State of Minnesota

Ombudsman for Mental Health and Developmental Disabilities

2008/2009 Biennium Report to the Governor

Mission Statement

Promoting the highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

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Ombudsman's Overview

During the 2008/2009 biennium, one of the major issues the agency focused on was the use of mechanical restraints on clients with developmental disabilities in a residential treatment facility run by the State of Minnesota.

The issue, as raised by family members of the residents, was the use of metal handcuffs and other law enforcement style restraints instead of the typical soft restraints used in a medical or treatment facility. In addition to the type of restraint used, the callers complained about how frequently they were used for minor behaviors that did not pose a threat of harm to either the resident or to others. The program the callers identified was the Minnesota Extended Treatment Options (METO) in Cambridge. Based on a preliminary review of the records, the Ombudsman made a determination to conduct a more in-depth review of the restraint practices employed at this facility.

The Ombudsman assigned three Regional Ombudsmen to conduct the review as a team. All of the team members had extensive experience in the needs and the rights of citizens with developmental disabilities. Initially, the assumption was that these practices were isolated to a few "difficult to serve" clients. The records revealed, however, that 65% of the residents of the program had experienced restraints and 73% of those restrained were restrained on multiple occasions. The highest use case was an individual who had been restrained 250 times in a specific year and 290 times in the year before that.

Agency staff reviewed the individual treatment plans of these residents and found a lack of positive behavioral programming. This programming is designed to teach adaptive skills in order to redirect the problematic behavior. Despite the residents' cognitive disabilities, the behavior was documented by staff as being willful misbehavior. The current practice standards view behavioral outburst as a form of communication. The challenge for staff should have been to try to understand what the behavior was trying to communicate, find an alternative strategy to redirect the behavior, and help residents improve their communication skills. The facility's management originally resisted the efforts of the Ombudsman Office to review their program and discuss possible recommendations to improve the quality of care and reduce the reliance on the use of restraints. Tensions mounted between the Office of Ombudsman and the management of the METO program that resulted in the Ombudsman seeking legislative clarification on her position's powers and authorities.

After twelve months of investigation, program reviews, management consultation, and recommendations, the Ombudsman Office concluded that the program was not willing to alter their policies or treatment modalities. The Ombudsman decided the only tool left was the issuance of a public report. In September of 2008, the Office of Ombudsman released the report "Just Plain Wrong."

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Client Services Overview

The agency has seen an increase in calls regarding persons with mental illness and developmental disabilities over the last biennium.

The Office of Ombudsman for Mental Health and Developmental Disabilities is, like other state agencies, working on how to balance the needs of persons with mental illness and disabilities with the challenge to live within its budget. The office continually reviews its mission to ensure high quality services to clients. To strengthen services after the retirement of the Client Services Director, the agency chose to have a Regional Ombudsman Supervisor, who would also cover a region.

During the 08/09 biennium, the regional staff members successfully kept pace with an increase in requests for services. The enlarged amount of calls from agency clients has been noted with those clients who have a mental illness. Report numbers from other client disability groups with whom the agency works have remained fairly stable.

Issues the agency deals with are detailed in the chart at right. Often, the issues can change focus based upon many factors affecting the clients we serve. The biggest increase the agency has seen is in the area of abuse/neglect. There were 2271 reports this biennium as opposed to 864 for the 06/07 biennium. The number of cases in this area has almost tripled over the past biennium. Some of this can be attributed to an increase in information sharing between this agency and the licensing agencies. The office has developed better communication with the Department of Human Services Licensing Division, the Department of Health Office of Health Facility Complaints, and the Department of Education. The regional staff work with clients to ensure reports are filed with the appropriate licensing agency as part of conducting a client case review, which continues to be a focus of the agency.

The issues of child custody, protection, visitation, and out of home placement have doubled over the past biennium. This type of call can be regarding a parent or parents with a disability having difficulty with

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The *Type of Issue* table represents issues clients raised during conversations with our Regional Ombudsmen.

Type of Issue	FY 08	FY 09	Total Biennium	Percentage
Abuse/Neglect	945	1271	2216	13%
Child Custody/Protection/Visitation	82	152	234	1%
Civil Commitment	239	289	528	3%
Client Rights	356	441	797	5%
Contracted Social Services Agency	23	59	82	0%
County Social Services	100	138	238	1%
Criminal	129	192	321	2%
Data Privacy/Client Records	23	44	67	0%
Death	647	716	1363	8%
Dignity and Respect	245	365	610	4%
ECT	1	3	4	0%
Education System	10	24	34	0%
Employment	23	44	67	0%
Financial	166	260	426	3%
Guardianship/Conservatorship/Rep Payee	46	111	157	1%
Housing	62	91	153	1%
Information	33	59	92	1%
Insurance	16	45	61	0%
Legal	80	108	188	1%
Managed Care	28	18	46	0%
Medical Issues	227	328	555	3%
Placement	306	423	729	4%
Psychotropic Meds	38	56	94	1%
Public Benefits	41	71	112	1%
Public Policy	11	29	40	0%
Referral	5	14	19	0%
Restraint/Seclusion/Rule 40	146	50	196	1%
Restrictions	49	63	112	1%
Serious Injury	1397	1677	3074	18%
Special Review Board	124	128	252	2%
Staff/Professional	945	1271	2216	13%
Training	11	23	34	0%
Transportation	42	69	111	1%
Treatment Issues	345	326	671	4%
Violations of Rule or Law	219	362	581	3%
Waivered Services	17	33	50	0%
Other	81	161	242	1%
Total	**7258**	**9514**	**16772**	**100%**

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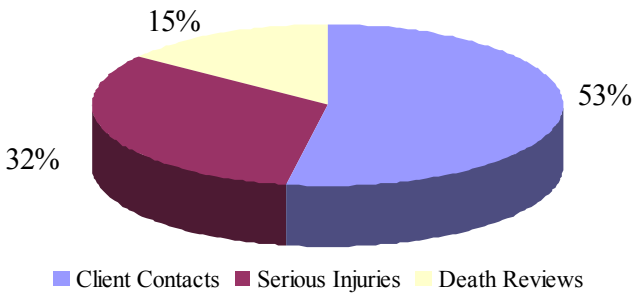
county child services or parents who have a child with a disability who needs services. The issue can be to assist with trying to find an appropriate placement for a child, assisting with accessing in-home services, or reviewing the actions of a county social service agency. These can often be time-consuming cases for the regional staff.

There is also an increase in contacts for assistance from people dealing with the legal system. Some of these cases involve a referral to an appropriate agency or to inform the client how to access legal assistance. Many of the referrals are about a person with a mental illness not being able to access psychiatric services or medications while incarcerated, and some have to do with clients being charged with crimes while in treatment. While the agency is not able to assist clients who may be in prison or jail, the agency ensures that there is an appropriate referral made.

There has also been an increase in the issue category of staff/ professional. These are complaints about persons that work with this agency's clients. There can be issues of staff attitudes, staff not assisting the client, or issues that do not fit into an abuse/neglect or dignity and respect category. This is an area that the agency continues to monitor closely to determine if the increase in contacts is a result of more reporting or a sign of a systematic problem affecting staff attitudes.

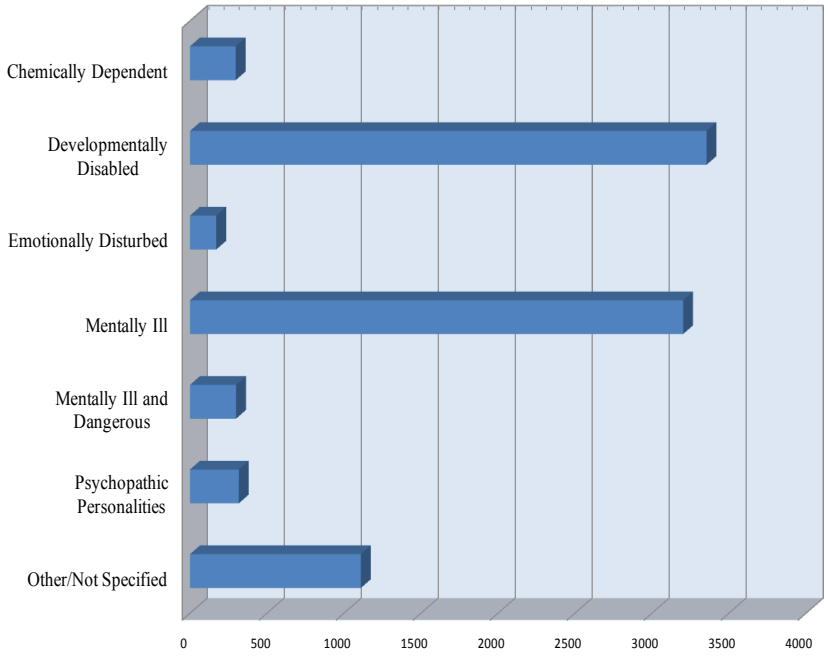
In addition to these issues, the regional staff continue to assist clients with becoming more able to advocate for themselves. The staff provide information to clients who are receiving services, family members, or members of the community who call with questions. The staff educate citizens on laws, rules, and policies so individuals have the knowledge to try to handle problems as they arise in the future. It is also the agency's policy that if staff are unable to directly assist the client, that staff will refer the client to an agency or individual who can help as much as possible to meet the needs of the client.

Contacts by Type for Biennium



Total client contacts for the biennium was 8,818 compared to 7,169 for the last biennium.

Contacts by Disability for Biennium



Medical Review Unit

Total number of reported deaths for the this Biennium was 1456.

This total of 1456 deaths compares with 1069 deaths reported in the previous Biennium.

The Medical Review Unit (MRU) is comprised of three staff persons: the Medical Review Coordinator (MRC), a part-time nursing evaluator, and a part-time reviewer for serious injuries. In April 2009, the full-time reviewer who performed full reviews and site visits was reassigned to a position as Regional Ombudsman.

The MRU serves as a support to the Medical Review Subcommittee (MRS), which includes volunteer members of the Ombudsman's Advisory Committee and is empowered under Minn. Stat. § 245.97.

The MRS met five times during FY08 and five times during FY09 to review the deaths and serious injuries of clients that met its established guidelines. During FY08, the MRS reviewed and closed eleven full reviews and 19 limited reviews. During FY09, the MRS reviewed and closed nine full reviews and 24 limited reviews. There were 610 deaths reported to the Medical Review Coordinator in FY08 and 846 deaths reported in FY09. This total of 1456 deaths compares with the total of 1069 deaths reported in the previous biennium, an increase of 36%.

Type of Death	FY 08	FY 09	Biennium Total	Percentage
Accident	60	71	131	9%
Homicide	5	6	11	1%
Natural	496	691	1187	82%
Suicide	37	54	91	6%
Undetermined	12	24	36	2%
TOTAL	**610**	**846**	**1456**	**100%**

Most death reports are closed by the MRC upon initial review when the information provided is complete or after the collection and review of additional records. Other death review cases are reassigned for further review by the part-time nursing evaluator. Cases receiving further review are either closed after further review by the MRU or brought before the MRS for additional review. The Regional Ombudsman is always notified of death reports from his or her region both when a report is received and again upon its closure.

There were 3251 serious injuries reported in the 08/09 biennium. This compares with 2498 serious injury reports during the previous biennium, which represents an increase of 753 reports or 30%. During the 08/09 biennium, 914 serious injury reports were received that were classified as "Other." Most of those reports were instances of clients requiring medical evaluation for a medical illness or for an incident of choking. Most serious injury reports are closed upon initial review by the MRC. The others are assigned for further review to the part-time serious injury reviewer or to a Regional Ombudsman. The Regional Ombudsman is always notified of serious injury reports in his or her region both when a report is received and again upon its closure.

In April 2008, the MRU began the practice of acknowledging the receipt of every serious injury report by fax or by mail. In May 2009, at the request of providers, the serious injury report form was updated to include a statement which, if checked by the reporter,

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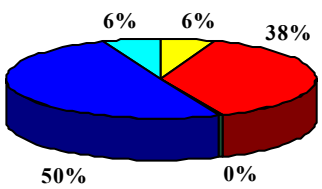
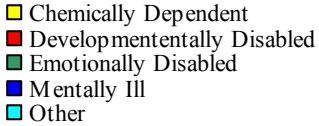
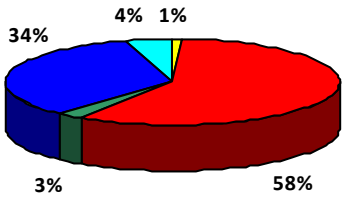
These pie charts represent the Deaths and Serious Injuries reported to our office for this Biennium.

Deaths by Disability for Biennium





Serious Injuries by Disability for Biennium



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eliminated the automatic fax or mail response.

The purpose of the Ombudsman Office's death review process is to seek opportunities to improve the care delivery system for living clients. The MRU has a quality-improvement focus and, by statute, avoids duplication of the work of agencies such as the Office of Health Facilities Complaints and DHS-Licensing, both of which perform detailed investigations and have sanction authority. If the MRU finds a situation that needs that type of investigation, referrals are made to the appropriate agencies or licensing boards. The MRU works collaboratively with other agencies or boards, but also avoids duplication of their work.

The Medical Review Unit has used the Ombudsman Office's website to improve its communication with providers and clients and to make more efficient use of technology. Editable Death Report and Serious Injury Report forms remain available on the website. Providers, clients, families, and other interested persons are encouraged to sign up for the agency's Medical Alerts E-Mail List Service, which sends e-mail notifications to subscribers when new information is available on the website.

The MRC produces a series of Summer and Winter Alerts, which are updated and released each year. These are available on the Ombudsman Office's website. The Summer Alerts – *Summer Alert, Heat Stroke, Water Safety, and Insect Sting Alerts* – are typically released in May of each year, while the Winter Alerts – *Winter Alert, Frostbite, Hypothermia, and Wind Chill Alerts* – are typically released annually in November. In addition, the MRC provides a cover letter that highlights recent FDA MedWatch warnings and that encourages providers to routinely visit the FDA's MedWatch website (http://www.fda.gov/medwatch/).

Medical Alerts are available on the website:
http://www. ombudmhdd.state.mn.us/alerts/default.htm

While seeking opportunities to improve the care delivery system, the MRS looks at not only individual cases but also for patterns and trends. When it identifies patterns or trends, the MRS uses that opportunity to make recommendations focused on the care delivery system. These recommendations may come in the form of a letter to a provider or agency, a Medical Update, an Alert, a recommendation for a systemic review by the Ombudsman Office, or the development of educational tools such as the agency brochure entitled *Information for Individuals and Families about Suicide Prevention*.

In addition to the Summer and Winter Alerts, the *Choking Alert* (November 2007) was created during the 08/09 biennium and remains available on the website listed above.

Additionally, the Medical Review Coordinator and the nurse evaluator are available upon request for tailored presentations at conferences and meetings throughout the state.

The Medical Review Unit thanks you for your interest in and cooperation with the agency's serious injury and death reporting process.

Type of Serious Injury	FY 08	FY 09	Biennium Total	Percentage
Burns - 2nd or 3rd degree	70	78	148	4.55%
Complication of Medical Treatment	28	37	65	2.00%
Complication of Previous Injury	8	7	15	0.46%
Dental Injury	29	37	66	2.03%
Dislocation	9	10	19	0.58%
Eye Injury	13	20	33	1.02%
Frostbite - 2nd or 3rd degree	0	2	2	0.06%
Head Injury w/Loss of Consciousness	47	43	90	2.77%
Heat Exhaustion/Sun Stroke	1	2	3	0.09%
Ingestion of Harmful Substance	28	68	96	2.95%
Internal Injury	13	23	36	1.11%
Laceration	54	65	119	3.66%
Major Fractures	200	271	471	14.49%
Minor Fractures	424	607	1031	31.71%
Multiple Fractures	51	92	143	4.40%
Near Drowning	0	0	0	0.00%
Other	378	536	914	28.11%
Total	**1353**	**1898**	**3251**	**100.00%**

Civil Commitment Training and Resource Center

The Center provides civil commitment information and referral, consultation, and advocacy services.

During the 08/09 biennium, the Civil Commitment Training and Resource Center (CCTRC) received numerous requests for training on the commitment act, found in Minn. Stat. Chapter 253B. Many of the trainings were for a county or groups of counties. These training sessions included social workers, county chemical dependency counselors, examiners, and health care providers. There was also a statewide ITV training set up by the DHS Adult Mental Health Division. This training event was attended by over two hundred county social workers.

Trainings were provided for staff of several community hospital mental health units and DHS State Operated Services staff. Training was also provided for hospitals in bordering states, that have contracts with Minnesota counties to provide service to Minnesota residents who have been placed on an emergency hold, and a hospital which also provides treatment to committed patients.

The CCTRC staff continued to be involved with presentations on the DHS Community Forensic Support Services program. The CCTRC staff presented on the discharge process for those individuals committed as mentally ill and dangerous (often referred to as MI&D). These presentations took place at regional sites statewide. CCTRC staff also presented at the meetings between providers and counties in greater Minnesota and staff of the DHS Mental Health Division and several metro area counties. These meetings were held to explain the commitment processes used by the metro counties as they can be different than that which is used in greater Minnesota.

There were also requests from groups that had not previously requested training. The CCTRC staff presented to a local advisory council and an advocacy organization in northwestern Minnesota. The CCTRC also became involved in Crisis Intervention Training (CIT) for law enforcement and emergency responders statewide. The CCTRC staff presented on the use of emergency hold orders. These were very intensive four day trainings. Law enforcement staff who attended these stated how much these CIT trainings have helped. The grant for these training sessions is almost exhausted so only a few sessions will be provided in the next biennium.

The CCTRC has had an increasing number of requests by other agencies and counties to be involved in meetings to discuss the issues related to the use of emergency hold orders, commitment, and also the Interstate Compact Law. These meetings were held to resolve issues and problems with the civil commitment process. Training included the transition from county case managers providing case management services to health care organizations providing this function for persons covered under their plan. CCTRC staff also trained on the Commitment and Treatment Act.

The CCTRC continues to receive an increasing number of questions and requests for technical advice on the use and implementation of the commitment process. These questions come from county social service staff, examiners, lawyers, health care providers, family members and clients.

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After the report became public, the legislature held hearings at the capitol, asking the Ombudsman to present the report and the Department of Human Services to respond on how they proposed to alter the program to protect the rights of its residents.

Since the release of the report, the Office of the Ombudsman and the Department of Human Services have been working cooperatively to move Minnesota State Operated Services towards a restraint-free environment.

Other Agency Issues

While the restraint issue took up a significant amount of the Ombudsman Office's time and agency resources over the two years the agency worked on this issue, the agency also faced challenges in the area of technology and data collection. The legislature appropriated funding to the Office of Enterprise Technology specifically for development of a new data intake and collection system for the Ombudsman Office. The agency had been working extensively on its own but lacked the technical knowledge for a project this large. Initially, the project stalled due to a variety of setbacks. However, as the end of the biennium approached, the Office of Enterprise Technology and the Office of Ombudsman worked together at record pace to complete the project by the deadline. On July 1, 2009, the Office of Ombudsman went live with a new data collection system. While the agency continues to work with the vendor to refine aspects of the software, the agency is able to proceed to collect needed data to help the agency monitor what is going on in the systems that serve its vulnerable clients.

Based upon lessons learned in the cases reviewed by the Office of Ombudsman, the agency identified areas where system improvements could be made through changes to Minnesota statutes. Working with a coalition of groups interested in protecting the rights of citizens served for their disability, the Ombudsman participated in the passage of three major pieces of legislation, including:

- A bill to prevent a person who is under a "stay of commitment" from being enrolled in a psychiatric drug study
- A bill to better protect vulnerable adults from financial exploitation and termination of services, and
- A bill to protect the rights of persons who have been placed under court-ordered guardianship or conservatorship.

The Ombudsman will continue to speak out on behalf of the rights of adults and children with mental illness, developmental disabilities, chemical dependency, and emotional disturbance.

Equal Opportunity Statement

The Office of Ombudsman does not discriminate on the basis of age, sex, race, color, creed, religion, national origin, marital status, or status with regard to public assistance, sexual orientation, membership in a local human rights commission, or disability in employment or the provision of services.

This material can be given to you in different forms, such as large print, Braille, or on CD-ROM, if you call 1-651-757-1800 Voice or 711 TTY and make a request.

"Giving voice to those seldom heard."

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A report issued under the authority of the Ombudsman, Roberta Opheim

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