



Minnesota Department of **Human Services**

**Rule 40 Advisory Committee Meeting  
Handout Table of Contents  
May 7, 2012, 9:00-3:30  
444 Lafayette Road, Room 3148**

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Minnesota Department of **Human Services**

**Rule 40 Advisory Committee**  
**Lafayette Building, Room 3148**  
**May 7, 2012 Agenda**

- I. Opening (9:00-9:15) Gail Dekker
- II. Settlement agreement (9:15-10:15) – Handout #2 Mike Tessneer and Shamus O’Meara
  - A. Agreement clarified
  - B. Framework components
- III. Approach and timeline (10:15-10:45) – Handout #3 Alex Bartolic
- IV. Break (10:45-11:00)
- V. Response to last month’s member questions (11:00-11:35)
  - A. Adult Mental health mobile crisis services – Handout #4 Lorraine Pierce
  - B. Other states – training, funding (Oregon, Missouri, Louisiana, Delaware) Alex Bartolic
- VI. Children’s Mental Health Division information (11:35-12:05) – Handout #5 Gary Cox
- VII. Lunch (12:05-12:40)
- VIII. Monthly updates (12:40-1:00)
  - A. Survey update – Handout #6 Dean Ritzman
  - B. Update on prone restraint, MDE – Handouts #7, 8, 9 Barbara Case
- IX. Framework components (1:00-2:00) Gail Dekker
  - A. What will it take?
- X. Break (2:00-2:15)
- XI. Continue Framework components (2:15-3:10)
- XII. Closing (3:10-3:30) Gail Dekker
  - A. Next meeting is scheduled for Monday, June 4, 9:00- 3:30 In Lafayette 3148
  - B. July meeting: Options: (1) first Monday (7.2), (2) second Monday (7.9), or (3) skip
  - C. Meeting evaluation: What worked well today? What didn’t work well? What would you change to improve future meetings?
    - 1. Email threads
    - 2. Next meeting’s agenda - your suggestions for next meeting’s agenda
  - D. Questions before we adjourn?
  - E. Thanks! and Adjourn

## Summary of Jensen Agreement conditions relative to use of restraint and seclusion

### V. PROHIBITED TECHNIQUES

- A. Except as provided in subpart V. B., below, the State and DHS shall immediately and permanently discontinue the use of mechanical restraint (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, posey cuffs, and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities. Medical restraint, and psychotropic and/or neuroleptic medications shall not be administered to residents for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior modification.
- B. **Policy.** Notwithstanding subpart V. A. above, the Facility's policy, "Therapeutic Interventions and Emergency Use of Personal Safety Techniques," Attachment A to this Agreement, defines manual restraint, mechanical restraint, and emergency, and provides that certain specified manual and mechanical restraints shall only be used in the event of an emergency. This policy also prohibits the use of prone restraint, chemical restraint, seclusion and time out. Attachment A is incorporated into this Agreement by reference.
- C. **Seclusion and Time Out from Positive Reinforcement.**
1. The Facility's use of seclusion is prohibited.
  2. Seclusion means the placement of a person alone in a room from which egress is:
    - a. noncontingent on the person's behavior; or
    - b. prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room.
  3. The Facility's use of Room Time out from positive reinforcement is prohibited.
  4. Time out means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the individual program plan for reduction or

elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked).

**D. Chemical Restraint.** The Facility shall not use chemical restraint.

1. A chemical restraint is the administration of a drug or medication when it is used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement and is not a standard treatment or dosage for the resident's condition.
2. Orders or prescriptions for the administration of medications to be used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement shall not be written as a standing order or on an as-needed basis (PRN).

**E. Third Party Expert.** The Department shall establish a protocol to contact, on a rotating basis, a qualified Third Party Expert from a list of at least five (5) qualified Third Party Experts pre-approved by Plaintiffs and Defendants. The costs for the Third Party Expert shall be paid by the Department. This consultation shall occur as soon as reasonably possible upon the emergency presenting but no later than thirty (30) minutes after an emergency use of restraint consistent with the Facility's policy, *Therapeutic Interventions and Emergency Use of Personal Safety Techniques*, Attachment A to this Agreement. The Facility staff shall consult with the Third Party Expert in order to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices. If the scheduled qualified Third Party Expert is not immediately available, DHS shall then utilize the Medical Officer Review protocol as described in subpart V. F, below. If the parties cannot develop the qualified list of Third Party Experts within 30 days of final approval of this Agreement, DHS shall utilize the Medical Officer Review described in subpart V. F, below.

**F. Medical Officer Review.** No later than thirty (30) minutes after an emergency use of restraint begins, the responsible supervisor shall contact the Department's medical officer on call in order that the medical officer may assess the situation, suggest strategies for de-escalating the situation, and approve of or discontinue the use of restraint. The consultation with the medical officer shall be documented in the resident's medical record.

## **VI. RESTRAINT REPORTING AND MANAGEMENT**

- A. METO Form 31032 (Attachment C “Documentation of Implementation of Controlled Procedures”) shall be completed by the end of the shift during which use is made of manual or mechanical restraint. Attachment C is incorporated into this Agreement by reference.
- B. DHS shall undertake reasonable efforts to submit within twenty four (24) hours, but no later than one (1) business day, the completed METO Form 31032 by electronic means, fax or personal delivery, to the following:
  - a. Office of Health Facility Complaints (“OHFC”);
  - b. Ombudsman for Mental Health and Developmental Disabilities;
  - c. DHS Licensing;
  - d. DHS Internal Reviewer;
  - e. Client’s family and/or legal representative;
  - f. Case manager;
  - g. Plaintiffs’ counsel.

### **C. Internal Reviewer.**

- a. The Department shall designate one employee with responsibility for monitoring the Facility’s use of restraints (“internal reviewer”). Presently this is Richard S. Amado, Ph.D., Director of the Department’s Office for Innovation in Clinical and Person Centered Excellence, whose duties include a focus on the elimination of restraints.
- b. The Facility shall complete METO Form 31032 and provide it to the internal reviewer, and all others listed in Section VI. B., above, within twenty four (24) hours of the use of manual or mechanical restraint.
- c. The internal reviewer shall consult with staff at the Facility in order to assist eliminating the use of manual and mechanical restraints.

### **D. External Reviewer.**

- a. The external reviewer will be approved by Plaintiffs and Defendants before hire and will be an employee of the Office of Health Facility Complaints, Minnesota Department of Health and shall have full enforcement authority consistent with the Office of Health Facility Complaints, as set forth in Minn. Stat. § 144A.53, *et. seq.*
- b. DHS will fund the costs of the external reviewer.
- c. The external reviewer will have the following credentials:

- i. Ph.D. in psychology, education, clinical social work, or a related field;
  - ii. Certification or eligible for certification as a Board certified Behavior Analyst at the Doctoral level;
  - iii. Experience in person centered planning;
  - iv. Experience using the integration of diagnostic findings, assessment results and intervention recommendations across disciplines in order to create an individual program plan;
  - v. Experience and demonstrated competence in the empirical evaluation of mood and behavior altering medications.
- d. Every three (3) months, the external reviewer shall issue a written report informing the Department whether the Facility is in substantial compliance with this Agreement and the policies incorporated herein. The report shall enumerate the factual basis for its conclusion and may make recommendations and offer technical assistance. The external reviewer shall provide Plaintiffs and the Department with a draft report. The Plaintiffs and the Department will have fifteen (15) business days to provide written comment. The external reviewer's final report shall be issued to Plaintiffs and the Department thereafter.
- e. The external reviewer shall issue quarterly reports to the Court for the duration of this Agreement. The reports shall describe whether the Facility is operating consistent with best practices, and with this Agreement. The external reviewer's reports shall be filed on the Court's public electronic court filing system, or any successor system, with appropriate redaction of the identities of residents or other personal data information that is statutorily protected from public disclosure.
- f. In addition to the external reviewer's authority described above, the following shall have access to the Facility and its records, including the medical records of residents for the purpose of ascertaining whether the Facility is complying with this Agreement:
  - i. The Office of Ombudsman for Mental Health and Developmental Disabilities, consistent with its authority under Minn. Stat. § 245.94. This Settlement Agreement shall be deemed adequate basis for the Office of Ombudsman to exercise its powers under Minn. Stat. § 245.94, subd. 1.

- ii. The Disability Law Center, consistent with its authority under 42 U.S.C. § 15043. This Settlement Agreement shall be deemed adequate basis for the Disability Law Center, as the designated Protection and Advocacy organization in Minnesota, to exercise its authority under 42 U.S.C. § 15043.
- iii. Plaintiffs' counsel, upon notice to and coordination with, the Minnesota Attorney General's Office and pursuant to the Protective Order in this case

- E. The Facility treatment staff shall receive training in positive behavioral supports, person centered approaches, therapeutic interventions, personal safety techniques, crisis intervention, and post crisis evaluation. The training is explained more fully in Attachment B which is incorporated into this Agreement by reference. All training shall be consistent with applicable best practices, including but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (<http://apbs.org>) (February, 2007).
- F. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to December 31, 2011:

- Therapeutic interventions 8
- Personal safety techniques 8
- Medically monitoring restraint 1

Staff at the Facility shall not be eligible to impose restraint until the above specified training has been completed, and then only certain restraints in an emergency as set forth in Attachment A to this Agreement, Therapeutic Interventions And Emergency Use Of Personal Safety Techniques.”

- a. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to March 31, 2012:

- Person centered planning and positive behavior supports (at least sixteen (16) hours on person centered thinking/planning) 40
- Post Crisis Evaluation and Assessment 4

**G. Rule 40.**

- a. Within sixty (60) days from the date of the Order approving this Agreement, the Department shall organize and convene a Rule 40 (Minn. R. 9525.2700-.2810) Advisory Committee (“Committee”) comprised of stakeholders, including parents, independent experts,

DHS representatives, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, Plaintiffs' counsel and others as agreed upon by the parties, to study, review and advise the Department on how to modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the "most integrated setting" and "person centered planning, and development of an 'Olmstead Plan'" consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999). The Committee's review of best practices shall include the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors.

- b.** Within sixty (60) days from the date of the Court's approval of this Agreement, a public notice of intent to undertake administrative rule making will be issued.





Minnesota Department of **Human Services**

**Rule 40 Advisory Committee  
Tentative Project Timeline  
Last Updated: 5/03/2012**

<b>No.</b>	<b>Task</b>	<b>Start</b>	<b>Finish</b>	<b>Duration</b>
1	Advisory Committee develops rule recommendations.	1/30/2012	09/14/2012	33 weeks
2	DHS staff drafts rule.	04/20/2012	10/31/2012	28 weeks
3	DHS management conducts reviews, makes policy decisions, and drafts statute, if needed.	10/01/2012	11/30/2012	9 weeks
4	DHS reconvenes Advisory Committee for final review.	12/03/2012	12/31/2012	4 weeks
5	DHS submits rule to Revisor and Governor's Office for approval.	12/07/2012	2/28/2013	12 weeks
6	DHS publishes proposed rule in State Register for 30-day comment period.	03/01/2013	03/29/2013	4 weeks
7	DHS holds public webinar(s) to inform public about rule.	03/07/2013	04/12/2013	5 weeks
8	Administrative Law Judge hold public hearing, followed by open testimony period, rebuttal period, and decision period.	04/15/2013	6/14/2013	9 weeks
9	Judge issues report.	06/17/2013	06/28/2013	2 weeks
10	DHS has 180 days to complete rulemaking, including addressing defects in rule, if any, noted by judge.	07/01/2013	12/31/2013	26 weeks

Mental Health Crisis Response Services placeholder

Presentation slides begin on the next page.

## Mental Health Crisis Response Services

*Lorraine Pierce, M.S., L.P.  
Adult Mental Health Division  
Minnesota Department  
of  
Human Services*

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## Mental Health Crisis

- From the individual's point of view
  - Thoughts of suicide
  - Extreme emotions (sadness, anger, etc.)
  - Seeing or hearing things that others don't seem to
  - Anxiety
  - Feeling emotionally overwhelmed and unable to cope

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## Mental Health Crisis

- From an observer perspective
  - Tearfulness, sadness, inability to engage in usual activities
  - Significant changes in mood and/or activity level
  - Expressions of being worthless or wanting to die
  - Seeming to respond to stimuli that the observer does not see or hear
  - Irritability, lack of patience

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## Critical Elements of a Crisis

- Sense of urgency-the situation cannot wait for the next business day
- Recognition of need for assistance from others to manage and alleviate distress
- Without assistance, the person will experience emotional, psychological or physical harm

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## Array of Crisis Response Services

- Crisis Phone Lines
  - Intervention
  - Screening/Triage
- Mobile Crisis Teams
  - Assessment/Intervention –
  - Stabilization
- Residential Crisis Stabilization

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## Mental Health Crisis Phone Lines

- 24 hour 7 day per week
- available in all 87 Minnesota counties
- Direct toll free telephone access
- 24 hour per day access to a mental health professional or a mental health practitioner

(Required by Minnesota Statutes 245.461 through 245.4861)




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## Mobile Crisis Assessment and Intervention Services

- Intent of services
  - to identify the factors contributing to the person's crisis
  - help the recipient cope with immediate stressors,
  - identify and utilize available resources and strengths, and
  - begin to return to the recipient's baseline level of functioning.

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## Eligibility

- Any individual who is over 18 years of age and currently in Minnesota
- The recipient must be able to benefit from the service
  - Severely intoxicated
  - Cognitively unable
  - Acutely psychotic



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## Place of Provision

- in the recipient's home
- home of a friend or family member
- a clinic
- emergency department
- provider office or
- a community setting



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## Response Time



- The goal is to meet with the person in crisis within ½ an hour from the first call or
- As soon as possible given the weather and/or other conditions
- Appointments that are made for the next day are not billable as a crisis service

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## Crisis Stabilization Services

- are voluntary short-term additional supports for those recipients who need more than brief crisis intervention because
  - the individual's stability is fragile,
  - his/her support system is weak or inconsistent
  - relapse is likely without these additional supports.

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## Crisis Stabilization Services

- Service Sites
  - recipients home
  - home of family or friend
  - provider office
  - another community setting
  - *short-term supervised licensed residential program*




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## Who, Why and Where?

- 7,646 individuals were served in 10,387 crisis episodes
  - Most often seen in their own home, the crisis team office and hospital EDs
- |   |
|---|
| <ul style="list-style-type: none"> <li>■ 5763 of the Crisis Episodes involved Suicidal Ideation and Depression</li> <li>■ 1247 episodes involved Anxiety</li> <li>■ 1406 involved Delusions or Psychosis</li> </ul> |
|---|

From CY 2010 Adult Mental Health Crisis Report

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## Who, Why and Where?(con't)

- 5059 were insured by a publicly funded Minnesota Health Care Program
- 4828 had another insurer or no insurance
- 3549 were self-referred or referred by family or friend
- 2871 were referred by a hospital ED
- 1064 episodes resulted in referral for inpatient hospitalization (10%)




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For Further Information about Mental Health Crisis Please See:

### **PRACTICE GUIDELINES: CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISIS;**

US DEPARTMENT OF HEALTH AND HUMAN SERVICES ADMINISTRATION  
CENTER FOR MENTAL HEALTH SERVICES  
[WWW.SAMHSA.GOV](http://WWW.SAMHSA.GOV)




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## Contact information

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  - lorraine.pierce@state.mn.us
- Phone
  - 651-431-2243

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## Presentation to the Rule 40 Committee

May 7, 2012, 9:30-12, Lafayette 3148

<b>Citations of state and federal laws/rules governing seclusion and restraint for mental health and other services</b>	
<b>NOTE:</b> Seclusion and restraint is regulated by facility type or service type—not by disability type or diagnosis type.	
Residential Treatment	Mn Rules, Part 2960.0680 referencing 2960.0710
Mental Health Centers and Clinics (Rule 29), including Community Mental Health Centers	Mn Rules, Part 2960.0710
Day Treatment--Children’s Mental Health	MS §245.8261
Children’s Mental Health Crisis Services	MS §245.8261
Emergency Services, children’s mental health	MS §245.8261
Family Community Support Services, children’s mental health	MS §245.8261
Therapeutic Support of Foster Care	MS §245.8261
Professional Home-Based Family Services, children’s MH	MS §245.8261
Treatment Foster Care (and all licensed family & corporate foster care)	Mn Rules, Part 2960.0710
Respite Care	Mn Rules, Part 2960.0710
Inpatient Psychiatric Hospitals--Community	Federal Hospital Patient’s Rights: 42 CFR Part 482.13 (e), (f), (g). Also The Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
State Hospitals	Mn Rules, Part 9515.3090
Residential Programs for Adults who are Mentally Ill	Mn Rules, Part 9520.0630, Subpart. 10.
Residential Chemical Dependency Treatment facilities	Mn Rules, Part 2960.0710
Electro-convulsive Therapy in state hospitals	Mn Rules, Parts 9515.0200 to 9515.0700
Juvenile Detention Centers	Mn Rules, Part 2960.0410, referencing 2960.0710
Licensed Shelters	Mn Rules, Part 2960.0710
MA does not cover aversive procedures	Mn Rules, Part 9505.0220
Special Education	M.S. 125A.0941

**Field –Test Survey Respondent Data Summary**

<u>Replies</u>	<u>1</u>			<u>2</u>			<u>3</u>			<u>4</u>			<u>5</u>			<u>6</u>			<u>7</u>			<u>8</u>			<u>9</u>			<u>10</u>			<u>*11</u>		
<u>Answer Key</u>	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A
<u>Questions</u>																																	
1	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
2	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
3	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
4	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
5	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
6	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
7	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
8	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
9	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
10	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
11	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
12	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
13	x		x		x	x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
14	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
15	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
16	x		x	x		x	x		x		x	x	x		x	x		x	x		x	x		x	x		x	x		x			x
17	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
18	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x		x	x			x
19		x	x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
20	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x
21	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x			x			x

## Field-Test Survey Respondent Data Summary

<u>Replies</u>	<u>1</u>			<u>2</u>			<u>3</u>			<u>4</u>			<u>5</u>			<u>6</u>			<u>7</u>			<u>8</u>			<u>9</u>			<u>10</u>			<u>*11</u>					
<u>Answer Key</u>	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A	C	U	A			
<u>Questions</u>																																				
22	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
23	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
24	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
25	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
26	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
27	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
28	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
29		x	x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
30	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
31	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		
32	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		x	x		

Answer Key C = Clear U = Unclear A = Answered Properly

### Summary:

- **Received** 11 provider responses out of 16 solicited service providers = @ 69 % reply rate.
- **Rate of return** required 1 MNITS mailbox distribution, 2 rounds of e-mail reminders and 1 round of personal telephone calls.
- **All 11 respondent providers** answered all questions 100% properly (some used N/A or left blank instead of using numeric 0 to indicate either not applicable or no one as the answer. Better highlighted instructions are needed for the use of numeric numeral 0.)
- **6 providers** expressed confusion with certain above highlighted questions. Sources of confusion were:
  - \* more clarity is needed in the instructions that this survey is about all planned and emergency uses of restrictive aversive/deprivation interventions beyond Rule # 40 emergency uses and controlled procedure programs;
  - \* question # 19 needs to be made simpler by asking straight forward about psychoactive medication usage, and eliminating the term or phrase, “behavioral control”;
  - \* question # 29 may require further refinement via a qualifier statement that excludes mental health clinician (psych., SW, therapist, counselor, etc.) clinic consultation sessions;
  - \*question # 18’s language may need some review to is if the question can be expressed more simpler; and finally,
  - \*Provider # 11 was a small ILST services provider, who found some questions awkward for his practice and small caseload (had no residences