community setting appropriate for the individual;
- Create discharge plans that provide individuals with the option to live in their own homes or a setting that is the most integrated adequately supported setting appropriate for their needs; and
- Productive early engagement with patients, their support network, and cross-system partners to achieve timely discharges with appropriate supports.

As part of the settlement, DSHS and HCA are seeking feedback from patients, their families, other support networks, and community partners to identify discharge barriers and solutions to improve discharge planning. We are asking family members and guardians of civilly committed patients at WSH and ESH to complete a brief on-line questionnaire.

Please do so here:
https://forms.office.com/r/X0yW4dWBWU

The questionnaire will be available online until March 30, 2023.

If you are unable to complete the questionnaire, need accommodations, or would prefer to speak to someone via phone, please call DRW to schedule a brief interview.

Participation in this survey is voluntary. You may skip questions or withdraw participation at any time. It should take about 10 minutes to complete. We are providing this survey to current and former civil patients at WSH/ESH, family members and guardians, state employees and community providers. Your information will be used to compile a report to improve discharge planning at the state hospitals. You will not be identified by name and any personally identifiable information will be removed.

Sincerely,

Todd Carlisle
Staff Attorney, Treatment Facilities Team
Disability Rights Washington
Phone: 206.324.1521 (Ext. 237) | fax: 206.957.0729

Chloe Merino
Staff Attorney, Treatment Facilities Team
Disability Rights Washington
Phone: 206.324.1521 (Ext. 131) | fax: 206.957.0729

Disability Rights
WASHINGTON
Washington's protection and advocacy system

March 10, 2023

To: **Former WSH and ESH Patients**

Re: **Civil Discharge settlement agreement- request for feedback**

Dear former patient,

We are writing to ask for your help to improve civil discharge planning at Western State Hospital and Eastern State Hospital.

The Washington State Department of Social and Health Services (DSHS) and Health Care Authority (HCA) recently entered into a settlement agreement with Disability Rights Washington (DRW) related to civil discharge planning at WSH & ESH. You can find out more about the settlement here- https://www.disabilityrightswa.org/cases/civil-discharge-settlement/

The main goals of the settlement are:

- timely discharge planning so people do not stay in the hospital longer than necessary.
- discharge planning that provides most people with the option to living in their own homes.
- early discharge planning that connects people with peer support, supported housing, and other supports that can help them when they are discharged.

As part of the settlement, DSHS and HCA are seeking feedback from former patients at WSH and ESH to identify discharge barriers and solutions to improve discharge planning. To provide your feedback, please fill out the attached questionnaire.

Participation in this survey is voluntary. You may skip questions or withdraw participation at any time without risk of losing any DSHS benefits you are entitled to. It should take about 10 minutes to complete. We are providing this survey to current and former civil patients at WSH/ESH, family members and guardians, state employees and community providers. Your information will be used to compile a report to improve discharge planning at the state hospitals. You will not be identified by name and any personally identifiable information will be removed.

If you are unable to complete the questionnaire, need accommodations, or would prefer to speak to someone via phone, please call DRW to schedule a brief interview.

Sincerely,

Todd Carlisle, Staff Attorney, Treatment Facilities Team
Disability Rights Washington
phone: 206.324.1521 (Ext. 237) | fax: 206.957.0729

Chloe Merino, Staff Attorney, Treatment Facilities Team
Disability Rights Washington
phone: 206.324.1521 (Ext. 131) | fax: 206.957.0729

Civil Discharge Settlement – Community Provider Questionnaire

Please fill out and return this questionnaire to: Disability Rights Washington at 315 5th Ave. South, Suite 850 Seattle, WA 98104, or by email to toddc@dr-wa.org. If you would prefer to speak with someone on the phone, need accommodations, or have questions, please call Chloe Merino or Todd Carlisle from Disability Rights Washington at (206) 324-1521.

What barriers do you think exist to timely and appropriate discharge planning at WSH/ESH? How do you think these barriers could be mitigated?

What challenges to early engagement in discharge planning for WSH/ESH patients do you see that cause delays in discharge? What changes would mitigate those challenges?

What are the most useful post-discharge services and supports for people discharging from WSH/ESH? What services and supports are the most difficult to access? What do you think would help remove barriers to accessing those services and supports?

Why do you think civil patients at WSH/ESH are not currently typically discharging to their own homes? What do you think would help more patients do so?

Survey for DSHS staff:

Participation in this survey is voluntary. You may skip questions or withdraw participation at any time with no risk to your employment status. It should take about 10 minutes to complete and you may use work time. We are providing this survey to current and former civil patients at WSH/ESH, family members and guardians, state employees and community providers. Your information will be used to compile a report to improve discharge planning at the state hospitals. You will not be identified by name and any personally identifiable information will be removed.

2.Agency and job title (optional)

3.What barriers do you think exist to timely and appropriate discharge planning at WSH/ESH? How do you think these barriers could be mitigated?

4.What challenges to early engagement in discharge planning for WSH/ESH patients do you see that cause delays in discharge? What changes would mitigate those challenges?

5.What do you think are the most useful post-discharge services and supports for people discharging from WSH/ESH?

6.What services and supports are the most difficult to access for people discharging from ESH/WSH? What do you think would help remove barriers to accessing those services and supports?

7.Why do you think civil patients at WSH/ESH are not currently typically discharging to their own homes? What do you think would help more patients do so?

Civil Discharge Patient Questionnaire – WSH and ESH

If you did not speak to anyone after the on-ward presentations, please fill out and return this questionnaire to: **Disability Rights Washington 315 5th Ave. South, Suite 850 Seattle, WA 98104**. If you would prefer to speak with someone on the phone, need accommodations, or have questions, please **call Chloe Merino or Todd Carlisle from Disability Rights Washington at (206) 324-1521.**

Participation in this survey is voluntary. You may skip questions or withdraw participation at any time with no risk of losing any DSHS benefits you are entitled to. It should take about 10 minutes to complete. We are providing this survey to current and former civil patients at WSH/ESH, family members and guardians, state employees and community providers. Your information will be used to compile a report to improve discharge planning at the state hospitals. You will not be identified by name and any personally identifiable information will be removed.

Are you on the discharge list? (optional):

1. Since you have been here at WSH/ESH, what information have you received about:
    a. being ready for discharge?
    b. discharge criteria?
    c. available services or housing options when you are discharged?

2. Have you been asked where you would like to live or what services you would like to receive when you are discharged from WSH/ESH?

3. How often have you had discharge planning discussions with your treatment team or your social worker?

4. What services have helped you in the past when you were living in the community?

5. What would help make discharge planning at WSH/ESH better?

6. Do you have anything else you would like us to know about discharge planning or your thoughts on the settlement agreement?