



## Annual Report on Activities SFY 2025 Office of Developmental Disabilities Ombuds

The Office of Developmental Disabilities Ombuds advocates for the rights, dignity, and humanity of people with developmental disabilities living in Washington-State.

"The Legislature finds and declares that the prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals." SB 6564 (2016)





Members of the Legislature  
Governor Bob Ferguson  
Angela Ramirez, Department of Social and Health Services  
Bee Rector, Home and Community Living Administration  
Kris Pederson, Developmental Disabilities Community Services

October 31, 2025

The legislature in 2016 created the Office of Developmental Disabilities Ombuds (DD Ombuds) program in response to abusive and neglectful conditions for people with developmental disabilities. In SFY 2025, the DD Ombuds completed another year of complaint resolution, monitoring, outreach and training, and systemic change policy work.

We assist people with developmental disabilities to resolve their complaints and address abuse and neglect, wherever they live in Washington. With 5.5 full-time staff, DD Ombuds reached more than 2,816 people through 124 events to talk about our services, show our videos about DD Ombuds and self-advocacy, and give presentations about rights and responsibilities. We opened 126 new individual complaint investigations this year. We conducted 134 monitoring visits across the state to review facilities, residences, and programs where people with developmental disabilities receive services. As part of our outreach and monitoring, we gave out materials, made observations, and listened.

We analyzed trends and used information gathered to bring attention to issues of concern. We brought those issues forward in meetings with state agencies and through the legislative process. We worked closely with The Developmental Disabilities Community Services (DDCS), formerly Developmental Disabilities Administration, as well as the Residential Care Services (RCS) on systemic change to improve services for people with developmental disabilities.

The DD Ombuds remains focused on systemic change for adults and youth who are stuck in the hospital. We also continue to call for the elimination of the Community Protection Program (CPP) based on the program's failures, including restricting the rights of people enrolled in the program and its continued noncompliance with federal rules.

We had great success this year in reaching people who may not otherwise have access to an advocate and look to find new ways to reach people who have concerns about, or experiences with, abuse and neglect. We will continue to engage in policy work to address the prevention of, and response to, abuse and neglect of people with developmental disabilities.

Thank you for this opportunity to serve and empower people with developmental disabilities.

A handwritten signature in black ink that reads "Betty Schwieterman". The signature is written in a cursive, flowing style.

Betty Schwieterman, Developmental Disabilities Ombuds Director  
Office of Developmental Disabilities Ombuds

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## **Policy Recommendations to the Washington State Legislature, Governor, and State Agencies**

The Legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to monitor and report on services to people with developmental disabilities. The DD Ombuds has the authority to investigate complaints, monitor services, and report on State services utilized by children and adults with developmental disabilities. The DD Ombuds also has the duty to make recommendations for service improvement to State agencies, the Governor, and the Legislature. Policy recommendations from the DD Ombuds are below, followed by a summary of the work of the DD Ombuds for the state fiscal year 2025.

### **Recommendation 1 - Eliminate the Community Protection Program (CPP) and use a person-centered process to ensure people have their needs met with other services.**

**Problem:** CPP is the most restrictive community program administered by Developmental Disabilities Community Services (DDCS). In 2021, the DD Ombuds wrote a report focused on areas of concerns with CPP including: 1. People are referred to the program at a young age before they have access to other supports and services. 2. Individuals must comply with DDCS's CPP strict and sometimes inappropriate recommendations or risk losing access to other services. 3. The path to less restrictive services is unclear and the program has a low graduation rate. 4. The DDCS documents produced at DD Ombuds' request showed lax adherence to policies that protect the rights of people with disabilities. In addition, our report outlines how people in the CPP routinely experience punishment in violation of the prohibition on punishment when using federal Home and Community Based Services funds. As a result of DD Ombuds advocacy, DDCS developed training and policies around the requirements necessary before restricting someone's rights. Unfortunately, we have not found the requirements uniformly enforced. While some people have fewer restrictions, and others have been allowed to graduate from the CPP; the punishment, stigma and isolation persist across the program. Based on these findings, the DD Ombuds recommends the CPP be eliminated.

**Proposal:** DDCS has prepared proposed agency-request legislation to eliminate the Community Protection Program and ensure people have their needs met through the existing waivers. The DD Ombuds agrees with this proposal and recommends that any changes must address the issues identified in the DD Ombuds report "[No Way Out – An Introduction to the Community Protection Program](#)" and ensure that services do not isolate people from the community.

- a. DDCS should collaborate with every person in CPP to create a person-centered service plan to transition them to other services to meet their needs.
- b. DDCS should find and develop resources to meet the needs of young people with developmental disabilities who are identified as having possible "community protection issues," and take other actions to divert them from the restrictive programs like CPP.
- c. DDCS should ensure each person has a clear path to graduation from CPP or other restrictions using a person-centered planning process.

- d. DDCS and their contracted providers must meet all federal, state and policy requirements to guarantee that people are not subjected to unwarranted restrictions of their civil and human rights.

## **Recommendation 2 - Prevent inappropriate hospitalization of children and adults with developmental disabilities.**

**Problem:** Community hospitals continue to be used as crisis placements for children and adults with developmental disabilities across the state. Since July 2018, DD Ombuds has worked with children and adults with developmental disabilities who were, or are, stuck waiting in a hospital without any medical need because Developmental Disabilities Community Services (DDCS) did not provide them with appropriate residential services in the community. The DD Ombuds released two reports about this issue our Youth report, [“I Want to Go Home”](#) in SFY 2023 and our Adult report, [“Stuck in the Hospital”](#) in 2018.

DDCS now collects data on people with developmental disabilities who are taken to the hospital and tracks demographics, the reason why the person was taken to the hospital, where they were living before hospitalization, and why they are stuck there. Tracking includes people of all ages, and people coming out of residential service settings and private homes.

The DD Ombuds continues to prioritize visiting people stuck in hospitals throughout Washington. As part of our advocacy, we look at their files where we find service plans that do not comply with state and federal requirements. We routinely find state-written plans that use abusive language to describe people and contain punishing consequences. While DDCS has new processes in place, the problem persists. Hospitals are not the place to provide residential services for people with developmental disabilities.

### **Proposal:**

- a. To prevent further or extended hospitalization, ensure that people currently waiting for placement are prioritized to receive services, have assessments and person-centered service plans that comply with all state and federal requirements, do not contain demeaning language, and meet the person’s medical and behavioral support needs.
- b. Expand the number and types of specialized providers such as psychologists and behavioral support specialists. DDCS should analyze the number and type of specialized providers needed to meet the current demands for service in each region. Using this data, DDCS should employ or contract directly with specialists who can provide the following services throughout the state: Psychological assessments; Consultation on behavior supports for family caregivers, staff, and medical providers; Behavior supports for people with developmental disabilities living in hospitals; and Specialized habilitation services.
- c. Direct DDCS to identify and remove barriers to utilization of behavioral support, such as in-home consultation, for children and adults who reside with parents.
- d. Fund additional community diversion beds, emergency respite or other bed capacity to meet the current need for crisis services so individuals with developmental disabilities have an appropriate placement available when needed.

- e. Continued increase in funding for complex transition care-coordinators or teams, mobile diversion rapid response, Intensive Habilitation Services, youth peer mentors, provider development, 24-hour personal care and state operated personal care, smaller caseloads, and enhanced support to providers to prevent unnecessary hospitalization and out of state placement.
- f. Follow the recommendations of the Complex Discharge Task Force July 2025 Report.
- g. Ensure behavioral health service providers are trained and equipped to serve youth with developmental disabilities.

**Recommendation 3 - Identify and fix systemic gaps with Washington’s abuse investigations, mortality reviews and END HARM line.**

**Problem:** There are numerous systemic gaps with how the Developmental Disabilities Administration (DDCS) and Residential Care Services (RCS) approach abuse investigations and investigate suspicious deaths. These gaps lead to abuse and neglect investigations being unfairly biased towards service-providers which could cause a lack of accountability that puts disabled people at risk. In SFY 2024 DDCS made significant improvements in their policies concerning reporting and responding to suspicious deaths DD Ombuds will continue to monitor. The DD Ombuds uncovered a major problem with the END HARM abuse reporting line and is meeting with DSHS to resolve the issues.

**Proposal:**

- a. Mandate RCS to create a suspicious death investigation and review protocol and track their reports of suspicious deaths to the coroner or medical examiner.
- b. Review how RCS enforces HCBS and client rights in residential settings.
- c. DDCS must monitor their new Mandatory Reporting requirements for DDCS staff to report suspicious deaths to the medical examiner or the coroner’s offices.
- d. Review how DDCS enforces residential quality standards for contracted providers.
- e. Create and fund increased quality assurance mechanisms for DDCS to use with residential providers.
- f. Ensure the END HARM line is a 24/7 line for reporting abuse of people with developmental disabilities.

**Recommendation 4 – Ensure the promise of “Nothing About Us Without Us.”**

**Problem:** People with developmental disabilities, their services and daily life are affected by decisions that are made by the legislature and workgroups that are created to address disability inequality in our state. In recent years there have been workgroups created that have not included self-advocates and people with lived experience to provide input and feedback.

**Proposal:**

The Nothing About Us, Without Us Act (HB 1541) ensures that people with disabilities are included in any group established by the legislature whose activities are related to people with disabilities. There needs to be funding to ensure agencies can support people and have funds

for the “Lived Experience Compensation” for those who qualify. Ensure that the Office of Equity has the resources to support Nothing About Us, Without Us Act.

**Recommendation 5 – Increase investment in quality community supports and services for children and adults with developmental disabilities to reduce use of crisis services.**

**Problem:** The long-term care system in Washington State is ranked as one of the best in the country. Not so for individuals with developmental disabilities: Washington State ranked 41<sup>st</sup> in the country for fiscal effort for services for people with developmental disabilities according to the 2019 State of the State Report. The staff turnover rate has made modest improvement since 2022 but is still unacceptably high at close to 40% in residential supported living services. The DD Ombuds sees a pattern of both children and adults with identified behavioral supports needs who are unable to access services to stay in their own home or at home with a parent. The DD Ombuds also sees a pattern that people currently in crisis don’t have service plans that meet the minimum requirements to prevent crisis.

**Proposal:**

- a. Increase direct service workers wages in supported living to reduce turnover and increase retention of well-trained staff.
- b. Expand the number of out of home respite services for people living with their families.
- c. Expand the number of State-Operated Living Alternatives (SOLAs) across the state.
- d. Continue focus on the needs of clients DDCS has identified who asked for services but are waiting (no paid services caseload) by increasing availability of waiver services. Restore case management for this group. Identify children and youth on the no paid services caseload, under the age of 21 and on Medicaid and determine if there are unmet needs and whether those can be met under the state Medicaid plan through EPSDT.
- e. Ensure that DDCS and contracted support providers have more training in developing individual and person-centered service plans that meet state and federal requirements to prevent crisis and comply with the Federal Integrated Settings and Access Rules.

**Recommendation 6 -Improve services for youth with developmental disabilities in foster care.**

**Problem:** There are children and youth with developmental disabilities in the Title IV-E foster care system. The DD Ombuds gathered information about how other states serve children with developmental disabilities in foster care in its report “Improving Services for Youth with Intellectual/Developmental Disabilities in Foster Care.” Children and youth in foster care recently gained access to DDCS waiver services. DD Ombuds continues to see problems with access to DDCS services and coordination among agencies.

**Proposal:**

- a. Direct the DDCS and DCYF to evaluate if children and youth with developmental disabilities in foster care are receiving DDCS waiver services as required.

- b. Identify gaps in services, including crisis stabilization services, for these children and report back to the legislature with a plan to improve services for children and youth with developmental disabilities.

**Recommendation 7 - Identify and close gaps in mental health/behavioral health services for children and youth people with developmental disabilities.**

**Problem:** The integration of Medicaid health care and behavioral health care created gaps in mental health services for children and youth with developmental disabilities. This major overhaul of the health care system did not adequately prepare to address the multifaceted needs of people with developmental disabilities.

**Proposal:** Create a behavioral/mental health service system inclusive of children and youth with developmental disabilities.

- a. Support Children & Youth Behavioral Health Work Group generated recommendations regarding proposals to identify and examine current gaps in mental health services for children and adults with developmental disabilities.
- b. Examine and follow recommendations from the WA Developmental Disabilities Council Bridge Forward report Crossing Barriers to Improved IDD and Behavioral Health Systems in Washington [https://cdn.prod.website-files.com/60bd96815ffd0919e385b4ed/68c1d131ddaf70d4f37bbbee\\_Bridge%20Forward%202025\\_Final%20Report\\_V4%20DIGITAL%20\(1\).pdf](https://cdn.prod.website-files.com/60bd96815ffd0919e385b4ed/68c1d131ddaf70d4f37bbbee_Bridge%20Forward%202025_Final%20Report_V4%20DIGITAL%20(1).pdf)
- c. Invest in non-institutional supports and services as opposed to institutional settings.
- d. Ensure funding for recommendations from the Children & Youth Behavioral Health Work Group for improvements to community based services for individuals with developmental disabilities. Link for Workgroup <https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhgw>

Priority recommendations include:

- Mandatory training for WISE to support youth with Autism/IDD
- Maintain state investments in school based Behavioral Health Services
- Expand the RUBI parent provider training program to reach more families with children with Autism and developmental disabilities with co-occurring behavioral health needs.
- Commercial coverage for pediatric Community Health Workers.

# Office of Developmental Disabilities Ombuds Annual Report SFY 2025

## Introduction

In 2016, the Washington State Legislature declared, “The prevalence of the abuse and neglect of individuals with developmental disabilities has become an issue that negatively affects the health and well-being of such individuals.” The legislature created an independent Office of Developmental Disabilities Ombuds (DD Ombuds) to investigate complaints and monitor and report on services for people with developmental disabilities.

## History

The DD Ombuds began its operations across the state of Washington on May 25, 2017. The Washington State Department of Commerce awarded the nonprofit Disability Rights Washington, through competitive bid, the contract to administer DD Ombuds program. Disability Rights Washington created a separate program to fulfill the contract. The DD Ombuds operates under the authority of RCW 43.382.

## Services for People with Developmental Disabilities in Washington State

Developmental Disabilities Community Services (DDCS) is part of Washington State’s Department of Social and Health Services (DSHS). DDCS administers programs for children and adults with developmental disabilities and their families to obtain services and supports based on individual assessments, needs, and preferences. According to DDCS data, there were 68,044 enrolled clients as of June 2025. Of the enrolled clients, 33,033 were receiving paid services. DSHS and other state agencies also administer services to children and adults with developmental disabilities. DD Ombuds has the duty and authority to investigate complaints and monitor and report on these services to resolve complaints and make recommendations to state agencies, the Governor, and the legislature.

## Powers and Duties of DD Ombuds

DD Ombuds has the duty to protect the rights and interests of people with developmental disabilities. DD Ombuds has the authority and duty to carry out the following:

- Provide information on the rights and responsibilities of people receiving DDCS services or other state services and on the procedures for providing these services.
- Investigate, upon its own initiative or upon receipt of a complaint, an issue related to a person with developmental disabilities. However, DD Ombuds may decline to investigate any complaint.
- Monitor procedures as established, implemented, and practiced by the department to carry out its responsibilities in the delivery of services to people with developmental disabilities.
- Review the facilities and procedures of state institutions, state-licensed facilities, and residences which serve persons with developmental disabilities.

- Recommend changes, at least annually, to procedures for addressing the needs of people with developmental disabilities to service providers, the department, and legislators.
- Establish procedures to preserve the confidentiality of records and sensitive information to ensure the identity of any complainant or person with developmental disabilities is protected.
- Maintain independence and authority within the bounds of DD Ombuds duties; and
- Carry out such other activities as determined by contract.
- The legislature added a significant duty in the 2025 session. By November 1, 2028, and in compliance with RCW 43.01.036, the office of the developmental disability ombuds shall submit a report to the appropriate committees of the legislature that includes summaries of resident, parent, and guardian feedback regarding transition of residents out of the Rainier school following the effective date of this section, July 2025

## **Budget and Staffing SFY 2025**

State appropriation: \$797,000

Commerce Administration fee \$39,850

DD Ombuds contract budget: **\$757,150**

**Staffing** - The Office of DD Ombuds operates with 5.5 full-time equivalent staff statewide.

Director - Betty Schwieterman

Region 1 DD Ombuds and Staff Attorney - Lisa Robbe

Region 2 DD Ombuds - Leigh Walters

Region 3 DD Ombuds - Noah Seidel

Self-Advocacy Educator - Tim McCue

Office Assistant – Trang Le

## **DD Ombuds Program Approach**

The 2016 legislature considered a proactive approach to DD Ombuds services. They recognized some people with developmental disabilities are isolated and do not have the resources or support to reach out for assistance. Therefore, DD Ombuds' approach is to provide services and take complaints in person as much as possible. Even in our very advanced technology dependent society, many people with developmental disabilities do not have access to a phone or the internet, or if they do, other people may control their use.

During 2025, DD Ombuds continued in-person visits although at times, had to cancel because of COVID outbreaks. DD Ombuds continues to take complaints by phone and through a website complaint form.

DD Ombuds resolves complaints at the lowest possible level. DD Ombuds protects choice, autonomy, and ensures people with developmental disabilities have access to advocacy. DD Ombuds promotes the well-being of people with developmental disabilities who receive state services. All DD Ombuds services are resident-directed and person-centered. DD Ombuds operates within strict confidentiality protocols.

DD Ombuds provides information on rights and responsibilities through presentations, trainings, community events, videos, social media, and DD Ombuds website at [www.ddombuds.org](http://www.ddombuds.org). DD Ombuds and people with developmental disabilities create these publications, videos, and website content.

DD Ombuds collects information from diverse stakeholders such as self-advocacy groups, parent groups, provider organizations, and others to guide its work. DD Ombuds convenes an advisory committee 5 times a year, with a membership comprised in majority of people with developmental disabilities. The committee meets virtually to review stakeholder input and advise DD Ombuds on priority setting, topics for systemic issue reports, organizational structure to ensure a person-centered, resident-directed program, and program expansion based on the Long-Term Care Ombuds model.

DD Ombuds participates in state-led workgroups and regularly meets with state agencies to exchange information and recommend policy and practice changes to improve services for people with developmental disabilities. The DD Ombuds continues to see increased responsiveness by DDCS to address concerns raised by the DD Ombuds. DD Ombuds recognizes larger culture change at DDCS is necessary to prevent and remedy harm and we support DDCS in this effort.

Each year, the DD Ombuds publishes this annual report on the work of the office, including the types of complaints received and resolved, facilities and residences visited, systemic issues addressed, recommendations formulated and achieved, and outreach and trainings presented.

### **Disability Justice Principles**

DD Ombuds examines our work with disability justice principles in mind. People can experience oppression as a direct result of the DDCS service system. DD Ombuds brings issues to DDCS that highlight that oppression and amplifies a narrative where people with developmental disabilities are free from abuse and neglect and able to live the life of their choosing. When creating work plans and attending meetings with DDCS, disability justice principles inform and guide our work. Here are some examples of those principles:

**Intentional Language** - DD Ombuds uses intentional language that centers individuals with disabilities as the ones who know best. There often is coded language used in oppressive systems and DD Ombuds questions this language when used by people working in the service system to bring them back to person-centered practices and the principle of “nothing about us without us.”

**Intersectionality** - DD Ombuds is mindful of intersectionality framework as we do our work, create our agendas and as discussions occur in meetings. DD Ombuds recognizes that people have multiple identities that make them whole and cannot be separated from the person.

**Leadership of the Most Impacted** - DD Ombuds centers the leadership of people with intellectual and developmental disabilities (I/DD). To do our work, we seek out opinions and listen to individuals with developmental disabilities. People who use services and supports must be involved in creating and evaluating those services.

## **Priorities**

The Washington State Legislature created DD Ombuds because of the high rates of abuse and neglect against people with developmental disabilities. All people have the right to be free from abuse and neglect. DD Ombuds program is a way to have eyes and ears on the ground to collect complaints as well as find and fight abuse against people with developmental disabilities.

DD Ombuds prioritizes issues related to abuse and neglect of individuals with developmental disabilities, including physical and sexual abuse; personal and financial exploitation; physical, mechanical, and chemical restraint; and verbal abuse, neglect, and self-neglect. This includes individuals who are stuck in the hospital, and people in the restrictive Community Protection Program.

## **The Work of DD Ombuds**

### **Information on Rights and Responsibilities**

DD Ombuds has the duty to provide information on the rights and responsibilities of individuals with developmental disabilities, including the right to access DD Ombuds services. Information is provided in a variety of formats and locations across the state.

**1. Training, Education and Outreach** - DD Ombuds reached 2,816 people with information about DD Ombuds services, trainings on topics such as how to navigate the service systems, voting, self-advocacy and problem solving, and responding to abuse, neglect, and sexual assault through presentations and outreach at 124 events.

### **Some examples of events and presentations:**

- DD Ombuds collaborated with Open Doors for Multicultural Families to deliver the Self Advocate Leadership Training (SALT) to multicultural youth with disabilities for the 4th year in a row. SALT youth learned about topics such as personal self-advocacy, voting, and advocating to local leaders on broader issues. The new Self Advocacy Educator at ODMF, a SALT trainee, has now taken over delivering the SALT trainings thanks to the DD Ombuds' guidance.
- DD Ombuds continued Emerging Leaders presentations during the 2025 Legislative Session over Zoom. Emerging Leaders support self-advocates with developing plans for

legislative advocacy, such as providing them with information on the current state of legislation and helping them figure out who their legislators are and how to meet them.

- At the end of the Legislative session, the DD Ombuds supported a group of students who participate in Student First through People First of Washington to come to the capitol building in Olympia. They were able to take a tour of the capital and learn all about the legislative process so they can advocate for disability rights.
- DD Ombuds attended the virtual Community Summit once again, where they supported SAIL, Allies in Advocacy, and People First to present on the work and opportunities within their respective advocacy organizations. The DD Ombuds also hosted a virtual resource table.
- The DD Ombuds was welcomed to present at the Father's Network Conference again and presented on resources that the DD Ombuds office can offer.
- DD Ombuds also participated in several resource fairs including the 2025 Spokane Disability Pride Event in Spokane for the second year in a row, "A Journey to Success- Navigating the DD World" in Yakima, and the Families United Conference in Sunnyside, WA, where members of the DD Ombuds collaborated with a Spanish speaking interpreter familiar with the DD system.

**2. Information and Referral** - DD Ombuds provided 96 detailed self-advocacy support services to people to assist them in resolving their issue. This type of service is more than just providing referrals. Examples of this type of service include providing explanations about and referrals to services, processes for applying for or requesting services including types of DDCS services, the DDCS eligibility process, the types of DDCS service plans, the process for applying for civil legal aid services, and explanation and referral to the complaint resolution unit for abuse and neglect complaints.

**3. Resource Development** – The DD Ombuds developed several updated presentations for this year, such as enhancing Supporting Self Advocacy with a new voting component, reimagining several presentations in the form of interactive activities and quizzes, and a new presentation on healthy relationships to be delivered to individuals with disabilities in transition programs.

DD Ombuds also has resources to inform people with developmental disabilities, their families, service providers, and the community about DD Ombuds and rights and responsibilities. A tri-fold brochure and two videos about DD Ombuds are used in presentations and outreach. One video explains the services of DD Ombuds, and the other covers the importance of self-advocacy. The videos are available on DD Ombuds website in ASL and with subtitles available in English and other languages: Chinese (Simplified and Traditional), Korean, Somali, Spanish, and Vietnamese. The tri-fold brochure is available in 8 languages and Braille. DD Ombuds partnered with People First of Washington to translate and caption 5 videos on client rights in five different languages.

**4. Website and Social Media** – The DD Ombuds website ([ddombuds.org](http://ddombuds.org)) posted 12 posts to the blog on a variety of subjects. DD Ombuds social media has 2.2k followers. For the period of July

1, 2024, to June 30, 2025, the website had 7,630 unique visitors. Those users engaged in a total of 9,470 individual sessions, or individual times they went to the website. Most of the visitors to the website over that period were new to the website, which means they had never visited before, which means that many new people are learning about DD Ombuds office and services.

## Complaints

People with developmental disabilities and who receive services from the state are eligible for services from DD Ombuds. Individuals with developmental disabilities, staff or providers, family members, guardians, or other interested individuals may make a complaint. DD Ombuds keeps the identity of those who make a complaint confidential.

Complaints are generated during in-person monitoring visits to places where people with developmental disabilities receive services and from individuals with developmental disabilities, parents or other family members, community members, or service providers. DD Ombuds receives complaints in person, by phone calls, or through DD Ombuds online complaint form.

DD Ombuds reviews, and may investigate, complaints on behalf of people with developmental disabilities who receive state services. Complaints may relate to abuse, neglect, exploitation, the quality of services, or access to services. Complaints regarding abuse or neglect are prioritized for services.

In response to a complaint, DD Ombuds may take steps to resolve the issue by talking with others involved, monitoring a facility or residence, researching DDCS policies or practices, reviewing records, and interviewing witnesses, or advocating on behalf of an individual or group to resolve a complaint. Only issues where DD Ombuds acted on an individual complaint are listed below. DD Ombuds addresses other issues by providing information or referral services. DD Ombuds uses information gained during complaint investigations to address larger systems issues and advocate for change to improve services and people’s lives.

### Complaints worked on in SFY 2025

Most complaints concerned administration issues (includes discharge/transfer from hospitals and from DSHS-funded residential programs); individual care issues (includes access to DDCS services); autonomy and exercise of rights (includes dignity/respect, guardianship, personal funds); and complaints about abuse, neglect, and exploitation.

<b>SFY 2025 Complaints</b>	
<b>Complaints from SFY 2024 carried over into SYF 2025</b>	39
<b>New complaints opened July 1, 2024, through June 30, 2025</b>	120
<b>Complaints Closed July 1, 2024, through June 30, 2025</b>	123
<b>Number of complaints carried over into SFY 2025</b>	36

This fiscal year DD Ombuds carried over 39 complaints from SFY 2024, responded to 120 new complaints, resolved/closed 123 complaints, and had 36 pending as of July 1, 2025.

## **New Complaints in SFY 2025 concerned people with the following issues**

Note the number of complaints in each issue category does not necessarily correlate to the seriousness of the issue system wide. For example, research shows that abuse and neglect occur at a high rate for people with developmental disabilities and it is underreported.

Most new complaints opened in SFY 2025 concerned discharge/transfer planning; access to DDCS services; autonomy and exercise of rights; and abuse/neglect.

**Abuse, Neglect, Exploitation** - 7 complaints concerning: Physical abuse (3), Neglect (4).

**Access to Information** - 2 complaints concerning: Access own records (1), Access Ombuds (1).

**Autonomy and Exercise of Rights** - 19 complaints concerning: Dignity/Respect (2); Right to Refuse Care/Treatment (3), Care Planning (4); Guardianship (4); Response to Complaints (2) and Other autonomy/exercise of rights (4).

**Individual Care** - 38 complaints concerning: Care plan individual assessment (3); Assistive devices or equipment (3); Mental Health Services (3); Access to DDCS Services (21); Access to other state services (5); and Healthcare (3).

**Restraints and Seclusion** - 2 complaints concerning: Seclusion/isolation (2).

**Quality of Life** - 2 complaints concerning: Active integration into community (1) and Social engagement (1).

**Administration** - 47 complaints concerning: Inappropriate or illegal administration (4); and Discharge/transfer planning (43).

**Staffing** - 1 complaint concerning: Staff training (1)

**Civil/Legal** - 1 complaint concerning: Civil commitment (1)

**Criminal Legal** - 1 complaint concerning: Criminal Justice issues (1)

## **Complaint Data – Summary, Analysis, and Identification of Systemic Issues**

DD Ombuds resolves individual complaints and looks for patterns that may indicate a systemic issue. Categories with the highest number of complaints include:

- **Discharge/Transfer.** The number one type of complaint DD Ombuds assisted with were Administration issues, primarily discharge/transfer. DD Ombuds continues to assist people who were in a hospital and unable to discharge into community services this past fiscal year. DD Ombuds identified this as a significant systemic issue in 2018, published a report, [“Stuck in the Hospital”](#) and made specific recommendations to address this issue. Toward the end of SFY 2022, DD Ombuds received an increase in the number of referrals of both children and adults stuck in the hospital. DD Ombuds researched the issues with children stuck in the hospital and published a report [“I Want To Go Home”](#) in SFY 2023. Although the state has made efforts to address this issue, there continues to be a significant area of concern for people with developmental disabilities and advocacy by the DD Ombuds.

- **Individual Care.** Most of the individual care complaints were about access to DDCS services. DD Ombuds has identified access to behavioral supports, access to mental health care, need for increased waiver funding for clients waiting for service, the wait times for assessments and the simplification and timeliness of the eligibility process as systemic issues to be addressed.
- **Abuse/neglect.** DD Ombuds assisted people who had complaints about abuse, neglect, or exploitation. The DD Ombuds works with the person to explain their rights and ways to complain. Often people want to complain but do not know how or where to complain. Sometimes people are afraid to complain for fear of retaliation. DD Ombuds identifies gaps or problems in the abuse response system and advocates for systemic improvements.
- **Autonomy and exercise of rights, which includes dignity and respect.** DD Ombuds helped individuals and their families' problem solve with their service providers and their case managers to address these issues. DD Ombuds identified Preference, Rights, and Choice as issues to address systemically. Many of these issues happen to people in the Community Protection Program. DD Ombuds has worked with many people who are in this restrictive program and do not have a copy of their program plan or know what they need to do to graduate. This continues to be a significant area of advocacy.

## **Complaint Resolution - Examples of assistance provided in SFY 2025**

**1. Summary of complaint:** The DD Ombuds received a complaint about a person who is in the Community Protection Program. They wanted information about their restrictions, goals and graduation requirements. Even after many years of focus on the CPP, people in the program still do not have their plans or information about what they need to do to graduate.

**Outcome:** The DD Ombuds met with the person and helped them request a copy of their Community Protection guidelines and graduation goals. After the person received this information, we set up a meeting with their Case Manager and Counselor to review the restrictions and goals. The person was able to have reductions in their restrictions and now understand their graduation goals.

**2. Summary of complaint:** The DD Ombuds received a complaint from a person who was now stuck at a Skilled Nursing Facility after having been stuck in a hospital for months. Their supported living service provider terminated services while they were in the hospital. No other supported living provider would agree to serve them so they could not return to their home. They had to discharge to the first Skilled Nursing Facility who would accept them. Unfortunately, they were discharged without their motorized wheelchair or a shower chair, making it difficult to stay clean or to move independently. When the DD Ombuds began an investigation, the person hadn't taken a shower in months or had the equipment needed to get out of bed and move about as they had previously. They stopped talking and joking with family members. Numerous state employees and contractors were aware of the lack of care and missing personal items but did not take the necessary steps to recover the items or report the abuse and neglect as they are required to do.

**Outcome:** The DD Ombuds raised this concern to the DD system leadership, but no one acknowledged the obvious failure to report neglect or any wrongdoing. When the regulators were finally alerted, no citation was issued to the provider, nor were any abuse or neglect findings substantiated by APS. Family members ultimately found the wheelchair in different Skilled Nursing Facility - where it had been sitting for over 6 months. The DD Ombuds stayed involved and the person found a new service provider and home where they can use their chair independently and visit and joke with family members regularly.

**3. Summary of complaint:** The DD Ombuds received a complaint from a person who said that almost every time their DD Case Manager visited their home, the case manager told them what to do and made them uncomfortable. They wanted to learn how to get a different Case Manager. They had already asked the DD system supervisor if they could change case managers and the supervisor said no.

**Outcome:** The DD Ombuds asked for a meeting with the supervisor to learn the reason behind the decision not to honor the request to change case managers. We discussed the necessity of building trust and developing relationships with people they serve to be effective as case managers. The DD system supervisor went with the case manager on their next visit to observe the interactions. As a result, they decided to change case managers. This decision resolved the person's concerns.

**4. Summary of complaint:** The DD Ombuds received a complaint about a person who was a legal resident, with non-citizen status who needed personal care and other state services. The person and their family asked for support to understand what services are available and how to apply for services.

**Outcome:** The DD Ombuds met with the family and helped them receive information in both English and Spanish. The DD Ombuds helped them understand the Health Care Authority and Developmental Disability Community Services eligibility process. The person was eligible for the Health Care Authority A-01 program. Once the person was deemed eligible the DD Ombuds ensured they were connected to a Case Resource Manager, and they understood what services they could receive.

**5. Summary of complaint:** The DD Ombuds received a complaint from a person who was in jail wanting to receive community residential services when they were released.

**Outcome:** The DD Ombuds spoke with the person about their past residential services and why they did not work for the person which led to incidents leading to their arrest. The DD Ombuds worked with DDCS staff about the concerns we had about the person waiting to receive services in the community and how to best support them once they were released from jail. Once the person was released, they met with providers and found a provider where they are currently living.

**6. Summary of complaint:** The DD Ombuds received a complaint about a person who was living in an Adult Family Home without 1-1 support, and they were falling and needing a higher level of support with their activities of daily living.

**Outcome:** The DD Ombuds met with the person, family, AFH Provider, and DDCS staff to find out if they can receive a higher level of support or a different residential setting. When a higher level of support through a Supported Living provider was not found. A different service, Intensive Behavioral Supportive Supervision (IBSS), was applied for and received so now the person is able to stay at their current placement and the home was able to hire staff to better support the person.

## Monitoring

DD Ombuds made 134 in-person monitoring visits across the state in SFY 2025 to talk with individuals with developmental disabilities and review facilities, residences, and programs. Monitoring visits accomplished several purposes. People who receive services, their families, their staff, and provider administrations receive information about DD Ombuds. DD Ombuds provides materials such as refrigerator magnets, door hangers, and coasters that have information about DD Ombuds and client rights. DD Ombuds observes living conditions and staff interactions and responsiveness to the residents they support. DD Ombuds also received complaints, initiated complaints, and identified locations for follow-up monitoring.

**DD Ombuds made 134 visits in person to the following facilities, residences, and programs:**

Certified Residential Services Settings	Number of visits
Supported Living	30
Supported Living Community Protection Program (CPP)	26
State Supported Living - SOLA	6
Group Training Home	1
<b>Total Visits</b>	<b>63</b>

Licensed Residential Settings	Number of visits
Adult Family Homes	11
Assisted Living Facilities	4
DD Group Home	2
Nursing Home	4
<b>Total Visits</b>	<b>21</b>

State Residential Habilitation Centers	Number of visits
Fircrest Intermediate Care Facility ICF	7
Fircrest NF	3

Lakeland ICF	11
Lakeland NF	5
Rainier	8
Yakima NF	5
<b>Total visits to cottages or programs</b>	<b>39</b>

<b>Hospitals and Community Psychiatric Facilities</b>	<b>Number of visits</b>
Adult Community Psychiatric	1
Eastern State Psychiatric Hospital	3
Western State Psychiatric Hospital	1
General Hospital	1
<b>Total visits</b>	<b>6</b>

<b>Youth Transitional Facility</b>	<b>Number of visits</b>
Lake Burien	4
<b>Total visits</b>	<b>4</b>

<b>Parent or Own Home</b>	
Parent Home	1
<b>Total visits</b>	<b>1</b>

## Systemic Change Outcomes

DD Ombuds identified numerous systemic issues through monitoring visits and complaints, and recommended system improvements. As a result, the following policies, procedures, or practices were changed.

### 1. Eliminate the harm caused by DDCS's Community Protection Program (CPP).

**Problem:** The Community Protection Program has resulted in segregation, prolonged hospitalization, and denial of community living for some people. DDCS has often not followed eligibility criteria which resulted in people getting swept into the program. Although against the federal Home and Community Based Services rules, many people in DDCS's Community Protection Program have been isolated for decades with their most basic human rights restricted. Many people in the program complain of having "no way out."

**Outcome:** Even though more people are graduating from the CPP as a result of the DD Ombuds advocacy, the program still does not follow federal rules. The DD Ombuds has long called for the elimination of the CPP and for DDCS to guarantee that the people in it do not lose services as a result. DDCS committed to agency request legislation to eliminate the CPP which was introduced in the 2025 session. The bill made great progress but stalled at the end of the session. DDCS has committed to again ask for the legislature to rescind the Community Protection Program and ensure that people in it don't lose necessary services.

Like last year, the DD Ombuds attended dozens of Community Protection Quarterly Treatment Team Meetings informing people that the federal Home and Community Based Services rules prevent blanket restrictions of human rights. While there are more DDCS employees and contractors who know about those rules, we still come across many who do not. DD Ombuds will continue advocacy in this area.

## **2. Improve services for children and youth with developmental disabilities and behavioral health needs.**

**Problem:** Children and youth with developmental disabilities have difficulty accessing behavioral support services which has led to hospitalization, institutional care, and youth being sent to out of state facilities. Outcomes for Youth in state run facilities have been poor.

**Outcome:** DD Ombuds visits state run facilities to build relationships with youth and their guardians. DD Ombuds participated in the Children and Youth Behavioral Health Workgroup. Within the group the DD Ombuds shared concerns about youth going to institutional setting and lack of access to community based services for youth with developmental disabilities and collaborated with other members of the group to work on solutions. New legislation and policy changes were created based on the recommendations of the workgroup.

## **3. Identify and fix systemic gaps with Washington's abuse investigations and mortality reviews. Problems: Mortality Reviews; the END HARM line; RCS Lack of Enforcement**

### **3a. Mortality Reviews**

**Problem:** In SFY 2024, The DD Ombuds uncovered numerous systemic gaps with how suspicious deaths are reported and investigated by the Developmental Disabilities Administration (DDCS) and Residential Care Services (RCS). These gaps lead to suspicious deaths not being reported and abuse/neglect investigations being unfairly biased towards service-providers. This lack of accountability could put disabled people at-risk for increased abuse and neglect.

**Outcome:** The DD Ombuds advocated for DDCS and RCS to change their policies so that they would not be biased towards service-providers and clarified the definition of suspicious death. In response to the DD Ombuds criticisms, DDCS made significant changes to their policies related to suspicious deaths, and abuse and neglect. The DD Ombuds are still in conversation with RCS about what they can do to improve how they respond to suspicious deaths.

### **3b. END HARM Line**

**Problem:** There is a toll-free phone number established by DSHS and the then Children's administration to have one place for the community to report to a live person 24/7 abuse of

children or vulnerable adults (seniors and people with disabilities in facilities, people with developmental disabilities.) The DD Ombuds assisted someone with making a call to the END HARM line and discovered it was very confusing and shuffled the caller to a line that was not answered by a live person. The instructions also referred the caller to a website URL.

**Outcome:** The DD Ombuds raised this issue with DDCs, RCS and HCLA. At first people were sure the line was a resource for people to report abuse of vulnerable adults – until they called the line themselves. All agreed the line needed to change and we learned DCYF oversaw its operation. HCLA arranged for a meeting with DCYF. The initial meeting was to outline the problem. Since it was decided it was a multi administration issue, there is a need to take it higher up in the agencies. DDCS changed its website and materials concerning END HARM line, so they are accurate. The END HARM line is still not a good resource for reporting vulnerable adult abuse 24/7. We will continue to work on this issue.

### **3c. Residential Care Services Lack of Enforcement**

**Problem:** Recently, DSHS and a DDCS certified residential provider settled a lawsuit alleging that a person was abused and neglected while in their care. The settlement was reportedly 9 million dollars. During the period the person was receiving residential care, there were numerous complaints filed and resulting investigations. However, only one citation was issued by RCS, the DSHS agency responsible for rule enforcement, and it was unrelated to the issues raised in the lawsuit. The DD Ombuds has long-standing concerns about the failures of RCS to enforce client rights and HCBS rules. If the agency responsible for rule enforcement found no failed provider practices, yet DSHS settled the lawsuit concerning abuse and neglect, this highlights a significant gap in rule enforcement and puts people at further risk of harm.

**Outcome:** We continue to monitor RCS's response to complaints and enforcement of rules. The recent reorganization at DSHS has presented challenges with monitoring and communication.

### **4. Educate DDCS about the harm that stems from DDCS's assessment and advocate for reforms.**

**Problem:** The DD Ombuds continues to report that DDCS's assessment requires everyone to be assessed using harmful terms and subjective language. The assessment requires DDCS Case Managers to ask people questions about their *attention-seeking, over-reactive, obsessive, and uncooperative* behavior. These terms are subjective. DDCS assesses tens of thousands of people who need DDCS services using this judgmental framework. Using this language to describe people with developmental disabilities is damaging to their credibility. Their staff, and even emergency responders are told not to believe the people who are most at risk for abuse and neglect. This, of course, increases the likelihood they will experience abuse and neglect.

When speaking to the DD Ombuds, DDCS agrees that the assessment uses harmful and subjective language. However, DDCS has denied there are any concerns with the assessment in their communications to CMS in waiver amendments and renewals.

**Outcome:** To alert DSHS employees of the scope of the name calling and harm, the DD Ombuds created a presentation titled *Sticks and Stones: Names Can Really Hurt Me*. This presentation was delivered multiple times to RCS, DDCS HQ, and DSHS regional personnel in SFY24 with the

hope of educating them on the harmful language found in DDCS's assessments and plans, as well as the pervasive practice of labeling people who report abuse as "making false allegations." The DD Ombuds discusses how the definition of mental abuse includes name calling and making threats. We recommend instead of name-calling, the first step in preventing abuse and neglect is to believe people when they report it.

Since those presentations, in SFY 2025 the DD Ombuds received feedback from DSHS employees on the impact of those presentations. Some DDCS employees said they were "shocked" that DDCS plans and assessments contain this language, reporting that they don't typically read them. While some DDCS leaders said they are going to "root" out this language in DDCS plans, we are not aware of any actual efforts to that end. The DD Ombuds has attended assessment meetings in each region and alerts DDCS employees of the harmful language so it can be acknowledged and corrected. We continue to monitor this problem.

### **5. Improve education about Supported Decision Making**

**Problem:** Washington State enacted Supported Decision Making, but it is not widely known and was not discussed in the DDCS Guardianship report.

**Outcome:** The DD Ombuds has presented on Supported Decision Making and is working with DDCS, the Developmental Disabilities Council and Advocates about how to expand the use of Supported Decision Making. The DD Ombuds worked with self-advocacy groups to develop a Supported Decision Making training that has been given to DDCS providers, parents, and other self-advocates. The DD Ombuds will continue to advocate for access to this service.

### **6. Monitor DDCS's implementation of Home and Community Based Settings (HCBS) Rule**

**Problem:** In FY23 the DD Ombuds highlighted the failure of DDCS to implement the HCBS settings rule and monitored DDCS as they rolled out new policies and training for their staff and providers. In FY24 and FY25 we have continued to monitor DDCS's implementation of these critical safeguards. The DD Ombuds continues to hear concerns from people receiving DDCS services about DDCS's employees and service providers who are exerting control over people's lives in violation of the HCBS rule.

The DD Ombuds continued to ask DDCS leadership to take more action to prevent this type of treatment. DDCS has thousands of contracted providers all over Washington who sign contracts agreeing to uphold DDCS client rights and follow state and federal law. However, as we've reported, some practices violate federal law and DDCS client rights.

**Outcome:** DD Ombuds alerted CMS to unauthorized restrictions in HCBS settings, particularly in the Community Protection Program in FY23. CMS visited Washington DSHS to review health and welfare concerns in September 2023 and issued a findings letter in March of 2024. CMS agreed with the DD Ombuds reporting that "Some goals to graduate from the program are unfair and unrealistic, for example no sexual thoughts, no cussing and no aggression." In FY25, DDCS added a section to their annual assessment to document answers to eight specific questions required by HCBS rule to prevent unfair and unrealistic goals that restrict people's basic rights. We believe this action has prevented some unauthorized restrictions, but more

oversight is needed. The DD Ombuds will continue to highlight HCBS violations in the CPP and other DDCS programs.

In FY24 new policies went into effect to train providers and case managers in these important rules and yet in FY25 we routinely find providers and case managers who are not aware of these rules. DDCS HQ indicated they would put more focus on contract compliance and enforcement regarding HCBS settings rules. We have yet to see this occur.

#### **7. Advocate for improvements to the Positive Behavior Supports Plan Processes.**

**Problem:** The DD Ombuds continues to highlight problems with DDCS's oversight and development of functional behavior assessment and Positive Behavior Support Plans and alert DDCS to problematic PBSP's that contain threats and punishment.

**Outcome:** There has been some re-organization of the clinical teams, the clinical psychologist has retired, DDCS implemented new training for PBSP plan writers. DD Ombuds continues to have concerns about the quality of PBSPs.

#### **8. Increase self-advocate involvement in DDCS policies and practices through the DDCS Self Advocacy Committees**

**Problem:** DDCS needs more involvement from self advocates to receive feedback and involve self advocates to shape policy.

**Outcome:** DD Ombuds staff participate in the DDCS HQ Self Advocacy Advisory Committee meetings to provide information and support others to have their voices heard.

#### **9. Create lived experience representation in meetings**

**Problem:** People with direct lived experience have been left out or could not participate in government-created workgroups that affect their lives.

**Outcome:** DD Ombuds helped with the implementation of the "Nothing about Us Without Us" Act. The DD Ombuds also provided input on how the Developmental Disabilities Council is compensating its members with lived experience. The DD Ombuds have shared opportunities for people to join workgroups, and helped people learn what they would need to do in workgroups.

#### **10. Protect the DD Ombuds' access to information for complaint investigations**

**Problem:** The DD Ombuds conducts investigations during the complaint process. In order for the investigation to proceed, DDCS must respond to the requests for information. Although required by statute, DDCS has long been inconsistent in completing their duty to respond to the DD Ombuds. Often, multiple emails are sent to remind DDCS to respond or inform them they sent the wrong documents. These delays waste our limited resources. The barriers in place by DDCS restrict our access to information in their possession and prevent us from completing our duties.

**Outcome:** DDCS agreed to make procedural changes in how they respond to our requests. In February 2024 we proposed a new version of DDCS's management bulletin with procedures and timelines for responding to our office which was implemented in early 2025. However,

gaining access to the information we need from DDCS continues to be an area of difficulty. We are exploring additional options to maintain our independence from the service system and complete our statutory duties.

### **11. Monitor Critical Case Protocol implementation and advocate for improvements**

**Problem:** DDCS clients were having their residential services terminated and being taken to general hospitals or other less supportive environments while new placements were sought. DDCS created a new policy, the Critical Case Protocol (CCCP), as a way to prevent hospitalizations and have people stay with their current supported living provider. However, instead of problem-solving so the person can maintain their placement, some providers appear to be using the process as a discharge plan

**Outcome:** DD Ombuds provided recommendations to DDCS on how to create person-centered meetings for people with developmental disabilities to give input on their services, what would help them be successful, and how they can best be served. DD Ombuds continues to monitor this process and bring concerns to DDCS when providers use the process to terminate services.

## **DD Ombuds comments on Washington Administrative Code (WACs)**

### **Developmental Disabilities Administration Service Rules**

The DD Ombuds reviewed proposed rules for the new Youth Transitional Care Facility at Lake Burien (WAC 388-843) as well as the new proposed rules for the civil transition program (WAC 388-848.) Similar to DD Ombuds comments on rules proposed last year, we recommend that DDCS continue to reduce provider-centric language, develop rules using plain language, and focus on the humanity of people who need DDCS services.

Additionally, throughout FY25, DDCS has been in the process of making changes to the 388-101D WACs. These are the WACs that govern the requirements for residential service providers. The DD Ombuds has been requesting DDCS to collaborate with our office on the numerous problems with these rules, but they have refused. Recently we discovered that DDCS filed a CR 101 but again failed to notify the public that the rule development process had begun. We alerted DDCS of the failure and they withdrew the CR 101. We will continue to monitor the rule development process and continue to request that the DD system involve our office so they can be alerted to problematic rules that lead to abuse and neglect of people with developmental disabilities.

### **DD Ombuds comments on Home and Community Based Services Waiver Amendments**

The DD Ombuds provided comment on the HCBS Waiver Amendments proposed in September 2024. Unfortunately, DDCS did not provide the notice to the public as required. We asked DDCS to extend the comment deadline and they agreed. However, they failed to acknowledge their errors and instead blamed the public for being uninformed.

The DD Ombuds comments provided on the HCBS Waiver Amendments, centered on DDCS's official responses to previous concerns that illustrate a pervasive organizational culture of

denying problems and blaming others instead of taking responsibility themselves. DDCS continues to ignore and deny obvious concerns about how people are treated in the DD system.

Also, in the waiver amendments we opposed the creation of a new service proposed for all waivers called “sexual health therapy”. Unlike actual sexual health therapy, DDCS had proposed that this service be delivered only by Sex Offender Treatment Providers and defined the service implying that the people needing it had committed a crime. CMS agreed with our office and denied the addition of that service in the amendment. After this denial, the HCA agreed with our office that anyone who needs therapy to address sexual health needs should be able to access that therapy through the state plan like everyone else, rather than requiring people with DD to get their needs met through a specialized service that labels them as deviant.

## **Legislative recommendations and outcomes (SFY 2025)**

One of the DD Ombuds duties is to make recommendations to the Washington State legislature. Each year the DD Ombuds reviews proposed legislation and weighs in on the issues important to people with developmental disabilities.

### **HB 1272-Extending the program to address complex cases of children in crisis.**

The DD Ombuds testified in support of the bill. The bill passed. The bill extends the child and youth multisystem care project director and other related programs to address complex cases of children in crisis are extended until June 30, 2027 (instead of expiring on June 30, 2025).

### **SB 5680 - Establishing a right to repair for mobility equipment for persons with physical disabilities.**

The DD Ombuds testified in support of the bill. The bill passed. Establishes the right to repair for mobility devices. It also provides for enforcement by the attorney general pursuant to the Consumer Protection Act.

### **SB 5393 - Closing the Rainier school by June 30, 2027.**

The DD Ombuds testified in support of the bill. The bill passed. This bill creates a structured closing of Rainier School, one of four Residential Habilitation Centers (RHCs) in Washington. By November 1, 2028, the Office of the Developmental Disability Ombuds (ODDO) will submit a report to the Legislature that includes summaries of resident, parent, and guardian feedback about the transition of residents out of the Rainier School.

### **SB 5253 - Extending special education services to students with disabilities until the end of the school year in which the student turns 22.**

The DD Ombuds testified in support of the bill. The bill passed. Special education and related services for students with disabilities must be provided to the end of the school year in which a student with disabilities turns 22, or high school graduation, whichever occurs first.

### **HB 1130 - Concerning utilization of developmental disabilities waivers.**

The DD Ombuds testified in support of the bill. The bill passed. The bill requires the Developmental Disabilities Administration (now DDCS) to prioritize certain populations when enrolling clients on home and community-based services waivers and for specific services.

**HB 1390 - Repealing the community protection program.**

The DD Ombuds testified in support of the bill. The bill did not pass. Eliminates the Community Protection Program (CPP) and removes references to the CPP from statute effective January 1, 2026. Requires the Developmental Disabilities Administration to develop and implement a plan to transition all individuals participating in the CPP into other services or programs by December 31, 2025. The DD Ombuds have reports about concerns with the Community Protection Program (<https://ddombuds.org/wp-content/uploads/2022/07/No-Way-Out-Short-Version-6-13-22.pdf>)

**HB 1493 -Concerning the age at which clients of the developmental disabilities administration may receive employment and community inclusion services.**

The DD Ombuds testified in support of the bill. The bill did not pass. The bill would have required the Developmental Disabilities Community Services (DDCS) to change the age of eligibility to receive employment and community inclusion services from age 21 to age 19.

**HB 1395- Streamlining the home care worker background check process.**

The DD Ombuds testified “other” on the bill. The bill passed. The DD Ombuds worked with the prime sponsor and other interested parties to express our concerns and work on changes to the bill language. The bill provides conditions under which an employer may not conduct a character, competence, and sustainability review for long-term care providers. Also, before an IP starts providing new services for a new managing employer when the last fingerprint on the authorized entity's file for the IP is five years old or more and the new managing employer may request a fingerprint-based background check. Clients who have elected to receive services from an IP must be notified of the IP's background check results and the client's right to request a copy of the background check's results

**SB 5394- Reducing the developmental disabilities administration's no-paid services caseload services.**

The DD Ombuds testified in opposition to the bill. The bill passed. The bill authorizes the Department of Social and Health Services Developmental Disabilities Community Services (DDCS) to provide limited case resource management services for clients on the No-Paid Services caseload. Specifies that inactive DDCS clients on the No-Paid Services caseload may not receive case resource management services.

**SB 5654/HB 1795 Addressing restraint or isolation of students in public schools and educational programs.**

The DD Ombuds signed in support of the bill. The bill did not pass. The bill would have: created limits to restraint and isolation of students, including by prohibiting chemical and mechanical restraint; modified requirements for incident notification, incident review, incident reporting, behavioral intervention planning, and policies and procedures; added staff and governing body

training requirements; established state compliance monitoring and support, including, subject to appropriation, trainings and coaching services; and required multiple reports from agencies to the Legislature.

### **HB 1200/ SB 5211- Authorizing payment for parental caregivers of minor children with developmental disabilities**

The DD Ombuds signed in support of the bill. The bill did not pass. The bill would require the Department of Social and Health Services to submit a request to amend applicable home and community-based services waivers to allow parents to receive payment for providing extraordinary personal care services.

**Budget Bills** - DD Ombuds testified on the state budget advocating for more funding for DD services in the community. DD Ombuds focused on caseload growth, caseload reduction for DDCS Case Resource Managers, funding for community capacity to transition clients out of residential habilitation centers to community settings, community supports for children and families caring for children, and youth with significant behavioral challenges, and Residential Crisis Stabilization Programs.

## **DD Ombuds Reports on Systemic Issues**

The DD Ombuds publishes reports on systemic issues to highlight the need for improvements and make recommendations.

### ***Rainier Report***

The legislature added a significant duty in the 2025 session. By November 1, 2028, and in compliance with RCW 43.01.036, the office of the Developmental Disability Ombuds shall submit a report to the appropriate committees of the legislature that includes summaries of resident, parent, and guardian feedback regarding transition of residents out of the Rainier school following the effective date of this section, July 2025

Less than 80 people live at Rainier Residential Habilitation Center in Buckley, WA. It wasn't long ago that more than 400 people lived there. Most people have moved out into the community. Soon, Rainier can no longer accept new residents. As people move, the DD Ombuds will gather information from the residents and their family and guardians about their transition into the community. The report is due in November of 2028.

### ***Stuck in the Hospital***

The issue of children and adults with developmental disabilities stuck in hospitals and unable to discharge is still prevalent in 2025.

DD Ombuds published the [“Stuck in the Hospital”](#) report in December 2018. The report responded to the high volume of complaints DD Ombuds received about adults with developmental disabilities stuck in a hospital without any medical need. Most of these individuals were Developmental Disabilities Administration (DDCS) clients who had been receiving residential services prior to hospitalization. Some individuals went to the hospital for

a medical condition, but when they were ready for discharge, they had no place to go because their residential services provider had terminated their services. Other individuals were dropped off at the hospital by a provider who could no longer manage their care. These individuals with developmental disabilities spent weeks or months or years in a hospital because DDCS could not locate available residential placement with staff to provide care. As a result, these individuals had to live in hospitals while waiting for residential placement. In SFY 2023, DD Ombuds published the report, [“I Want to Go Home – Reevaluating DDCS’ Children’s Services to Prevent Hospitalization and Out of State Placement”](#).

Children and adults with developmental disabilities continue to be boarded in community hospitals without a medical need. They are not receiving the habilitative services they need, sometimes they are restrained and cannot go outside for the duration of their stay. Hospital staff often have not received the training they need to work with individuals with developmental disabilities. Hospitals do not have the capacity to board individuals who have no medical need to be hospitalized.

### ***Community Protection Program***

DD Ombuds focused this report, [“No Way Out - An Introduction to the Community Protection Program”](#), on the Developmental Disabilities Administration’s (DDCS) Community Protection Program (CPP). DD Ombuds hears many complaints regarding CPP. This report provides background on CPP and identifies concerns resulting from monitoring and complaint investigation. In the course of developing this report, DD Ombuds identified additional concerns to investigate further and report on in the future.

CPP is far and away the most restrictive community program administered by DDCS. DD Ombuds focused on five areas of concern with CPP:

1. People are referred to the program at a young age before they have access to other supports and services.
2. Individuals must comply with DDCS’s CPP recommendations or risk losing access to other services.
3. The program has a low graduation rate.
4. The documents produced at DD Ombuds’ request showed lax adherence to policies that protect the rights of people with disabilities.

To address these concerns, DDCS must ensure that person-centered, less restrictive supported living alternatives are offered instead of a referral to CPP. DDCS must also ensure that entry into any services is truly voluntary and that other DDCS services are not restricted if an individual declines CPP. Each participant must know and understand their path to graduation. Participants must be informed of their rights and the process that must be followed before any restriction of rights is planned. DDCS leadership must ensure DDCS staff and DDCS contracted providers meet federal, state and policy requirements that protect the rights of people with disabilities.

### ***Office of Developmental Disabilities Expansion Plan***

DD Ombuds proposed in November 2019, an expansion plan based on DD Ombuds experience providing services, analysis of the LTC Ombudsman Program model and stakeholder input. The

DD Ombuds has not yet been funded to expand services. DD Ombuds continues to do this important work with the hope to serve more people across the state with additional resources.

### **Key areas of focus for expansion**

- Reach people with developmental disabilities in rural areas and isolated settings.
- Reach people with developmental disabilities from diverse communities.
- Increase visits to people with developmental disabilities living in certified and licensed residences.
- Increase number of complaints resolved/closed from people living in the community.
- Increase capacity to respond to incidents which affect groups of people with developmental disabilities, such as a facility closure or provider decertification.
- Increase capacity to provide self-advocacy trainings and support.
- Increase capacity to work with policy makers on improvements to the service system.

The plan proposes a graduated increase in paid staff and use of volunteers over three biennia. Phase one would be to stabilize the certainty of the funding for the program by moving DD Ombuds budget into the maintenance budget, which has been completed. In Phase 2, with increased funding, a volunteer coordinator, self-advocacy educator and three DD Ombuds are added. Then staffing is increased by three DD Ombuds and an Office Assistant. The DD Ombuds continues to look for opportunities to expand services.

### **Annual Report Conclusion**

The DD Ombuds staff are dedicated to listening to the concerns and complaints of individuals with developmental disabilities and their families. The DD Ombuds then works with individuals to resolve their complaints and when necessary, takes action at the systemic level to improve systems of supports. As evidenced by the information in this report, much progress has been made in SFY 2025 and the need for the DD Ombuds work continues.

### **Questions or comments about this report?**

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