



Minnesota Department of **Human Services**

Rule 40 Advisory Committee Meeting Summary: 5.7.12

Attending:

Committee members:

Steven Anderson, Kay Hendrikson, Anne Henry, Tim Moore, Leanne Negley, Shamus O’Meara, Andrew Pietsch, Kelly Ruiz, Bonnie Jean Smith, Gloria Steinbring, Rebecca Walsh and Colleen Wieck

DHS Staff: Alex Bartolic, Donovan Chandler, Gary Cox, Lori Dablow, Stacy Danov, Gail Dekker, Katherine Finlayson, Dan Hohmann, Jill Johnson, Jennifer Kirchen, Bob Klukas, Natalie Marr, Lorraine Pierce, Dean Ritzman, Michael Tessneer, Munna Yasiri, Charles Young, Rick Amado, Gregory Gray, Sharon Mack and Suzanne Todnem

Other State Staff: Barbara Case (Minnesota Department of Education), Michelle Ness (Minnesota Department of Health) and Steve Alpert (Minnesota Attorney General’s Office)

Other Organizations: Rick Cardenas (Advocating Change Together, “ACT”), Matt Burdick (NAMI of Minnesota), Brad Hansen and Barbara Kleist (The Arc Greater Twin Cities), Sharon Mack and Sue McGuigan (Brain Injury Association of Minnesota)

Committee Charge The Rule 40 Advisory Committee was formed as part of a settlement agreement. The committee will study, review and advise the Department of Human Services on how to modernize Rule 40 to reflect current best practices. This was the fourth meeting of the Rule 40 Advisory Committee, which met from 9:00 a.m. to 3:00 p.m.

Presentations The Committee heard presentations from Mike Tessneer and Shamus O’Meara, Alex Bartolic, Lorraine, Pierce, Gary Cox, Dean Ritzman and Barbara Case.

Mike Tessneer, of the Minnesota Department of Human Services Office of Chief Compliance Office, and Shamus O’Meara of Johnson & Condon and plaintiffs’ attorney in the lawsuit, walked the committee through the terms in the settlement agreement that the Department agreed to for the Cambridge facility (f.k.a. “METO”) and its successor. The terms discussed include:

- Prohibited techniques
- Therapeutic Interventions and Emergency Use of Personal Safety Techniques (Attachment A to the settlement agreement)

- Seclusion and time out from positive reinforcement
- Chemical restraint
- Use of the third-party expert
- Medical officer review of emergency use of restraint
- Restraint reporting and management
- Role of internal reviewer
- Role of external reviewer

The Rule 40 revision was one of the ways the department and plaintiffs agreed to make system-wide changes to the way individuals are treated.

The advisory committee accepted a framework based on the settlement agreement mandates for the Cambridge facility.

The framework includes these components:

1. Prohibited techniques
2. Exceptions for emergencies
3. Monitoring, oversight, reporting, enforcement
4. Training
5. Positive behavior supports and person-centered planning
6. Bill of rights, protection of rights

Concerns and Question Related to Framework

Before adopting the framework, committee members raised concerns and questions that they want to see addressed:

1. Enforcement: what will this be?
2. Include a transition plan to move away from programmatic use of restraints.
3. More emphasis on positive behavioral support (PBS) plans, implementation and monitoring
4. Ensure coordination with Olmstead planning process.
5. Consider feasibility, especially funding, of system.
6. Coordination with broader quality assurance efforts.
7. Coordination with new legislation, Minn. Stat. 245D on provider standards
8. Ensure that training is broad, covering PBS, client-centered planning, and monitoring
9. Include a purpose section in the revised rule
10. CRF Rule 2960 on use of seclusion and restraint. Document standards.

Work The advisory committee began discussion on how to achieve the ideal accepted in the morning. Everyone received printed copies of “Attachment A” to the settlement agreement titled “Therapeutic Interventions and Emergency Use of Personal Safety Techniques” and the form Cambridge currently uses to report use of restraint.

Prohibited Techniques

Tentative Agreement – Details to be determined

The committee agreed that these techniques should be prohibited, with the understanding that discussion of exceptions would follow at the next meeting:

1. Mechanical restraints
2. Manual restraints
3. Prone restraint
4. Seclusion
5. Chemical restraint
6. Medical restraint used to punish, as substitute for habilitation, skills training, behavior support plans, staff convenience, or behavior modification
7. Aversive techniques are not to be used as therapeutic or programmatic services.
8. Painful techniques to punish. Pain is an aversive technique that includes physical pain, mental pain or emotional distress.
9. Abusive or derogatory language.
10. Current Rule 40 prohibitions *[Need these to be delineated]*
11. Positions *[Need more description here. Assume this refers to requiring a person to assume and maintain stressful or painful positions]*

More Discussion Needed

Committee members did not reach agreement on whether to prohibit or permit this item:

1. Techniques or practices that violate a person's bill of rights.

Comments

These comments apply to prohibited techniques above

1. Be aware of trauma-informed care principles. Because these are vulnerable people who have experienced trauma in care settings, their responses will be affected by this trauma.
2. What should this committee recommend with regard to the interface with professional standards, as when a psychologist might misapply trauma treatment, such as having the person relive a trauma as part of treatment? This is a bona fide treatment procedure but it can be misapplied.
3. When is "extinction" an overcorrection? (Extinction is a behavior analysis procedure that means withholding or eliminating reinforcers that maintain behavior. As applied, this could mean withholding rewards or attention [i.e., ignoring] behavior that interferes with learning an adaptive response.) This is not addressed in the current rule.
4. When is "satiation" an overcorrection? (Satiation means a technique used to decrease the occurrence of a behavior by providing excessive amounts of reinforcers maintaining the behavior in order to reduce the reinforcing value for maladaptive response.) This is not addressed in the current rule.
5. Where is the accountability for protection of rights when guardians may make decisions that violate a person's rights?

What Will It Take to Make Prohibited Techniques Work?

1. Funding—to increase staff, pay for special transportation
2. We may see more potential injuries.
3. Training needed.
4. In the "Umbrella Rule," restraints used for transportation section has special training requirements for staff. Perhaps this could be a model for the revised rule.
5. For safety, permit transition period when people engage in self-injurious behavior.

6. Clients may see changes in services
7. Inadequate crisis system.
8. Is the adaptation of a seatbelt to prevent a person from unlatching the belt a use of a prohibited mechanical restraint? If extra staff is needed to ensure safety because this adapted seatbelt cannot be used, this will require increased funding.
9. Re: above item: We need to watch the slippery slope. Primary care doctors may sign off of a guardian or provider request, when they have little training on DD clients' needs. It is not sufficient to say, "We have a doctor's order for that."
10. Who is part of the review team and are they well trained in DD? What does the assessment require?
11. Will this lead to charges of neglect if we change health and safety adaptations (re: Item #8)?
Response: Is the adaptation temporary? If it is temporary, does it ever go away?
12. Another example of problematic physician sign-off: Bed rails or adult cribs. This is because the patient is "falling" out of bed (involuntary), when examination shows that the patient is climbing out of bed (voluntary). The ISP needs to deal with the voluntary behavior, not call the behavior involuntary and rely on bed rails.
13. It would be helpful to have traveling expertise on transition planning (like Barb Roberts' group), that can go to providers and work with them. Concern about funding for this.
14. It would be helpful to have a formal transition plan for providers that includes training and time. Not all providers have METO's resources.
15. General needs: resources, training, oversight, reporting.
16. Focus on educational process for providers and give them incentives to do the right things. Revised rule should model positive behavior practices itself and not rely on punishment to get behavior change.
17. Concern about loss of providers who are willing to serve challenging populations.
18. Need a way to raise exceptions to prohibited techniques. For example, a person has Prader-Willi Syndrome (a congenital disease where people have an intense craving for food, resulting in great weight gain and health problems of obesity). The recommended treatment is to lock food away. Is that prohibited? A violation of rights?

Response: Can person-centered planning help? Access to support and technical assistance?

19. How can we incorporate a person's choice and permit the dignity of risk?
20. Some people deal with their symptoms (say, of anxiety) through self-administration of PRN medications. If PRN medications are prohibited, how will they be able to do this?

Response: In the METO settlement, we wanted a doctor, not direct care staff, to make this decision.

Alex Bartolic from Disability Services Division Director talked to the committee members about approach and timeline. We are slightly shifting direction because we were getting into the weeds without an agreement on a framework to work within. The committee has formed a framework today and now we can move forward to see what is workable and how to achieve the outcomes that were just agreed to. There are many other department initiatives that will dovetail into the work being done here such as the provider standards initiative.

The timeline we have put forth anticipates a rule draft in October; reconvene the rule advisory committee in November; publish the new rule in February or March of 2013; and have a completed rule by end of calendar year 2013 or sooner if possible. We will be able to consider implications of the draft rule into the legislative process for the 2013 session.

Lorraine Pierce from Adult Mental Health Division presented on adult mental health mobile crisis services. Pierce's presentation included descriptions some observations might see in the person in need of crisis services, the elements of a crisis, the type of crisis responses available, who is eligible, where services can take place and the intent of the services.

Alex Bartolic responded to a question raised at the April advisory committee meeting. One committee member inquired about what other states are doing for training – e.g., who provides the training, how much did it cost the state. As promised, DHS consulted the director's list serve of which it is a member and solicited information from other states. Bartolic provided a summary of the information DHS received and how Minnesota is able to fund training.

Gary Cox from Children's Mental Health division shared with the committee some concerns he has about an expansion of this rule that might affect their populations and cause confusion. Cox explained how mental health has taken a facilities-based approach to their standards rather than a population-based approach to regulation. Mental health has been working with the Minnesota Department of Education and they have come to some agreement on regulating the use of seclusion and restraint in schools. Cox recommended:

- i. Forming detailed training standards for people allowed to use restrictive procedures
- ii. Determining what standards are needed in each type of facility
- iii. Requiring intentionality – that is, what is appropriate for each individual
- iv. Requiring notification to a person's family, and
- v. Requiring accountability

Dean Ritzman from Disability Services Division provided an update on the survey and survey evaluation sent out to limited providers. Overall the providers who participated in the field test found the survey was clear and they answered the questions properly. A couple of questions on the survey will be revised before the survey is sent out statewide.

Barb Case from the Department of Education reported on recently passed legislation addressing prone restraint used in schools. Case reported that the Department of Education does not advocate for use of prone restraint in schools.

From September 2011 to February 2012, there were 286 reports of prone restraint used in Minnesota schools. From February 2012 to today (February, March, April), there were 237 reports of prone restraint used in Minnesota schools. The number of reports is different from the number of "incidents." For example, one report might include multiple incidents of the child being restrained in prone position, let up, then again into the prone restraint.

Case reviewed Senate File 1917, a summary of it prepared by the Department of Education and a reporting form schools must use to report prone restraint use. The form is currently undergoing modifications. She and her team are working on getting the next report out and hopes to have it done in the next month to six weeks. Other highlights reported include:

- Definition of “physical holding” was amended
- Prone restraint was defined in the statute
- Additional prohibition against restricting a child’s ability to breath, communicate distress, places pressure or weight on a child’s head, throat, neck, chest, lungs, sternum, diaphragm, back, or abdomen, or results in straddling a child’s torso
- School districts may use prone restraint until August 1, 2013
- Additional restriction that prone restraint can be used only on children age 5 or older
- Reporting requirements were amended

Closing The committee was asked to evaluate the meeting: What suggestions do you have for improvement? In preparation for the next meeting, committee members were asked to talk to their colleagues and networks about prohibited techniques and exceptions and to bring back questions about how things might apply in practice and not just theory.

Recommendations to Improve Future Meetings

1. One person appreciated the posters and going over the settlement provisions.
2. Provide a one-page summary of METO settlement every month.
3. Provide the framework every month.

Evaluation of Use of Email Threads Discussion

1. Found it frustrating. I prefer to talk with people. It was too easy to misinterpret messages.
2. This was a great conversation but too lengthy for emails.
3. Appreciate new links and new info that people shared.
4. Got a lot out of it, but recognize the shortcomings. I liked it, but four threads at one time was too many.
5. Suzanne was asked her experience: There was a lot to track and it wasn’t linear.
6. Could we use another process: Perhaps people could respond to a question by sending their responses to Suzanne in Week 1. She could summarize them and send them out. Recognize this would make more work for Suzanne.

As always, if members or observers have questions, please email them to the Rule 40 email box at:

DHS.rule40@state.mn.us