Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Improving Patient and Staff Safety in State Hospitals – Status Report

Engrossed Substitute Senate Bill 5187, Section 202 (11)

December 1, 2024

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The 2023 Washington State Legislature passed Engrossed Substitute Senate Bill 5187, making the 2023-2025 fiscal biennium operating appropriations. Section 202 (11) established that $4,949,000 of the general fund–state appropriation for fiscal year 2024, $7,535,000 of the general fund–state appropriation for fiscal year 2025, and $672,000 of the general fund--federal appropriation are provided solely for the Department [DSHS] to establish a violence reduction team at Western State Hospital to improve patient and staff safety at Eastern and Western State Hospitals.

The reporting requirement of the bill states:

A report to the legislature is required by December 1, 2023, and December 1, 2024, which includes a description of the violence reduction or safety strategy, a profile of the types of patients being served, the staffing model being used, and outcomes associated with each strategy. The outcomes section should include tracking data on facility-wide metrics related to patient and staff safety as well as individual outcomes related to the patients served.

The December 1, 2023 Report to the Legislature, *Improving Patient and Staff Safety in State Hospitals – Status Report*, reviewed progress and accomplishments of the Behavior Management Team (BMT), along with other Western State Hospital (WSH) resources in addressing patient acuity, aggression or violence toward peers or staff, frequent episodes of seclusion and restraint, and other challenging behaviors experienced on wards that were not improving with planned interventions.

It was noted that the Trueblood v. DSHS Federal court ruling on July 7, 2023, required discharging a large number of patients from Western State Hospital's Gage Center of Forensic Excellence (GCFE) in a 60-day period to allow the admission of patients from jails who were awaiting competency evaluations and restoration services. To accomplish this, the Western State Hospital's Civil Center of Excellence (CCE) discharged a high volume of patients to open bedspace to accommodate the majority of GCFE's discharges for patients who were civilly committed under RCW 71.05, Behavioral Health Disorders. This forced the GCFE to transfer patients to the CCE sooner than had been the practice. Consequently, the patients were less psychiatrically stable and more acute. Additionally, these patients had an increased level of aggressive and assaultive behavior which is reflected in the number of assaults to peers and staff along with other measures such as seclusion and restraint in the CCE for the limited timeframe of data in the last report to the legislature. As these patients were less stable, the CCE experienced the increased levels of assault compared to what the CCE had previously experienced and was reported in the 2022 report to the legislature. In the two months that data were available after the Federal court ruling, there was an increase in CCE patient assaults and it was anticipated that given the dynamics of the transferring patients that this trend might continue. As anticipated, the CCE has continued to experience a high level of acuity and patient aggression and assaults. The CCE continues to address the ongoing acuity and the BMT remains a valuable resource to treatment teams to help address particularly challenging patients.

BACKGROUND AND INTENSIVE CARE MODEL

The 2023 Washington State Legislature enacted Engrossed Substitute Senate Bill 5187, the 2023-2025 Operating Budget. Section 202 (11) established that $4,949,000 of the general fund--state appropriation for fiscal year 2024, $7,535,000 of the general fund–state appropriation for fiscal year 2025, and $672,000 of the general fund–federal appropriation are provided solely for the Department to establish a violence reduction teams to improve patient and staff safety at Eastern and Western State Hospitals.

A report to the legislature is required by December 1, 2023 and December 1, 2024 that includes a description of the violence reduction or safety strategies, a profile of the types of patients being served, the staffing model being used, and outcomes associated with each strategy. The layout of this report follows a similar structure. First, a background is provided which includes a summary of the previous reports and details of the Intensive Care Model at Western State Hospital. Then, the staffing model being used at the state hospital is discussed in detail, followed by a section that explains the profiles of patients being served. The following section is the outcomes section which track data on facility-wide metrics related to patient and staff safety as well as individual outcomes related to the patients served. The report is concluded by offering future directions and a summary as the hospital continues enhancing patient and staff safety.

Summary of Previous Reports

This report to the legislature was previously required and a brief overview of the last two reports is provided for further context. The December 1, 2022, Report to the Legislature, *Improving Patient and Staff Safety in State Hospitals – Status Report* for Western State Hospital's (WSH) Civil Center of Excellence reported many changes that occurred at WSH. In the first biennium, 2021, the legislature provided funding to address the causes of violence and aggression of patients at WSH. To address violence, WSH established a Specialized Treatment and Recovery (STAR) Program in February 2020. The STAR Program was a ward where the 10 most violent patients were served with intensive treatment(s) to reduce violent episodes. The STAR Program involved treatment in two phases, with the second provided on a Step-up Ward, where additional treatment would have been provided as the patient transitioned to discharge or a return to a Civil Center of Excellence ward. However, just as the STAR Program launched, COVID-19 pandemic occurred, which derailed the program. Specifically, the Step-up Ward became the COVID-19 medical isolation ward and simultaneously adversely affected the STAR Program's staffing as the locum nurses (who primarily staffed the STAR Program) became staff of the COVID-19 ward. This loss of staff resulted in the program being discontinued for staff and patient safety. The patients were transferred to other Civil Center of Excellence wards and the remaining STAR Program staff became the Consult Liaison Service--assisting the wards that received the STAR Program patients in managing those patients. These staff also began assisting with other challenging patients on wards as they were combined with the Violence Reduction Team and became the Behavior Management Team (BMT).

As reported in the December 1, 2023 Report to the Legislature, *Improving Patient and Staff Safety in State Hospitals – Status Report* for Western State Hospital's (WSH) Civil Center of Excellence (CCE), the July 7, 2023 US District Court ruling in Trueblood v. DSHS required the discharge of patients from the Gage Center of Forensic Excellence (GCFE) whose civil commitment was converted from RCW 10.77 to RCW 71.05 who were occupying a forensic bed

within 60 days. This was to make room for patients who were in jail awaiting admission for competency evaluation and restoration services. This created an emphasis on discharges from both the GCFE and the Civil Center of Excellence (CCE) since the ruling ordered the CCE to only admit patients with civil conversions from the GCFE to allow the GCFE to admit Trueblood members. Although last year's report to the legislature was written shortly after the ruling, with two months of data, it suggested that the CCE would experience an increase in acuity with patients who were psychiatrically less stable than those previously admitted to the CCE and that it would result in increased levels of patient aggression and assaults. Last year's report suggestion is reflected throughout 2024 as we see that as a result of the ruling, the CCE has had a constant admission of patients with high acuity and aggressiveness.

Intensive Care Model

WSH's first line of intervention is provided by the GCFE's and CCE's ward treatment teams through medications and other therapies tailored to the patient's individual needs based on their psychiatric presentation. The treatment team develops goals with supporting strategies or interventions in the patient's treatment plan to address the patient's concerns including aggression/violence, repeated use of seclusion and restraint, and other behavioral challenges such as assisting the patient with developing self-regulation skills to manage their acuity. The treatment team reviews each violence episode and updates the patient's treatment plan to address the underlying concern. When repeated incidents occur, alternative interventions are implemented. If it appears warranted, the treatment team requests a BMT consult for their assistance with the patient.

The treatment teams have assistance from the Centers' Psychiatric Emergency Response Team (PERT) and Security in responding to unexpected escalations of behavioral challenges. The treatment teams continue to have access to a multidisciplinary consultation team, the Behavior Management Team (BMT), to assist the teams with patients with high levels of aggression/violence and frequent episodes of seclusion and restraint that may be considered chronic and not responsive to the prescribed treatment approach when treatment efforts have been less than optimal.

The Behavior Management Team (BMT). The BMT is composed of the program director, administrative assistant, psychiatrist, psychologist, psychiatric social worker, 4 psychology associates, 3 therapies supervisors and 20 Institutional Counselor 3s. The therapies supervisors and institutional counselors are divided into 3 teams that provides coverage to all wards during the day (6:30 am to 3:00 pm) and evening (3:00 pm to 11:00 pm) shifts, seven days per week. The BMT's goal is to assist treatment teams with responding to patients with aggressive episodes toward peers or staff, frequent seclusion and/or restraint events, or other challenging behaviors that are not responding to their current treatment plan. The BMT responds as a consulting service to the ward treatment teams' referral requests in the Gage Center of Forensic Excellence and the Civil Center of Excellence. The BMT's purpose is to support improved patient care and increased staff safety. Although the BMT is primarily a consultation service requested by treatment teams, the Centers' executive leadership teams may also refer cases to the BMT. The goal is to provide treatment teams with interventions to decrease the patient's challenging behaviors by working with all members of the treatment team to effectively implement treatment recommendations beneficial for both our patients and staff. The BMT's involvement is intended

to be brief, from two to three weeks to up to three months, depending on the needs of the patient and treatment team.

To receive services, a treatment team member, usually the psychiatric practitioner, completes a referral request, which is reviewed by the BMT Director and triaged with select team members to determine if the BMT can assist, and what resources might be needed. The BMT intake process involves reviewing the referral request, conducting an extensive patient records review, and meeting with the patient and as many members of the referring treatment team as possible. Members of the referring treatment team include the psychiatric practitioner, nurses, clinical members of the treatment team (e.g., psychiatric social worker, psychologist, etc.), and the Mental Health Technicians working directly with the patient. The BMT develops a list of recommendations which may include suggesting medications, adjusting nursing or other care practices, making changes to the ward environment or routine, and behavioral intervention recommendations. The treatment team selects the BMT recommendations they prefer and the BMT collaborates with the treatment team to implement them by working with the patient and the treatment team to adopt the recommendations by providing coaching, modeling, and training. The BMT monitors the treatment team's efforts to utilize the recommended interventions and provides feedback as needed. As the treatment team successfully implements the recommendations, the BMT gradually reduces their support as the treatment team proceeds independently. If the BMT was providing only medication recommendations, the BMT's psychiatrist would work with the treatment team's psychiatric practitioner and pharmacist to adjust the medication regimen and remain available to the treating psychiatric practitioner, as needed. Medication adjustments would be a short-term response, compared to providing a longer course of behavioral interventions for a patient with a complex history of multiple aggressive episodes.

Additionally, the BMT may consult to review diagnoses, make medication recommendations, review behavioral processes that lead to seclusion and restraint (including efforts to first use less restrictive alternatives, review seclusion and restraint paperwork, the debrief process between the team and patient, etc.), review physical health concerns, provide therapeutic consults to ward psychiatric social workers and psychology associates, provide behavioral analysis and interventions, and make additional recommendations to lower ward acuity. The BMT also provides micro-trainings to ward staff and treatment teams on various topics such as milieu management, de-escalation skills, situational awareness, intervention strategies, and patient engagement strategies.

Psychiatric Emergency Response Team (PERT). The PERT teams in the GCFE and the CCE have continued to be a resource in WSH's approach to maintaining patient and staff safety by addressing patients' aggressive and violent behaviors in emergent situations. PERT staff in both Centers consists of 14 team members, working day and evening shifts, seven days per week. Both teams are called upon multiple times per day and they perform a variety of services for treatment teams and patients. One of PERT's primary activities is to provide an immediate response team for incidents on their Center's wards involving agitated and aggressive patients. The PERT members follow the direction of the ward Charge Nurse to either assist with de-escalation of the patient, help the nursing staff manage the other patients on the ward, engage with other patients to prevent behavior escalation, or assist the ward staff with containing the

agitated patient in seclusion or restraint when less restrictive measures have been ineffective in calming the patient and lowering their acuity. PERT responds to medical emergencies for patients and staff on the wards, where they engage the patients to move them from the area of the emergency and to help them remain calm. When the patient is unable to cooperate with ward staff, GCFE PERT helps provide support to patients to assist them with activities of daily living, or ADLs (e.g., showering, shaving, haircuts, etc.), and using skills to assist the patient with completing the task while remaining calm. The CCE PERT assists ward staff by facilitating communication with the patient to encourage them to complete ADLs activities. PERT members in both Centers engage with patients who are experiencing emotional distress, agitation, anxiety, are responding to internal stimulation (e.g., auditory hallucinations), or are disrupting the ward environment, and help the patient return to their baseline calm state. Additionally, PERT supports ward staff when COVID positive patients do not want to participate in COVID protocols, such as isolating in their room. PERT also assists nursing staff with providing court-ordered or emergent medications to patients by helping the patient with being cooperative for their safety and for staff safety. Further, PERT assists wards when the patient receives unwanted or potentially unwelcomed information, such as when a patient's request cannot be met. PERT also goes to wards to meet with patients at their request; as patients develop rapport with PERT members, patients themselves may call PERT to help them with remaining calm.

When not responding to emergent situations on the wards, the PERT members visit their Center's wards to check-in with staff and patients, who they have supported in previous deployments. As ward staff work more closely with PERT, they are being used more preemptively before a behavior crisis develops. As this continues, and expands, it is expected to have a positive impact in reducing patients' aggression/assaultive behavior, along with the need for seclusion and restraint, improving patient and staff safety. It is anticipated that the staffing model used will help further facilitate such outcomes.

STAFFING MODEL

The staffing model created provides support to the BMT's mission of providing consultation to treatment teams in the GCFE and CCE to help reduce patient acuity and provides staff with micro-trainings to improve engagement skills with patients.

The BMT provides micro-trainings to ward staff to help the team decrease patient aggression by improving staff members' skill levels and efficacy in reducing patient violence. These trainings use a trauma informed approach and cover a variety of subjects, including de-escalation skills, use of Crisis Prevention Institute (CPI) and Advanced Crisis Intervention Training (ACIT) strategies for de-escalation and containment, seclusion and restraint procedures, and situational awareness. Fittingly, the CPI training that BMT has provided to staff has helped them remain certified to use this intervention.

Below is the staffing model that facilitates BMT's multi-disciplinary approach to respond to treatment team requests for consultation to support patients experiencing challenging behaviors who are not responding to the treatment plan (See Table 1). The staffing model facilitates the review of diagnosis, medications, nursing interventions related to seclusion and restraint, less restrictive alternatives to seclusion and restraint, physical health concerns, therapeutic services

with the treatment team, and for providing micro-trainings. The BMT Psychiatrist 4 is shared by two psychiatrists. The BMT engages with the patient and provides coaching to the treatment team on effective interventions with the patient. This model includes three teams of Institutional Counselor-3s led by a Therapies Supervisor to work with the referred patient and treatment team providing support seven days a week during day and evening shifts.

Table 1. BMT Staffing Model

BMT	
Position	**FTE**
Program Director	1.0
Administrative Assistant-3	1.0
Psychologist-4	1.0
Psychiatrist-4	1.0
Psychology Associate	4.0
Psychiatric Social Worker-3	1.0
Therapies Supervisor	3.0
Institutional Counselor-3	20.0
Registered Nurse-4	1.0
Registered Nurse-3	4.0
Total	37.0

Additionally, the WSH Civil Center of Excellence continues to utilize Safety Proviso funds (per the HJ2 Violence Reduction Team Step and Section 202 (11) in ESSB 5187) to add the following FTEs (laid out in Table 2), which contribute directly to the safety of patients and staff through their roles:

Table 2. Additional Positions Funded by Safety Proviso

Safety Proviso Funded Positions	
Position	**FTE**
Security Guard-2	8.0
Institutional Counselor-3	7.0
Safety Officer 1	2.0
Facilities Planner 2	3.0
BHA Safety/Risk Administrator	1.0

This staffing model was designed to enhance patient care with patient and staff safety at the forefront. In the next section, patient profiles and types of patients served are discussed in detail.

PATIENT PROFILE

In the interim since last year's report, the BMT has worked with 44 patients, receiving 12 referrals from the Gage Center of Forensic Excellence (GCFE) and 32 from the Civil Center of Excellence (CCE). The BMT has 14 current active consultations, 1 in GCFE and 13 in the CCE, and has closed 30 consultations. As noted in the Background and Intensive Care Model section, the BMT replaced the STAR Program model, which was intended to, and had the maximum

capacity of, treating 10 patients with aggressive/assaultive behaviors, and provided protracted treatment to lower patient acuity in preparation for discharge.

The BMT closed 30 consultations provided for 28 males and 2 females with average consultation time of 126 days, about 3 months and 6 days, with a range of 3 to 64 weeks. By comparison, in last year's report, the BMT had closed 10 consultations with an average consultation period of 137 days. The table below summarizes BMT referrals receiving services, active consultation cases, and consultations closed since the last report.

Table 3. BMT Consultation Summary

2024 BMT Consultation Summary					
Consultations Delivered		**Active Cases**		**Consultations Closed**	
GCFE	CCE	GCFE	CCE	GCFE	CCE
12	32	1	13	14	16
44		14		30	

Types of Patients Served

Consultations received in 2024 were primarily in response to verbal and physical aggression/assault toward peers (Patient-to-Patient) and staff (Patient-to-Staff), ranging from one to as many as five in a month, and repeated episodes of seclusion and restraint. There were 16 patients referred to the BMT from the GCFE, and 14 from the CCE. The most common diagnoses for these referred patients were schizoaffective disorder, one of various substance use disorders, personality disorders, schizophrenia, and a substance induced psychotic disorder. By the time BMT closed their consultation for aggressive/assaultive behavior, the number of assaults were greatly reduced, most often to zero. Similarly, the BMT was able to significantly reduce the time the referred patients spent in seclusion or restraint. Some referred patients had a low number of hours in seclusion or restraint. However, one patient had 352 hours in restraint, which was reduced to 118 hours of restraint. In another case, a patient was continually in restraint, with the highest number of hours being 308 hours. The BMT worked with the patient and staff extensively to help decrease the amount of time in restraint. As they did so, the number of hours in restraint decreased to as low as 41 hours in a month, mainly for transport purposes rather than due to assaultive events. With this same patient, their seclusion hours were as high as 250 hours in a month, and with BMT's intervention, the patient has currently had zero hours of seclusion hours. The BMT continued to work with this patient and when the case was closed, the patient had six hours in restraint and zero hours in seclusion. The BMT is currently working with another patient in near-constant restraint due to aggressive behavior and has been working with the treatment team to engage with the patient so that they have the opportunity remain out of restraint. There have been sizeable reductions in restraint hours. Consultation with the patient and their treatment team continues**.**

Some of the referred patients were receiving monitoring by two staff members around the clock for safety due to assaultive behavior, and in most cases, this was either reduced to 1 monitoring staff or completely discontinued. The BMT continues to provide coaching and modeling to the treatment teams regarding communication with patients and ways to establish and build rapport. The BMT also continues to provide referred patients psychoeducation in emotional

self-regulation, mindfulness techniques, distress tolerance, problem solving, and coping skills for anxiety, stress and frustration. The BMT helped patients become involved in activities on and off their ward, representing a significant improvement in the patient's engagement with treatment.

For the 14 cases that the BMT currently supports, 13 are males. Three of the referrals originated from the GCFE and 11 from the CCE. The average BMT consultation period has lasted approximately 174 days. The primary reason for the referrals was verbal aggression, including threats and intimidation of peers and staff, and physical aggression/assault toward peers (Patient-to-Patient) and staff (Patient-to-Staff), accompanied by repeated episodes of seclusion and restraint. The Patient-to-Patient assaults ranged from one to five assaults in a month and Patient-to-Staff assaults ranged from one to 13 in a month. Efforts to reduce assaults toward patients and staff are ongoing as the consultations are still active, but good progress is generally reported. The most common diagnosis for the referred patients was schizophrenia, followed by a substance use disorder, a personality disorder, schizoaffective disorder, and posttraumatic stress disorder. Restraint and seclusion hours per month varied among the referred patients, but good progress was reported as this is an ongoing consultation target.

The efforts of the BMT have included working with the referred patients to build rapport and trust, identify triggers to stressors and assaults, improve social skills, develop self-regulation skills, use mindfulness strategies, improve coping skills for anxiety, stress and frustration, and manage behavioral health symptoms. The BMT worked with treatment teams to improve engagement with patients, enhance communication skills, and improve situational awareness by modeling and coaching the treatment team staff. Although these 14 cases are active and ongoing, the BMT is showing good progress and leading WSH's treatment teams in improving patient and staff safety. The next section highlights these outcomes along with other outcomes related to patient and staff safety.

OUTCOMES

Tables 4, 5, and 6 report the WSH Civil Center of Excellence (CCE) Patient-to-Patient (Pt Pt) and Patient-to-Staff (Pt St) assault data for the fiscal year (FY) 2023, FY 2024 and for the first two months of FY 2025 (latest available data). They include the number of assaults in each month and the assault rate per 1,000 Patient Days, which allows for standardized comparisons (captured in the columns labeled). In Table 4, the data for FY 2023 shows variation-- although the Patient-to-Patient assaults trended downward, the Patient-to-Staff assaults remained consistent. The cells highlighted green reflect that the assault rate met, or was below, the BHA target. The target represents a goal of a 10% reduction year-over-year. Table 4 also captures Fiscal Year data that allows Fiscal Year comparisons and shows good progress from FY 2021 to FY 2022 and to FY 2023.

Table 4. Civil Center of Excellence, FY 2023, Assaults per 1,000 Patient Days by Month with Prior Fiscal Year Comparisons

FY 2023

Month	Patient to Patient		Patient to Staff	
	#	*Rate*	*#*	*Rate*
July 2022	33	3.44	26	2.71
August 2022	34	3.79	28	3.12
September 2022	42	4.92	28	3.28
October 2022	32	3.69	30	3.46
November 2022	22	2.70	21	2.58
December 2022	31	3.74	24	2.90
January 2023	39	4.82	27	3.34
February 2023	32	4.49	15	2.10
March 2023	25	3.22	33	4.25
April 2023	23	3.14	17	2.32
May 2023	25	3.44	32	4.41
June 2023	23	3.55	22	3.40
2023 FYTD	**361**	**3.75**	**303**	**3.15**
2022 FYTD Comparison	**524**	**4.27**	**395**	**3.22**
2021 FYTD Comparison	**652**	**4.88**	**682**	**5.10**

As indicated in the Table 5 below, in FY 2024 the Patient-to-Patient and Patient-to-Staff assault rates show increases, which reflects the previously discussed impact of the July 2023 Federal court ruling in Trueblood v. DSHS. The earlier discharges of patients from the Gage Center of Forensic Excellence (GCFE) to the CCE resulted in an increase in admissions of individuals who were less psychiatrically stable and more aggressive or assaultive than prior to the ruling. The GCFE is better accommodated to respond to patient aggression in both the physical layout of their wards where all patients have a single room compared to the CCE where most patients have at least one roommate, and the GCFE has more staffing, which allows more staff engagement compared to the CCE. Although the CCE was seeing consistently decreasing trends for both categories of assaults shown in Table 4 and reported as a positive trend in last year's report, the Federal court ruling (that occurred in July 2023) directly contributed to the increase in the assault rates for Patient-to-Patient and Patient-to-Staff nearly doubling throughout FY 2024 when compared to June 2023 and the FY 2023 data trends.

Table 5. Civil Center of Excellence FY 2024 Assaults per 1,000 Patient Days by Month with Prior Fiscal Year Comparisons

Month	Patient to Patient		Patient to Staff	
	#	*Rate*	*#*	*Rate*
July 2023	30	4.60	17	2.60
August 2023	22	3.35	17	2.59
September 2023	21	3.48	20	3.31
October 2023	49	7.56	24	3.70
November 2023	45	7.02	42	6.55
December 2023	44	6.39	44	6.39
January 2024	46	6.60	42	6.03
February 2024	51	7.65	47	7.05
March 2024	48	6.60	43	5.92
April 2024	45	6.34	50	7.04
May 2024	53	7.17	57	7.71
June 2024	47	6.56	47	6.56
2024 FYTD	**501**	**6.15**	**450**	**5.52**
2023 FYTD Comparison	**361**	**3.75**	**303**	**3.15**
2022 FYTD Comparison	**525**	**4.27**	**396**	**3.22**

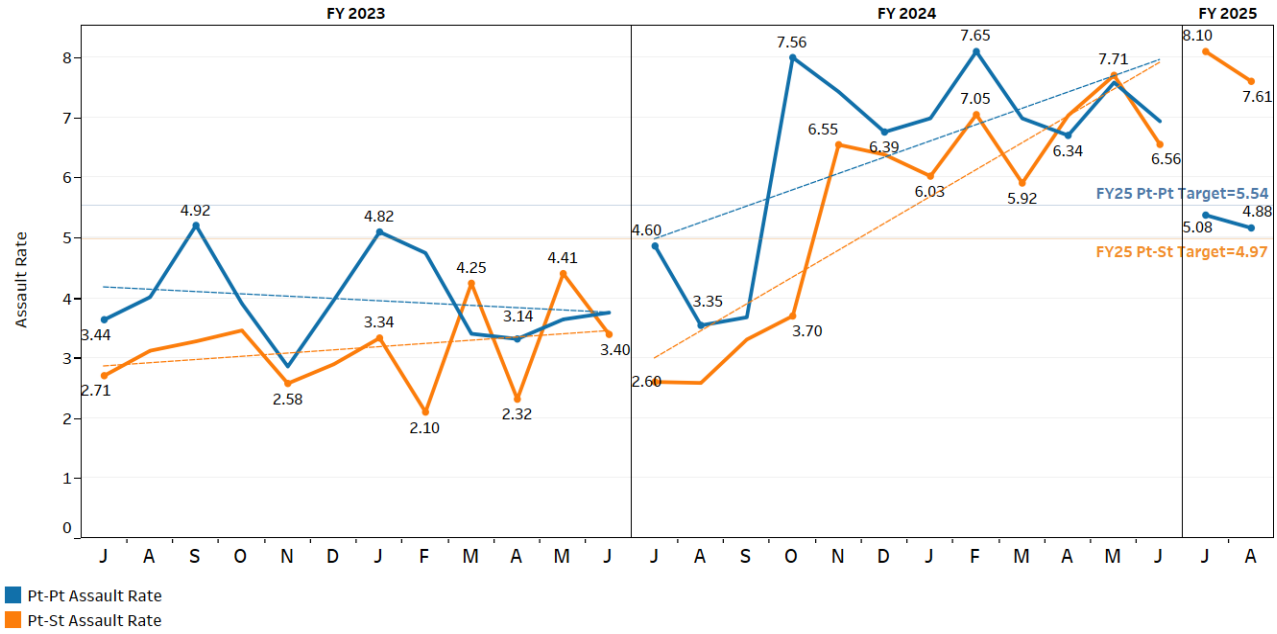
In Table 6, the limited data available for FY 2025 shows a slight downward trend for both Patient-to-Patient and Patient-to-Staff assaults. This is likely due to a combination of factors, including an emphasis within the nursing team to engage with patients and the continued work of the BMT with patients referred for aggressive and assaultive behavior to assist treatment teams in addressing acuity on their wards. The BMT supports efforts in violence reduction, as a primary resource provided to support treatment teams.

Table 6. Civil Center of Excellence FY 2025 Assaults per 1,000 Patient Days by Month with Prior Fiscal Year Comparisons

Month	Patient to Patient		Patient to Staff	
	#	*Rate*	*#*	*Rate*
July 2024	37	5.08	59	8.10
August 2024	34	4.88	53	7.61
2025 FYTD	**71**	**4.98**	**112**	**7.86**
2024 FYTD Comparison	**52**	**3.97**	**34**	**2.60**
2023 FYTD Comparison	**67**	**3.61**	**54**	**2.91**

Figure 1 below graphically reports Patient-to-Patient (Pt-Pt) and Patient-to-Staff (Pt-St) assault trend line data per 1,000 patient days for FY 2023, FY 2024 and FY 2025. During FY 2023, Patient-to-Patient (Pt Pt) assaults trended slightly downward, and Patient-to-Staff (Pt St) assaults experienced a slight upward trend--while both assault rates trended upward in FY 2024. Both assault rates are tentatively trending downward in the early part of FY 2025.

Figure 1. Civil Center of Excellence, Patient-to-Patient & Patient-to-Staff Assault Rates per 1,000 Patient Days, FY2023 – FY 2025



The data in Table 7 below reports Assault-Related Injuries, comparing monthly data for FY 2023, FY 2024 and FY 2025 in the categories of Patient-to-Patient and Patient-to-Staff. Consistent with the reported levels of assaults in FY 2023 showing positive downward trending, the Assault-Related Injuries for Patients and Staff were showing favorable trends with several months meeting BHA targets (reflected by green cell highlights). However, as depicted in FY 2024's data (corresponding with the above noted increase in Patient to Patient and Patient to Staff assaults) injuries also increased and BHA targets were exceeded--shown by red cell highlights below. In the first two months of FY 2025, Assault-Related Patient Injuries are showing a decrease, while Assault-Related Staff Injuries appear unchanged from the prior fiscal year trend.

Table 7. Civil Center of Excellence, FY2023 – FY2025 Assault-Related Injuries per 1,000 Patient Days by Month with Prior Year Comparisons

FY 2023

Month	Assault-Related Patient Injuries		Assault-Related Staff Injuries	
	#	*Rate*	*#*	*Rate*
July 2022	13	1.35	8	0.83
August 2022	16	1.79	3	0.33
September 2022	21	2.46	4	0.47
October 2022	11	1.27	7	0.81
November 2022	7	0.86	8	0.98
December 2022	10	1.21	7	0.85
January 2023	19	2.35	3	0.37

February 2023	22	3.08	5	0.70
March 2023	6	0.77	9	1.16
April 2023	8	1.09	5	0.68
May 2023	6	0.83	6	0.83
June 2023	7	1.08	3	0.46
2023 FYTD	**146**	**1.52**	**68**	**0.71**
2022 FYTD Comparison	**217**	**1.77**	**96**	**0.78**
2021 FYTD Comparison	**243**	**1.82**	**262**	**1.98**

FY 2024

Month	**Assault-Related Patient Injuries**		**Assault-Related Staff Injuries**	
	#	***Rate***	***#***	***Rate***
July 2023	8	1.23	9	1.38
August 2023	7	1.07	10	1.52
September 2023	7	1.16	13	2.15
October 2023	19	2.93	11	1.70
November 2023	10	1.56	17	2.65
December 2023	23	3.34	24	3.48
January 2024	15	2.15	23	3.30
February 2024	14	2.10	21	3.15
March 2024	16	2.20	17	2.34
April 2024	10	1.41	13	1.83
May 2024	12	1.62	30	4.06
June 2024	18	2.51	16	2.23
2024 FYTD	**159**	**1.95**	**204**	**2.50**
2023 FYTD Comparison	**146**	**1.52**	**137**	**1.42**
2022 FYTD Comparison	**217**	**1.77**	**117**	**0.95**

FY 2025

Month	**Assault-Related Patient Injuries**		**Assault-Related Staff Injuries**	
	#	***Rate***	***#***	***Rate***
July 2024	8	1.10	28	3.85
August 2024	8	1.15	21	3.01
2025 FYTD	**16**	**1.12**	**49**	**3.44**
2024 FYTD Comparison	**15**	**1.15**	**19**	**1.45**
2023 FYTD Comparison	**29**	**1.56**	**19**	**1.02**

Figure 2 summarizes Patient-to-Patient (Pt-Pt) Assaults per 1,000 Patient Days by month for FY2023 to FY2025 and shows variability that is consistent with assault data above. During FY 2023, there was a slight downward trend in Patient-to-Patient Assaults, with an increase in FY 2024 and a slight decrease in the early part of FY 2025.

Figure 2. Civil Center Patient to Patient Assaults per 1,000 Patient Days, FY23 – Present

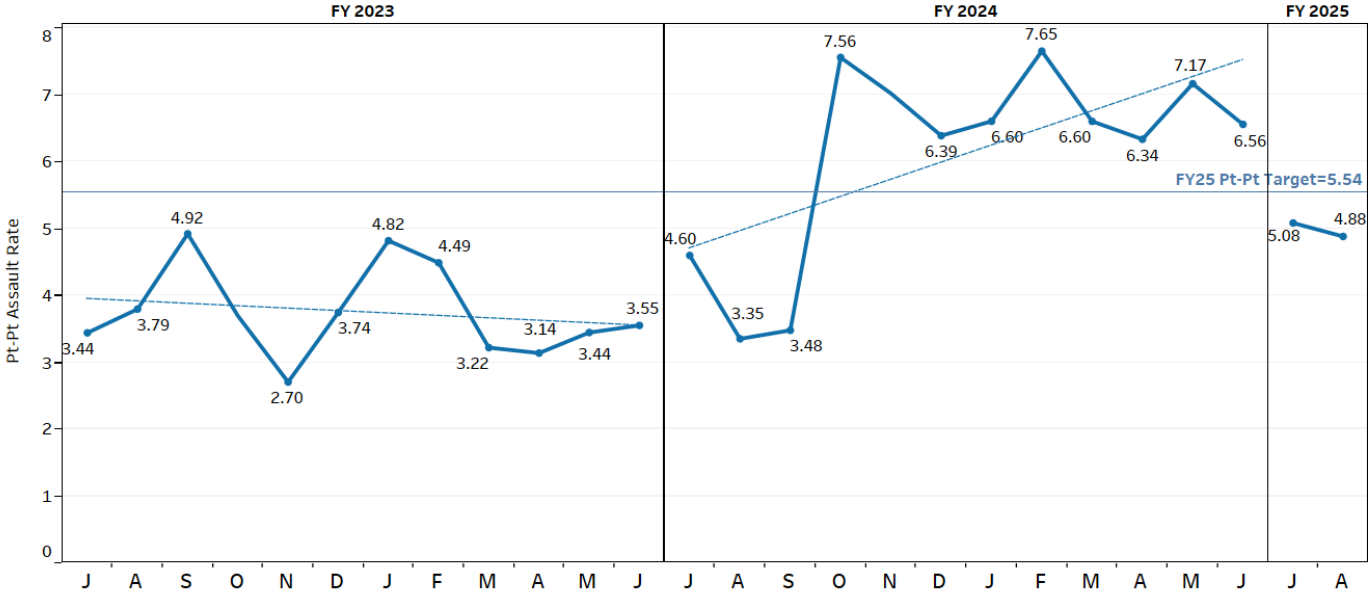


Figure 3 summarizes Patient-to-Staff (Pt-St) Assaults per 1,000 Patient Days by month for FY2023 to FY2025 and shows the variability described in the assault data above. During FY 2023, the Patient-to-Staff Assaults trend was relatively unchanged, but there was a noticeable increase in FY 2024. In the early part of FY 2025, there has been a slight decrease consistent with the above data.

Figure 3. Civil Center, Patient to Staff Assaults per 1,000 Patient Days, FY23 – Present

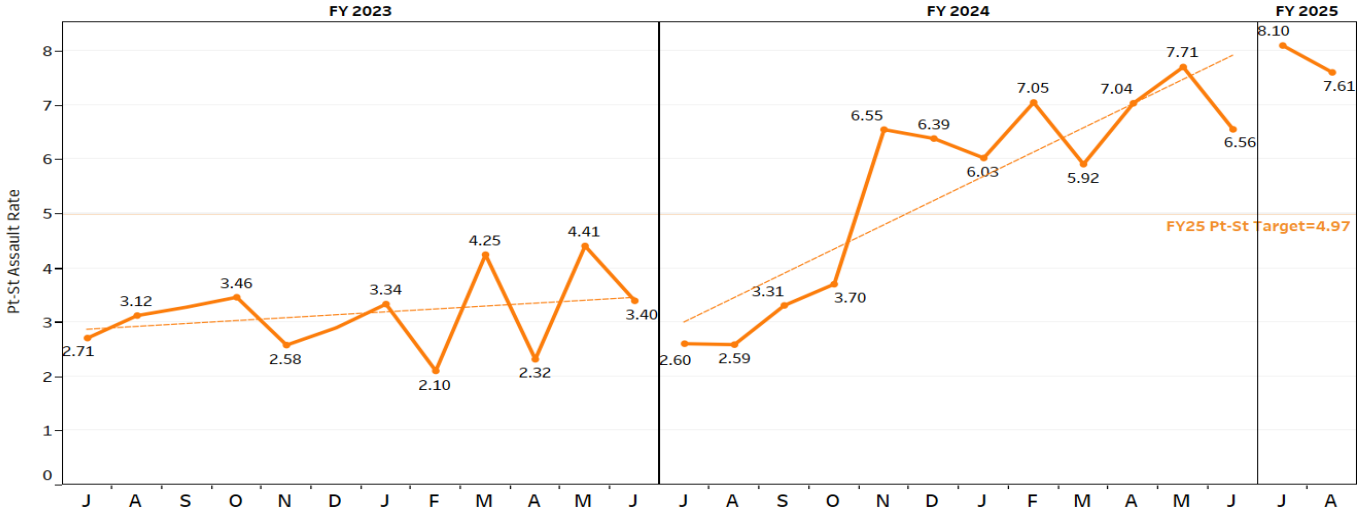


Figure 4 presents Assault-Related Patient Injuries per 1,000 Patient Days by month for FY2023 to FY2025 and shows variability that is consistent with the assault data above.

Figure 4. Civil Center Assault-Related Patient Injuries per 1,000 Patient Days, FY23 – Present

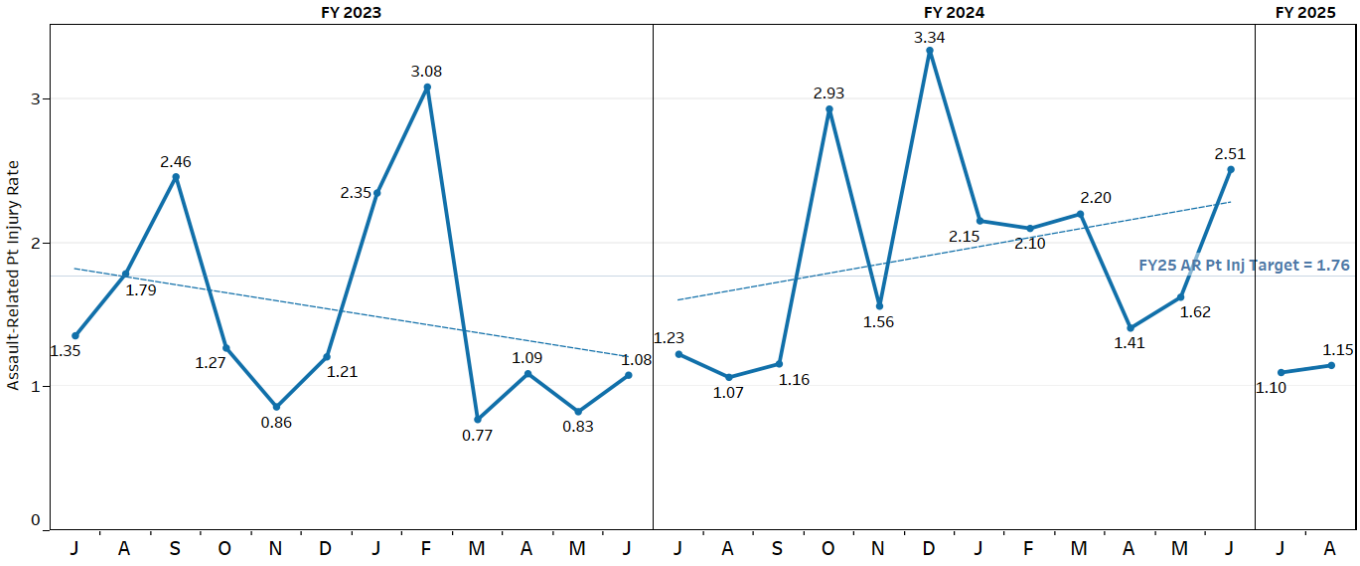
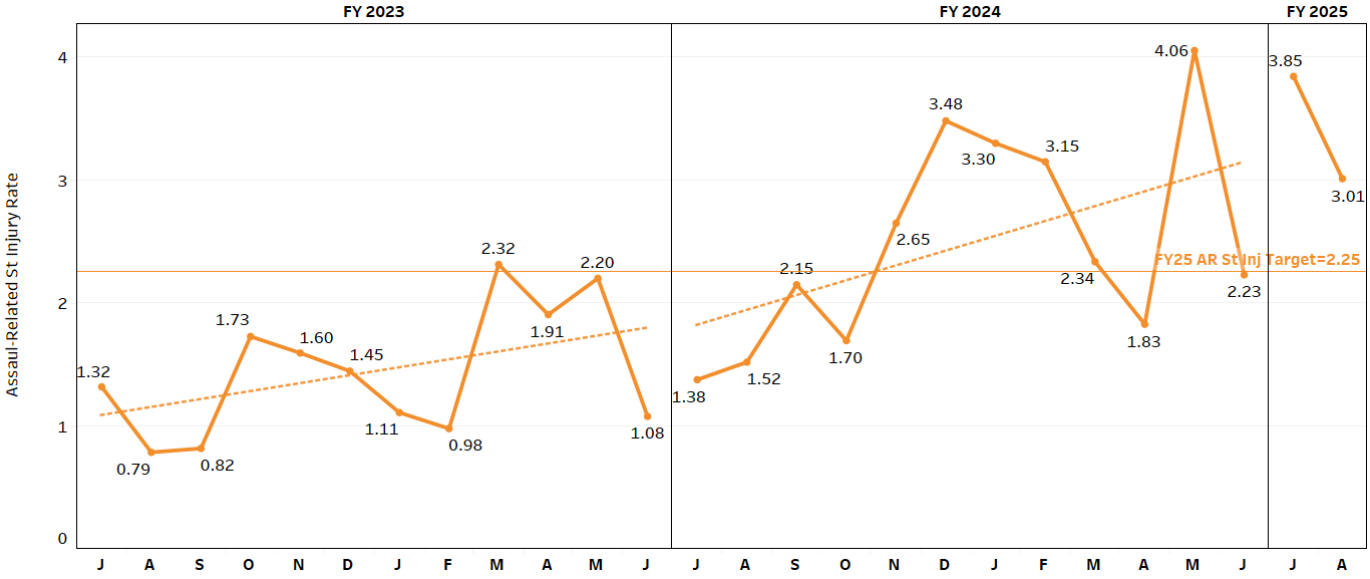


Figure 5 summarizes Assault-Related Staff Injuries per 1,000 Patient Days by month for FY2023-FY2025 and shows an upward trend in FY 2023 and FY 2024, with a downward trend during the early part of FY 2025 for which there is data.

Figure 5. Civil Center Assault-Related Staff Injuries per 1,000 Patient Days, FY23 – Present



The BMT has received kudos from treatment teams in since last year's report thanking them for their assistance and involvement with some particularly challenging patients. The referring treatment teams recognize the contributions of the BMT in helping with patient and staff safety.

FUTURE DIRECTIONS AND SUMMARY

The December 1, 2023, Report to the Legislature, *Improving Patient and Staff Safety in State Hospitals – Status Report* for Western State Hospital's (WSH) Civil Center of Excellence, reviewed the impact of the Trueblood v. DSHS Federal court ruling on the Civil Center of Excellence, which was the likelihood of increased levels of aggression/assaults on our wards. The result of the decision was that the Civil Center of Excellence could no longer admit lower acuity patients from the community and was forced to only admit patients who were transferred from the Gage Center of Forensic Excellence. These admissions occurred sooner than prior to the decision and the patients are consequently less psychiatrically stable with higher levels of acuity and increased aggression/violence. As anticipated (due to the ruling), 2023 saw increased levels of Patient-to-Patient and Patient-to-Staff assaults in the Civil Center of Excellence.

Overall, ward layouts having only single-patient bedrooms and higher levels of staffing assists the Gage Center of Excellence with managing the acuity of patients who are admitted from jails for competency evaluations and restoration services. However, to comply with the Federal court ruling, the patients are transferred to the Civil Center of Excellence while they continue to have a high level of acuity and aggressive/assaultive behavior. Unfortunately, the Civil Center of Excellence does not enjoy the same facility layout and has mostly shared bedrooms, and lower levels of staffing. The ward treatment teams are the primary treatment providers for their ward's patients and are the first line of intervention as individuals who continue to work with these high acuity patients. In addition, the treatment team often calls on the Civil Center of Excellence's Security staff and the Psychiatric Emergency Response Team to help manage psychiatric emergencies as they occur.

As the treatment teams attempt to stabilize their patients, some patients who do not respond in the expected way to their treatment interventions, continue to have high levels of aggressive and assaultive behavior and as a result have frequent episodes of seclusion and restraint. These patients are referred to the Behavior Management Team, which served 44 patients in the past year. Of those patients, 14 continue to receive active BMT support. Being able to close 30 referrals in the past year is a testament to BMT's contribution to reducing the level of patient aggression, assaults, and episodes of seclusion and restraint. During the early part of FY 2025, the rates of Patient-to-Patient and Patient-to-Staff assaults have trended downward, which is attributable to the efforts of the Civil Center of Excellence's treatment teams and those of the BMT.

The BMT in combination with PERT, the ward treatment teams, and other staff services, will continue to provide services to reduce the ward acuity through effectively addressing aggressive and violent patient behaviors. The BMT has continued to improve patient care and staff safety in both the Gage Center of Forensic Excellence and in the Civil Center of Excellence.