October 22, 2017

ECF Filed

The Honorable Becky R. Thorson
United States Magistrate Judge
United States District Court - District of Minnesota
Warren E. Burger Federal Building
316 North Robert Street
St. Paul, MN 55101

Re: Jensen et al v. Minnesota Department of Human Services et al

Court File No: 09-CV-1775 DWF/FLN

Our File No.: 7400-001

Dear Magistrate Judge Thorson:

Pursuant to the Court's Order (<u>Doc. 652</u>), and after interacting with the Consultants, we submit this letter outlining ongoing noncompliance with the settlement and this Court's Orders by defendants Minnesota Department of Human Services and the State of Minnesota.

At the outset, we note this matter began with a September 2008 report by the State's Ombudsman documenting the appalling abuse of people with developmental disabilities at a state operated facility. Restraint with metal handcuffs and leg shackles was commonplace at Minnesota Extended Treatment Options, for trivial or no reason. There can be no justification, excuse, exemption or variance for the abuse of our vulnerable citizens - not then, or now.

dd: 952.806.0438

SHAMUS P. O'MEARA

Class Action Complaint (<u>Doc. 3</u>); Answer (<u>Doc. 24</u>) ¶ 39 (admitting use of restraints);

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¹ State Ombudsman's report, *Just Plain Wrong* at 17 (Doc. 3-1) ("Documents in individual records revealed that people were being routinely restrained in a prone face down position and placed in metal handcuffs and leg hobbles. In at least one case, a client that the metal handcuffs and leg hobbles were secured together behind the person, further immobilizing the arms and legs, reported it to the Ombudsman staff. Some individuals were restrained with a waist belt restraint that cuffed their hands to their waist. An individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall. Others were being restrained on a restraint board with straps across their limbs and trunk."). *See also* Amended

Repeated noncompliance and delay in the implementation of the class action settlement following this documented abuse have been hallmarks of defendants' post settlement conduct, forcing a motion for sanctions and Court action to appoint a court monitor and order compliance on repeated occasions:

From the outset, based on the Settlement Agreement's mandates, the Court has emphasized the dual nature of Defendants' obligations: (1) protection of individuals while they live in an institution; and (2) assurance of transition to quality care in the community. Nonetheless, the DHS has repeatedly failed to comply with these obligations. (See, e.g., Doc. No. 223 at 10; Doc. No. 159 at 12-13.) Whether this failure is due to the breadth of the necessary system changes, including training, coordinating, and holding accountable the State's eighty-seven counties, or the DHS' lack of a full-fledged Jensen oversight office until mandated in the Comprehensive Plan of Action (Doc. No. 283), or the DHS' indifference to or intentional non-compliance with the Settlement Agreement and related Orders of the Court (Doc. No. 259 at 5; Doc. No. 251 at 3), the Court respectfully directs the DHS to comply with the terms of the Court's Orders.

* * *

The Court can no longer tolerate continued delay in implementation of the Settlement Agreement. Adherence to the Court's Orders by the DHS officials and staff at all levels is essential, not discretionary. The interests of justice and fairness to each Class member and similarly situated individuals requires no less.

Order (<u>Doc. 340</u>) at 3-6.

After years of court-identified findings of noncompliance with their settlement promises, defendants claim there is nothing else to be done. Rather than complying with this Court's orders to identify and collaborate to complete their settlement obligations, (*see* Doc. 638, 652),² defendants have now filed a motion for an "order staying their

² See also Doc. 233 at 1-3; at 7 ("In lieu of contempt and other sanctions at this time, the Court requires Defendants to fulfill their obligations in a timely manner for the Court's review and approval; attend any status conferences that may be scheduled by the undersigned or Magistrate Judge Becky R. Thorson regarding the Olmstead Plan; and actively seek input from the consultants to the parties, Dr. Colleen Wieck and Roberta Opheim, in this process."); The Court encourages Defendants to timely fulfill their obligations under the Settlement Agreement."); Order dated May 5, 2015 at 7 (Doc. 435) ("The Court has repeatedly expressed its concerns regarding Defendants' pattern of noncompliance with the terms of the Settlement Agreement that were announced at the Final Approval Hearing before this Court on December 1, 2011, and reaffirmed in this Court's numerous subsequent orders. (See, e.g., Doc. No. 188; Doc. No. 205, Doc. No. 212, Doc. No. 223, Doc. No. 259, Doc. No. 368, Doc. No. 400.)

obligations related to the parties' Settlement Agreement and the Court's subsequent orders." (Doc. 655).

This eleventh hour filing by defendants, rather than engaging in the collaboration required by the Court, is telling. It portends a very real danger that if granted a stay and left on their own defendants will continue their delay and noncompliance and may no longer honor settlement obligations, even perhaps continuing to roll back agreed upon protections. See, e.g., Doc 586 (referencing use of variances to the Positive Supports Rule to allow for mechanical restraint and other abuses on people with developmental disabilities), at p. 12 ("DHS failure to clarify and provide guidance by its internal enforcement division points up a critical danger to people with developmental disabilities in this state, leaving facilities, and families, without clear, direct guidance needed to avoid misinterpretation about the PSR, increasing the risk the using of prohibitive abusive procedures on vulnerable citizens. This DHS inaction further supports Court involvement and active monitoring to ensure that the CPA is properly implemented, and the PSR properly enforced by DHS.")

Importantly, "[a] stay is not a matter of right, even if irreparable injury might otherwise result to the appellant. It is an exercise of judicial discretion. The propriety of its issue is dependent upon the circumstances of the particular case." *Scripps-Howard Radio v. F.C.C.*, 316 U.S. 4, 10-11 (1942); *Niken v. Holder*, 556 U.S. 418, 433 (2009). Here, there is a significant backdrop of noncompliance and delay caused by the defendants clearly demonstrated in the six year record since the approval of the settlement agreement. Mindful of this record, the Court should exercise its sound discretion and continue enforcing its orders to implement the settlement agreement "as the Court deems just and equitable" and avoid additional delay in the delivery of justice pursuant to the parties' agreement. *See, e.g.*, Order (Doc. 340) ("The Court can no longer tolerate continued delay in implementation of the Settlement Agreement. Adherence to the Court's Orders by the DHS officials and staff at all levels is essential, not discretionary. The interests of justice and fairness to each Class member and similarly situated individuals requires no

³ This motion comes *four* months after the Court ordered defendants to identify the remaining issues for the completion of their settlement obligations, and after many hours have been expended by the Consultants and our office working to identify these issues. A motion to stay should be entered only where it is a proper exercise of the court's discretion, *Rhines v. Weber*, 544 U.S. 269, 276 (2005). Here, the defendants cannot meet their heavy burden of establishing the need for a stay from court involvement that was necessitated by their own conduct. *Nken v. Holder*, 556 U.S. 418, 433-34 (2009); Charles Alan Wright, Arthur R. Miller, Mary Kay Kane, Richard L. Marcus, & Adam N. Steinman, *Federal Practice and Procedure* § 2904 (3d ed. 2015) ("[B]ecause the burden of meeting the standard is a heavy one, more commonly stay requests will be found not to meet this standard and will be denied.").

less."); *Robinson Rubber Prods. Co., Inc. v. Hennepin Cty.*, Minn., 927 F. Supp. 343, 348 (D. Minn. 1996) (the public interest favors the enforcement of the United States Constitution); *Ecolab, Inc. v. FMC Corp.*, No. 05-CV-831, 2007 WL 1582677 (D. Minn. 2007) ("Courts have denied motions to stay when 'there is an inexplicable or unjustified delay in seeking re-examination' or when it appears that a stay 'will serve simply to delay proceedings."")

As shown below, the State's Ombudsman, still involved in protecting our vulnerable citizens, along with the executive director of the Minnesota Governor's Council on Developmental Disabilities, serving as Consultants in this matter, have a much different view of defendants' remaining settlement obligations. The Independent Court Monitor, moreover, appointed by the Court after ongoing noncompliance by the defendants,⁴ has identified many areas of noncompliance.

NONCOMPLIANCE IDENTIFIED BY THE CONSULTANTS

The Consultants recently identified the following regarding DHS ongoing noncompliance:

We remain concerned about several areas where DHS has not complied with the Jensen Settlement Agreement and Comprehensive Plan of Action. Of great concern is the lack of adequate housing and services for people who would previously have been served by

⁴ Order (<u>Doc. 159</u>) at 14 n.22 ("Defendants have requested Mr. Ferleger's consultation to advise the Olmstead Committee under the Settlement Agreement."); at p. 11 ("Appointment of an independent advisor, consultant, or monitor is appropriate in light of the nature and complexity of the Defendants' obligations under the court-approved Settlement Agreement, the fact that Defendants admit they are already in non-compliance with an important element of their obligations (appointment of the "external reviewer"), the gaps and deficiencies in the Defendants' May 14 and July 9, 2012 compliance reports, the failure to file required reports by the External Reviewer, the compliance deficiencies raised by Plaintiffs' Class Counsel, and the special expertise required for effective review of the systemic elements of the Settlement Agreement."); Order (Doc. 156) at 10; Order (Doc. 160) at 1; Order (Doc. 205) at 5-7 ("In the context of the issue of noncompliance with the original Settlement Agreement the Court respectfully declines; absent further order of the Court, to modify the role of David Ferleger or to otherwise approve the stipulation of the parties at this time." "[T]he focus of David Ferleger will be to evaluate compliance and noncompliance vis a vis a mediation approach."); Order (Doc. 551) ("The Court Monitor was appointed by the Court on July 17, 2012. (Doc. No. 159.) Over the years, the Court has assigned various duties to the Court Monitor in order to promote compliance with the Jensen Settlement Agreement. Many of these duties evolved through the agreement and cooperation of the parties. The Court will consider modifying aspects of the Court Monitor's role if DHS's new internal and external verification mechanisms are demonstrated to appropriately (internally and externally, through independent review) audit compliance with the Jensen Settlement Agreement and the CPA.")

METO. There continues to be inadequate services for: "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety." (Evaluation Criteria IV.3.) Although MN Life Bridge [MLB] was intended to meet some of this need by providing crisis stabilization services for 90 to 180 days (EC 93) people have remained there for much lengthier stays, including one person who has lived there for over two years. (See Evaluation Criteria 88, 48 and 95.) In addition, although the settlement said that four homes would be provided it also said that more could be developed based upon need. (See EC 88.) The need for services is demonstrated by the list of people who are not served as identified in the Diversion Minutes dated 9/11/17:

- Of 18 persons not formally referred for admission into Minnesota Life Bridge there are three who have been on the list for more than a year;
- Of the 14 people who would formally be referred to MLB one has been on the list more than one year, one has been waiting for an opening at MSH since May 2017 and remains in the hospital;
- The status of transition planning for 9 persons shows that two have been on the list since 2015 and three have been on the list for over a year; and
- Page 6 of the Weekly Diversion Meeting minutes, first section, under "Current Status" states: "Typically placement takes 3-6 months."

The lengthy stays perpetuate the shortage of crisis service options available and directly relates to the Olmstead Plan goal and vision of people with disabilities living in the most integrated setting of their choice. People must be able to receive appropriate short term crisis stabilization services in order to be reintegrated to their community setting as early as possible.

Our second concern is that transition plans did not meet EC 54-60 which identify the use of person centered planning for each resident through-out the planning process. This is shown by:

- Evaluation Criteria 48, Doc. No. 589, pp. 28-29 ("However, it took longer than 30 days to develop a transition plan for two of the persons admitted during the reporting period. MLB reported that the delay in initiating the two transition plans was due in part to a delay in receiving documentation from the referral source.")
- Doc. No. 589, pp. 30-31 ("JOQACO also identified opportunities for performance improvement, including the following: JOQACO determined that MLB staff initiated only two of the four draft Transition Plans reviewed within the 30-day period stated in Action 48.1. This delay in initiating the Transition Plan is a barrier to transition that MLB needs to address.")

- EC 50-53. DHS contracted with The Arc Minnesota to do desk audits of any person centered plans of class members. We were able to review an excel spreadsheet and it appears that 1/3 of the class members have PCPs and of that group 1/3 have PCPs that meet criteria. This information cross references to EC 110 and 111. EC 48, pages 19-20, Transition planning is central. [See enclosed Arc PCP Survey Summary which was developed by the DD Council, in draft form as no response to the document was provided].
- We also remain concerned about the use of prohibited procedures and the lack of community jobs for MLB residents (EC90).

The Consultants also summarized several noncompliance areas identified by the Court Monitor:

Noncompliant EC—9/29/16 (Doc. No. 595)

EC25. Abuse/Neglect Investigations

- For the reports by the DHS OIG, DHS reports nothing about the circumstances, any commonalities or differences, or how the abuse/neglect was addressed by DHS or the providers.
- DHS reports no information on whether DHS OIG investigators, interviewers and writers received the required training with regard to the 14 cases.
- DHS reports no information on whether there is an electronic data management system and, if so, whether it meets the requirements.
- DHS reports no information on whether substantiated allegations are documented in the individuals' Facility records.
- Unreported staff arrest for sexual abuse.

EC26. Abuse/Neglect Staff Discipline

- Except for 1 of the cases, DHS fails to report on any discipline or other action in these staff abuse/neglect cases.
- There is no statement in the DHS report that the perpetrators in both cases were disciplined; only one case (3 employees) is referenced as involving discipline.
- Again, the unreported staff arrest for sexual abuse.

EC58. Facility Staff Training: Person-Centered

• MLB was supposed to produce an action plan on the processes and expectations for training —particularly the content, competency and documentation requirements associate with self-study training hours— to better ensure the consistency and quality of training. Did this happen?

EC69. Long Term Monitoring

- DHS reported and verified that 61 individuals are in long term monitoring but the requirement is that approximately 75 individuals are targeted for long term monitoring.
- DHS does not assert in their reports that there are no more than 61 individuals who meet the criteria for long term monitoring.
- The EC Actions include detailed identification process and criteria as well as a requirement for specific semi-annual status reviews. No information was provided on these elements.

EC93. Diversion Supports & Data Analysis

- Comprehensive data analysis on the diversion supports: augmentative service supports, consultation, mobile teams, and training to those supporting the person.
 DHS does not report that there is such analysis or, if not, when and how it will be provided.
- An effectively functioning system, serving hundreds of individuals under this EC with dozens of professional staff, requires analysis of data on what is happening (or not happening) for the individuals intended to benefit from the activity. DHS acknowledged that this piece was missed, but what has it done in the meantime to remedy it?

The Consultants also identified several areas where DHS admits it is noncompliant:

- EC1, <u>Doc. 604</u>, <u>p.11</u>. DHS acknowledges that it could do a better job of reporting.
- <u>Doc. 622</u>, <u>p. 9</u> ("The Department acknowledged, however, that the specificity of reporting for EC 1 could improve to better illustrate the extent of the Department's efforts in this area.")
- Doc. 622, p. 14 n. 12 ("As previously reported (e.g., Doc. No. 614-1 at 31), length of stay at Minnesota Life Bridge remains a challenge due mainly to community capacity for serving people with challenging behaviors, complex mental health needs, or legal issues.")
- <u>Doc. 622, p. 16</u> ("The *Jensen* Internal Reviewer and JOQACO analyst observed that three areas—work, transportation, and lifelong learning/education—were not expressly addressed in any of the reviewed CSSP or CSSP-A documents.")
- EC 5, 10, 13 and 14 MLB continues to use EUMR, PRNs, and 911 calls. (See the most recent Table below).
- EC 15-21. These ECs reference external experts who were to be consulted contemporaneously with any EUMR. DHS never complied and called the Medical

Officer. However, it should be noted that the MLB staff did not consult in a timely fashion.

- EC 47, <u>Doc. 589</u>, <u>p. 27</u> ("In the Ninth Compliance Update Report (Doc. No. 531), the Department reported that it was difficult for some treatment teams to accept the direction or expectations of MLB during the person's stay, such as the importance of seeking permanent options of the importance of positive behavior supports/personcentered approaches. (*Id.* at 34.)")
- Doc. 589, p. 27 ("In the Ninth Compliance Update Report (Doc. No. 531), the Department also reported that one of the challenges to continued compliance with [EC 47] is a lack of community capacity for transitioning persons out of MLB.")
- EC 48, Doc. No. 589, pp. 28-29 ("However, it took longer than 30 days to develop a transition plan for two of the persons admitted during the reporting period. MLB reported that the delay in initiating the two transition plans was due in part to a delay in receiving documentation from the referral source.")
- Doc. No. 589, pp. 30-31 ("JOQACO also identified opportunities for performance improvement, including the following:
 - JOQACO determined that MLB staff initiated only two of the four draft Transition Plans reviewed within the 30-day period stated in Action 48.1. This delay in initiating the Transition Plan is a barrier to transition that MLB needs to address.
 - MLB needs to provide clearer documentation in the Transition Plan regarding options that have been pursued, identification of outcomes and any barriers to transition.
 - After identification of a provider, MLB should have a standardized process for transition planning to clarify who is responsible for each task and the necessary timeline (for areas such as operations, clinical, and logistics).
 - MLB and Community-Based Services need to develop strategies regarding the transition of persons who no longer require MLB level of services but are reluctant to leave MLB.")
 - EC 49, Doc. No. 604, p. 20 Court Monitor said that verification is missing because there were no visits and no interviews.
 - EC 50-53--DHS CONTRACTED WITH THE ARC MINNESOTA TO DO DESK AUDITS OF ANY PERSON CENTERED PLANS OF CLASS MEMBERS. WE WERE ABLE TO REVIEW AN EXCEL SPREADSHEET AND IT APPEARS THAT 1/3 OF THE CLASS MEMBERS HAVE PCPS AND OF THAT GROUP 1/3 HAVE PCPS THAT MEET CRITERIA. THIS INFORMATION CROSS REFERENCES TO EC 110 AND 111.

- EC 85, Doc. No. 604, p. 33. DHS does not limit to class members and there is no mention of class members. Proposed follow-up of commitments to Anoka has no relation to EC 85. Anoka seems to have received the least attention across many of the provisions.
- EC 90, Doc. No. 604, p. 34. Vocational issues at facilities. Vocational services ended when MSHS-Cambridge opened on July 1, 2011. Since then there have been no vocational services provided. DHS hired a subject matter expert and a new position was created. Individuals are now beginning the discovery process for employment. Work is underway. (I have a chronology of this EC that dates back a couple of years)
- EC 93. The MLB length of stay is not short term. As envisioned MLB would be short term stabilization for 90 days. One person has lived at MLB for more than 2 years. We can calculate length of stay across all people if needed.
- EC 98. Successful Life Project. The Court stated (Doc. 551, 3/18/16) "Based upon the information in the Report, the court is unable to evaluate outcomes for individuals in the therapeutic follow-up group. While DHS describes the Successful Life Project in some detail, it has not provided sufficient information regarding the outcomes of the project. (This led to Dan Baker, Peg Booth and David Ferleger in a stalemate about the results of SLP.)

Table 1: Monthly Summary of DHS 3654 Forms Completed

Month	Location	PRN	911 Call	PRN & 911 Call	EUMR	EUMR & PRN	EUMR & 911 Call	EUMR & PRN & 911 Call
January 2017	Stratton							
	Broberg's	2						
	Eagle	8	2	1	3	1	2	
February 2017	Stratton		1		1		1	
	Broberg's				1	1		
	Eagle	5	1	1			1	
March 2017	Stratton		1					
	Broberg's				1		2	
	Eagle	4				2	1	
April 2017	Stratton	4	2					
	Broberg's		2			1		
	Eagle	1	4					
May 2017	Stratton		1					
	Broberg's	1	1				1	1
	Eagle	2	1	1	1			

Month	Location	PRN	911 Call	PRN & 911 Call	EUMR	EUMR & PRN	EUMR & 911 Call	EUMR & PRN & 911 Call
	Stratton							
June	Broberg's	1	1	1				
2017	Eagle	4	1					2
	TOTALS	32	18	4	7	5	8	3

- The court monitor report (<u>Doc. 595</u>) contains the most details about non-compliance.
- Weaknesses in Defendants' Self-reporting. The assessment makes plain several weaknesses in Defendants' self-reporting and verification which impact on assessing substantial compliance:
- Outcomes related to quality of life or required interactions among people are not verified, and typically not reported, in the DHS compliance reports.
- Interviews with individuals with first hand compliance information do not take place as a regular part of DHS self-evaluation.
- Document review is virtually the sole source of DHS compliance information.
- Verification of the adequacy of community settings and services takes place without visits to the community settings or services, or meeting the individuals.
- The reliability and completeness of the reported information is in doubt in some respects.
- For elements with a "best efforts" standard, information demonstrating best efforts is not provided.

DEFENDANT DEPARTMENT OF HUMAN SERVICES' AUGUST 2017 SEMI-ANNUAL COMPLIANCE REPORT (DOC. 643) IDENTIFIES ADDITIONAL NONCOMPLIANCE

The Minnesota Department of Human Services August 2017 Semi-Annual Compliance Report (<u>Doc. 643</u>) (August Report) shows that DHS admits to ongoing compliance issues. Evaluation Criteria 47 of the Comprehensive Plan of Action for the implementation of the Settlement Agreement, which was ordered by the Court without objection by defendants, provides:

"The State undertakes best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. Each individual currently living at the Facility, and all individuals admitted, will be assisted to move towards more integrated community settings. These settings are highly individualized and maximize the opportunity for social and physical integration, given each person's legal standing. In every situation, opportunities to move to a living situation with more freedom, and which is more typical, will be pursued."

August Report (Doc. 643), at p. 24.

Evaluation Criteria 48 of the Comprehensive Plan of Action provides:

"The State actively pursues the appropriate discharge of residents and provided them with adequate and appropriate transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting and to which the individual does not object."

August Report [Doc. 643], at p. 25.

The August Report shows that despite its design as a temporary treatment program individuals with developmental disabilities residents have resided there for lengthy time periods, often approaching and exceeding one year including 350 days, 695 days, 296 days, and 534 days. (Doc. 643), at pp. 29-30. The August Report also describes several impediments to transitioning residents into the most integrated setting including hesitancy to providing supports in the community, problems with negotiating county reimbursement rates, finding a landlord, buyers backing out of real estate deals, frustration with the length of time for transition, delays from construction of a new home, and ongoing searches for property located close to friends and family. *Id.* The report stated that DHS continues to work on developing transition planning and providing transition of residents. *Id.*, at pp. 31-33.

Evaluation Criteria 102 covers the Positive Support Strategies and Restrictive Interventions Rule (Positive Support Rule), which was developed as part of the modernization of Rule 40 pursuant to the Settlement Agreement and the Comprehensive Plan of Action. Ex. T (Doc. 283), at p. 33. EC 103 provides:

Within thirty (30) days of the promulgation of the Adopted Rule, Plaintiffs' Class Counsel, the Court Monitor, the Ombudsman for Mental Health and Developmental Disabilities, or the Executive Director of the Governor's Council on Developmental Disabilities may suggest to the Department of Human Services and/or to the Olmstead Implementation Office that there are elements in the Rule 40 Advisory Committee Recommendations on Best Practices and Modernization of Rule 40 (Final Version - July 2013) which have not been addressed, or have not adequately or properly been addressed

in the Adopted Rule. In that event, those elements shall be considered within the process for modifications of the Olmstead Plan. The State shall address these suggestions through Olmstead Plan sub-cabinet and the Olmstead Implementation Office. Unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court.

Id; (<u>Doc. 643</u>), at p. 97.

The August Report (Doc. 643), at p. 97 states:

The Department continues to meet with the Office of Ombudsman for Mental Health and Developmental Disabilities and the Governor's Council on Developmental Disabilities to discuss elements of the Rule 40 Advisory Committee recommendations that may not be adequately or properly addressed by the Positive Supports Rule or other Department efforts.

In addition, the undersigned has expressed significant concerns involving recent DHS attempts to create variances in the application of the Positive Supports Rule to allow for the use of restraints and seclusion on people with developmental disabilities, despite their specific settlement promises to prohibit their use and their statements as part of the rulemaking process that they would ensure that restraints and seclusion are not used at state operated and licensed facilities. *See e.g.*, (Doc. 586) (enclosed), at p. 11 (citing DHS Statement of Need and Reasonableness, Proposed New Permanent Rules Governing Positive Supports, and Prohibitions and Limits on Restrictive Interventions ("in connection with the Jensen Settlement Agreement" and "As a result of the proposed rule, no Department-licensed service or facility will be permitted to use outdated and unacceptable practices for persons governed by the statute and rule."), and citing to the May 18, 2016, letter from the Minnesota Disability Law Center expressing concern about a purpose-based exception having the potential to render the entire "Prohibited Procedures" portion of the Positive Supports Rule null and void. *Id*.

The Consultants advise that they continue to work with defendants to address several remaining issues involving the implementation of the Settlement Agreement, including lengthy stays (some well over a year) at Minnesota Life Bridge, and that residents at MLB do not have Transition Plans or Person Centered Plans that comply with the Settlement Agreement and its implementation requirements, and that they have minimal or no vocational plans. They further advise that they continue to work with defendants concerning ongoing issues involving Evaluation Criteria 103 to address important concerns involving the scope and implementation of the Positive Supports Rule to ensure that people with developmental disabilities are protected against restraint and seclusion.

The State Ombudsman further advises that she remains concerned about the lack of progress to develop crisis homes and appropriate crisis response for people with

developmental disabilities as part of the Olmstead Plan and defendants' commitments to protect and support people with developmental disabilities.

CONCLUSION

The defendants have created the current post settlement situation through years of non-compliance with the settlement, including documented failures to implement proper transition planning for people with disabilities, and ongoing use of abusive punishment procedures on people with developmental disabilities. There remains a continuing need for the Court's involvement and monitoring to ensure proper implementation of the settlement with all current reporting obligations to remain in place.

Thank you.

Respectfully submitted,

O'MEARA, LEER, WAGNER & KOHL, P.A.

/s/ Shamus P. O'Meara

Shamus P. O'Meara SPO:tlb Enclosures

Arc Desk Audit: Person-Centered Planning

Survey Summary

Overview.

The Arc surveyed 196 (61%) of the Jensen Class Members between March and July 2015.

Of the Class Members surveyed:

- 73 (37%) had a distinct Person-Centered Plan;
- 54 (28%) did not have a distinct Person-Centered Plan; and
- 69 (35%) did not answer.

Plan Type.

For Class Members with a distinct Person-Centered Plan, respondents were asked which person-centered planning processes were used. No Class Members used more than three (3) processes. Of the Class Members surveyed:

- 18 (9%) used Essential Life Plan (ELP);
- 1 used MAPS;
- 1 used Personal Futures Planning;
- 3 (1%) used Planning Alternative Tomorrow with Hope (PATH);
- 23 (12%) used Picture of a Life;
- 20 (10%) used One Page Profile;
- 27 (14%) used Person Centered Description;
- 9 (5%) used an unknown or unidentified plan; and
- 72 (37%) used another plan.

For Class Members without a distinct Person-Centered Plan, respondents were asked which plans were reviewed to complete the survey.² One (1) Class Member used more than three (3) plans. Of these Class Members surveyed:

- 28 (14%) used Coordinated Service and Support Plan (CSSP);
- 18 (9%) used Coordinated Service and Support Plan Addendum (CSSP-Addendum);
- 8 (4%) used Individual Abuse and Prevention Plan (IAPP); and
- 54 (28%) used another plan.

¹ This question was intended only for those Class Members with a distinct Person-Centered Plan, however, some respondents that did not answer the first question indicated that a person-centered process was indeed used. Therefore, percentages are for all Class Members surveyed (196) instead of the 73 Class Members with a distinct Person-Centered Plan.

² Again, some respondents that did not answer the first question indicated that other plans were reviewed to complete the survey. Thus, percentages are for all Class Members surveyed and not for those that did not have a distinct Person-Centered Plan.

Plan Characteristics.

General Critical Figures.

Respondents were asked to review and rate the entire plan by seven General Critical Figures (CF), which are:

- 1. Person-Centered Planning goals attempt to increase quality of life, not simply maintain it;
- 2. The plan is designed to make a meaningful positive difference in the life of the person;
- 3. The plan clearly reflects the values and beliefs (philosophy and foundation) of Person-Centered Planning;
- 4. The plan has sufficient detail to answer what is important to the person;
- 5. The plan describes what is important for the person in the context of what is important to the person;
- 6. The plan addresses what needs to stay the same, to be maintained, or enhanced; and
- 7. The plan addresses what needs to change.

Only three (3) Class Members had a plan that contained all seven General CF. On average, plans contained between two (2) and three (3) of the seven General CF (36.7%). Of the Class Members surveyed:

- 1. 73 (37%) had a plan that attempted to increase quality of life;
- 2. 79 (40%) had a plan that was designed to make a meaningful positive difference in their life;
- 3. 63 (32%) had a plan that clearly reflected the values and beliefs of Person-Centered Planning;
- 4. 104 (53%) had a plan with sufficient detail to answer what is important to the person;
- 5. 82 (42%) had a plan describing what is important for the person in the context of what is important to the person;
- 6. 69 (35%) had a plan addressing what needs to stay the same, be maintained, or enhanced; and
- 7. 34 (17%) had a plan addressing what needs to change.

Other Criteria.

For a variety of criteria divided into three categories (planning, supports, follow-up), respondents were asked to score Class Member plans two (2) points for complete information, one (1) point for incomplete information and zero (0) points for no information, for a possible **62 points total**.

The criteria for planning are:

- Identifying Information;
- Personal Information
 - Brief history of the person's life;
 - o Important places for the person;
 - Opportunities for the person to interact with friends or family;
 - Description of the person's strengths;
 - Description of the person's preferred method of communication;
 - Opportunities for choice in the person's current environment;
 - Description of current health and physiology issues;
 - Description of mobility (motor and transportation) issues;
 - Description of current rituals and routines;

• Specific Information

- People important to the person;
- Person Centered tools and skills to collect information on how the person wants to live;
- Global statement of the person's dreams;
- Description of the person's preferred living setting;
- With whom the person wants to live;
- With whom the person wants to socialize;
- o Description of the work or school activities the person wants to do;
- Description of the social, leisure, or religious activities in which the person wants to participate;
- o Description of the skills or leisure activities the person wants to learn; and
- Description of barriers to achieving the person's preferences.

The criteria for supports are:

- Person-Centered Planning
 - Description of goals or skills related to the person's preferences to be achieved;
 - Description of activities needed to assist the person to achieve goals;
 - Description of support staff training needed to assist the person to achieve goals;
 - Description of materials, equipment, assistive technology needed to assist the person to achieve goals;
 - o Description of extra services and supports needed to assist the person to achieve goals;
- General Considerations and Contextual Fit
 - Description of resources needed for implementation;
 - o Description of process for monitoring the Person Centered Plan; and
 - o Evidence of consideration of team members' values and expectations.

The criteria for follow-up are:

- Evaluation of goals achievement;
- Inclusion of statements regarding Specific Information (see planning category) in the evaluation of changes in the person's Person-Centered Plan; and
- Existence of a revision plan in the event of changes to the Person-Centered Plan, achievement of goals, or the provision of an unresponsive service.

For the Class Members surveyed (62 points total):

- The average **planning score** was 16.54 (41.3%);
- The average **supports score** was 3.60 (22.5%);
- The average follow-up score was 1.23 (20.6%); and
- The average **overall score** was 21.37 (34.5%).

Conclusion.

The data suggest that **more than one-third** of *Jensen* Class Members have a Person-Centered Plan and, on average, *Jensen* Class Members' Person-Centered Plans are **little more than one-third complete**.

August 24, 2016

ECF Filed

The Honorable Donovan W. Frank United States District Court - District of Minnesota Warren E. Burger Federal Building 316 North Robert Street St. Paul, MN 55101

Re: Jensen et al v. Minnesota Department of Human Services et al

Court File No: 09-CV-1775 DWF/FLN

Our File No.: 7400-001

Dear Judge Frank:

We submit this letter pursuant to the Court's August 19, 2016, Text Order, in opposition to the August 16, 2016, DHS request to reconsider the Court's July 22, 2016 Order (Doc. 580). DHS has not established any manifest error or compelling basis for reconsideration. Rather, DHS actively sought the participation and guidance of the Court, Court Monitor and Consultants on the very issue it now wants to disclaim. In addition, the years long, admitted, non-compliance by DHS on fundamental aspects of the Stipulated Class Action Settlement Agreement, including documented failures to implement proper transition planning for people with disabilities, and recent DHS advocacy for the use of ongoing abusive punishment procedures on people with developmental disabilities, requires active ongoing involvement and monitoring by the Court.

In the Settlement, DHS expressly agreed to the Court's jurisdiction:

The Court shall retain jurisdiction over this matter for two (2) years from its approval of this Agreement for the purposes of receiving reports and information required by this Agreement, or resolving disputes between the parties to this Agreement, or as the Court deems just and equitable.

Final Approval Order for Stipulated Class Action Settlement (Doc. 104) Ex. A at Sec. XVIII.B.¹

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¹ The Court also has ancillary jurisdiction to enforce a settlement agreement "if the parties' obligation to comply with the terms of the settlement agreement is made part of the order of dismissal; either by...a provision retaining jurisdiction over the settlement agreement or by incorporation of the terms of the settlement agreement in the order." *Kokkonen v. Guardian Life Insurance Co. of America*, 511 U.S. 375 (1994). Additionally, the parties' settlement and stipulated dismissal does not deprive the Court of its power to impose sanctions under its inherent authority. *See Fox v. Acadia State Bank*, 937 F.2d 1566,

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The Honorable Donovan W. Frank August 24, 2016 Page 2

The Settlement includes substantial statewide promises and action to protect and improve the lives of people with disabilities, including the development of best practices, rules and protections.² Over four years ago, the Court made clear to the parties and public what this iurisdiction meant in this wide-sweeping, complicated settlement:

The subject matter encompassed by the Settlement Agreement is specialized and its implementation is admittedly complex, involving intricate and interlocking activities by multiple state agencies, state officials, and others, over many months. As the Court stated at the settlement approval hearing, the credibility and reliability of the judicial process is at stake when an order such as this is entered and, therefore, the Court intended to ensure that it was fully informed on the progress of implementation. The First Circuit Court of Appeals expressed this view in a systemic education case, explaining that "the monitoring process is a basic responsibility of the court. To the extent that the myriad of minor problems which will arise can be resolved without the necessity of resorting to the district judge, the process of implementation will be facilitated." Morgan v. Kerrigan, 530 F.2d 401, 429 (1st Cir. 1976), cert. denied, 426 U.S. 935 (1976).

[T]he Court also acknowledged, at that time, its obligation to oversee, facilitate, and enforce compliance with the terms of the Settlement Agreement, which was intended to benefit many individuals with developmental disabilities for years to come.

Order of July 17, 2012 at 12. (Doc 159); see Order of December 20, 2012 at 3 (Doc. No. 188); In re Corrugated Container Antitrust Litig., 752 F.2d 137, 141 (5th Cir. 1985) ("In a class action, the district court has a duty to class members to see that any settlement it approves is completed, and not merely to approve a promise, even in the form of a negotiable instrument, to pay the relief to which it has decided class members are entitled.")

The Court has clearly, and repeatedly, reinforced the gravity of the Settlement and the role of the Court as requested by the parties. Significantly, DHS never previously objected to the Court's jurisdiction over the Settlement. Instead, DHS sought the Court's involvement over the Settlement, reaffirmed through DHS active participation with the Court, Court Monitor and Consultants, seeking their involvement in hundreds of issues throughout the multi-year

1568–1569 (11th Cir. 1991) (ruling that the parties' settlement and stipulated dismissal pursuant to Rule 41(a)(2) did not deprive the district of jurisdiction to impose sanctions on motion of a party); Adduono v. World Hockey Ass'n, 824 F.2d 617, 621-22 (8th Cir. 1987).

² Amended Order of August 28, 2013 at 7 (Doc. 224) ("The historic settlement in this litigation was

hailed by Plaintiffs and Defendants alike as one which would fundamentally improve the lives of individuals with disabilities in Minnesota and serve as a national model. The settlement's innovations were both with regard to replacement of mechanical and other restraints with positive behavioral supports and development of a comprehensive all-disabilities plan to implement the Supreme Court's decision

under the Americans with Disabilities Act in Olmstead v. L.C., <u>527 U.S. 581</u> (1999).")

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implementation of the Settlement. DHS has been the catalyst for Court action to facilitate implementation of the Settlement, as expected by DHS.³

We are now into the sixth year after the State and DHS signed the Settlement, and nearly five years from the Court's final approval of the Settlement. The delay in implementing the Settlement, and the Court's active involvement, falls directly on DHS for its documented failures and non-compliance, often admitted by DHS, 4 to meet its critical Settlement promises to people with disabilities, and its public statements and policies affecting the lives and civil rights of these citizens and their families. DHS non-compliance has led to additional extensions of the Court's jurisdiction, agreed upon by DHS, and the appointment of an Independent Court Monitor. 5

Despite its explicit orders, the Court continued to find DHS in non-compliance and the ongoing need for Court involvement. For example, in its August 27, 2013, Order the Court stated:

On April 25, 2013, the Court issued an Amended Order and Memorandum ("Order of April 25, 2013") in this matter and again expressed its continued concern over the status of the case and its ongoing concern with noncompliance with the Settlement Agreement by the Defendants. (Doc. No. 212.) The Court remains concerned with the status of compliance or noncompliance by the Defendants with the provisions of the Stipulated Class Action Settlement Agreement ("Settlement Agreement"), (Doc. No. 104), and its impact on the individuals with developmental disabilities who are Class Members and, in light of the promises made by the parties at the December 1, 2011 hearing for final approval of the Settlement Agreement, the promises and representations to all individuals with developmental disabilities.

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³ See e.g., Order of July 17, 2012 at 10-11 (<u>Doc. 159</u>) ("Defendants acknowledge that they expect to have their compliance monitored. Anne Barry, Deputy Commissioner of the Defendant Minnesota Department of Human Services, affirmed at the settlement approval hearing that Defendants expected external scrutiny in this case: "First of all, we fully expect that watchfulness and scrutiny. We are in the business of public service, so we understand we will be watched. We expect that we will be watched.")

⁴ See e.g., Doc. 159 at 8 ("Considered in full, Defendants' most recent filing presents serious questions and seemingly contradictory information regarding compliance. DHS itself is highly critical of the "first quarterly report," repeatedly pointing out its weaknesses and omissions with regard to "core elements to the Jensen settlement."). See also Matter of Westling Mfg., Inc., 442 N.W.2d 328, 333 (Minn. Ct. App. 1989) ("Those who deal with Government are expected to know the law . . . ").

⁵ Doc. 159 at 14 n.22 ("Defendants have requested Mr. Ferleger's consultation to advise the Olmstead Committee under the Settlement Agreement."); *Id* at 11 ("Appointment of an independent advisor, consultant, or monitor is appropriate in light of the nature and complexity of the Defendants' obligations under the court-approved Settlement Agreement, the fact that Defendants admit they are already in non-compliance with an important element of their obligations (appointment of the "external reviewer"), the gaps and deficiencies in the Defendants' May 14 and July 9, 2012 compliance reports, the failure to file required reports by the External Reviewer, the compliance deficiencies raised by Plaintiffs' Class Counsel, and the special expertise required for effective review of the systemic elements of the Settlement Agreement.")

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Based upon the presentations and submissions of the parties since the Court's Order of April 25, 2013, including the submissions of the Court Monitor, and given the continued concerns of this Court, as noted above, relating to the status of the case and ongoing concerns with noncompliance with the Settlement Agreement by the Defendants; the Court having again reviewed the procedural history of the case; and the Court being otherwise duly advised in the premises, the Court hereby enters the following:

ORDER

1. Extension of Jurisdiction

The Court, having been advised by the Court Monitor that the parties have agreed that the Court's retention of jurisdiction over the above-entitled matter may be extended for an additional year to December 4, 2014, beyond the current December 4, 2013 date, pursuant to Section XVIII.B. of the Settlement Agreement, the Court hereby extends its jurisdiction over this matter to December 4, 2014. However, the Court expressly reserves the authority and jurisdiction to order an additional extension of jurisdiction, depending upon the status of compliance by the Defendants with the specific provisions of the Settlement Agreement, absent stipulation of the parties.

Doc. 233 at 1-3; at 7 ("In lieu of contempt and other sanctions at this time, the Court requires Defendants to fulfill their obligations in a timely manner for the Court's review and approval; attend any status conferences that may be scheduled by the undersigned or Magistrate Judge Becky R. Thorson regarding the Olmstead Plan; and actively seek input from the consultants to the parties, Dr. Colleen Wieck and Roberta Opheim, in this process."); Order of April 25, 2013 at 5 (Doc. 223) ("Finally, the Court has learned there is an omnibus DHS bill moving through the state legislature. Surprisingly to this Court, and without explanation or notice to the Court as to its relationship to the Settlement Agreement, it appears that DHS has proposed a ban on all restraint and seclusion, EXCEPT for individuals with developmental disabilities."); Id. at 12 ("For several reasons, it is evident that heightened supervision of Defendants' actions is appropriate at this time. Two reasons are set forth above: compliance continues to be insufficient and Defendants have not established a comprehensive implementation plan."); see gen. April 28, 2015 class counsel letter to Court (Doc. 430); Order of March 19, 2015 at 2 (Doc. 400) ("Defendants' request needlessly delays closure on final approval of the Olmstead Plan. The Court reminds Defendants of their promise to "develop and implement a comprehensive Olmstead Plan" more than three years ago at the time of the Settlement Agreement. (See Doc. No. 136, Ex. A at 18.) Defendants have failed to meet previous Olmstead Plan filing deadlines, resulting in revised deadlines and additional delays. (See, e.g., Doc. No. 265 (extending Defendants' November 1, 2013 filing deadline to July 15, 2014).) The Court encourages Defendants to timely fulfill their obligations under the Settlement Agreement."); Order dated May 5, 2015 at 7 (Doc. 435) ("The Court has repeatedly expressed its concerns regarding Defendants' pattern of noncompliance with the terms of the Settlement Agreement that were announced at the Final Approval Hearing before this Court on December 1, 2011, and reaffirmed in this Court's numerous subsequent orders. (See, e.g., Doc. No. 188; Doc. No. 205, Doc. No. 212, Doc. No. 223, Doc. No. 259, Doc. No. 368, Doc. No. 400.) More recently, the Court has expressed its concern regarding Defendants' evident unfamiliarity or unawareness of this Court's rules and orders regarding filing deadlines and the Local Rules regarding motions for

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clarification or reconsideration.); Order dated March 18, 2016 at 18 (<u>Doc. 551</u>) ("The Court Monitor was appointed by the Court on July 17, 2012. (Doc. No. 159.) Over the years, the Court has assigned various duties to the Court Monitor in order to promote compliance with the Jensen Settlement Agreement. Many of these duties evolved through the agreement and cooperation of the parties. The Court will consider modifying aspects of the Court Monitor's role if DHS's new internal and external verification mechanisms are demonstrated to appropriately (internally and externally, through independent review) audit compliance with the Jensen Settlement Agreement and the CPA.")

Importantly, the State and DHS are obligated to properly transition people with disabilities into the most integrated settings within their communities and use person-centered planning as a fundamental aspect of this process. *See Olmstead v. L.C.*, 527 U.S. 582 (1999); Settlement, Doc. 136-1 at 18 (requiring development of an *Olmstead* Plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*); Order, Doc. 224 at 10 ("Defendants are not free to defer or to pick and choose which provisions and directives of the Settlement Agreement to comply with."); *cf. Matter of Westling Mfg., Inc.*, 442 N.W.2d 328, 333 (Minn. Ct. App. 1989) ("Those who deal with Government are expected to know the law . . ."). DHS has failed repeatedly on this important Settlement compliance issue:

From the outset, based on the Settlement Agreement's mandates, the Court has emphasized the dual nature of Defendants' obligations: (1) protection of individuals while they live in an institution; and (2) assurance of transition to quality care in the community. Nonetheless, the DHS has repeatedly failed to comply with these obligations. (See, e.g., Doc. No. 223 at 10; Doc. No. 159 at 12-13.) Whether this failure is due to the breadth of the necessary system changes, including training, coordinating, and holding accountable the State's eighty-seven counties, or the DHS' lack of a full-fledged Jensen oversight office until mandated in the Comprehensive Plan of Action (Doc. No. 283), or the DHS' indifference to or intentional non-compliance with the Settlement Agreement and related Orders of the Court (Doc. No. 259 at 5; Doc. No. 251 at 3), the Court respectfully directs the DHS to comply with the terms of the Court's Orders.

The Court has expressed its concern with non-compliance on prior occasions. In its August 28, 2013 Order, the Court identified community integration as a particular concern regarding non-compliance: "The Court deems this an opportune and appropriate time to consider the pace of Defendants' implementation of the obligations they undertook both as to the facility and system-wide, including but not limited to community integration under Olmstead v. L.C." (Doc. No. 224 at 10.) The Court also expressed its concern "with the sluggish pace of implementation of the specific terms of the Settlement Agreement and the resulting noncompliance." (Id.)

The Court Monitor has similarly expressed concerns with non-compliance. In a June 11, 2013 Status Report on Compliance, the Court Monitor cited non-compliance in all areas under transition planning. (Doc. No. 217 at 103-08.) After finding that "[g]aps between the County service systems and the DHS hinder effective and timely transition planning and the development of appropriate individual placements," the Court Monitor reported that "County case management must be revised to enable compliance." (Id. at 104, 106.)

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The Court Monitor reiterated these "past and current Transition Plan concerns" in its September 23, 2013 Recommendation to the Parties: Transition Planning and the Repurposing of MSHS-Cambridge. (Doc. No. 226 at 3.)

In response to the Court Monitor's June 11, 2013 Status Report on Compliance, the DHS commissioned an independent review of the transition planning by the University of Minnesota's Institute on Community Integration ("ICI"). On April 30, 2014, ICI issued its Independent Review of Transitions: Three Individuals with Developmental Disabilities Who Moved from the Minnesota Security Hospital to the Community, which concluded that transitions were not completed with a person-centered plan or an Olmstead analysis and that moves to the community failed to comply with the required transition planning pursuant to the Settlement Agreement. (Doc. No. 301-20.)

Regrettably, nothing in the record demonstrates meaningful, let alone best efforts, to train and educate the county systems. The Court can no longer tolerate continued delay in implementation of the Settlement Agreement. Adherence to the Court's Orders by the DHS officials and staff at all levels is essential, not discretionary. The interests of justice and fairness to each Class member and similarly situated individuals requires no less.

Order of September 3, 2014 at 3-6 (Doc. 340).6

Here, DHS unilaterally transferred W.O., a minor solely committed with a developmental disability, into the Minnesota Security Hospital, a dangerous forensic setting, without notice or permission from the Court, and then wrote to the Court stating:

I write to notify the Court that on May 18, 2015, the Department placed W.O., a person committed solely as a person with a developmental disability, to the Minnesota Security Hospital (MSH). This impacts our compliance with Evaluation Criteria No. 82 of the Comprehensive Plan of Action (Doc. No. 283) and Amended Order (Doc. No. 284).

May 20, 2015, letter from DHS assistant commissioner to Court. DHS then filed a Motion for Relief from Judgment (Doc 446), asking the Court's permission to keep W.O. at the Minnesota Security Hospital after DHS had secretly placed W.O. there in a direct, and intentional, violation of the Court's Order.⁷ At the public hearing (transcript, Doc 469), DHS identified W.O.'s initials

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⁶ *Id.* at 2-3 ("DHS does not contest the Court Monitor's findings of non-compliance with regard to adequacy of care and planning for clients who have moved from the Minnesota Extended Treatment Option ("METO") or Minnesota Specialty Health Systems ("MSHS")-Cambridge facilities into the community. (See Doc. No. 324 at 1.) The DHS identifies those assessments with which it agrees as follows: 'When [] clients are placed in community settings via county case managers or licensed providers, the transition plans are often not being adhered to. Furthermore, county staff have not been adequately trained in person centered planning and many county staff are unfamiliar with the Jensen Settlement Agreement and Minnesota's Olmstead Plan. Finally, the Court Monitor has suggested that DHS has not provided adequate oversight of counties with regard to the use of person-centered planning concepts, as well as transition plans and both of these are neither created nor used by county staff.")

⁷ DHS had also received the Court Monitor's January 30, 2015, notice of noncompliance regarding the Comprehensive Plan of Action stating, "The Comprehensive Plan of Action forbids confinement at the Minnesota Security Hospital of persons committed solely as individuals..."

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as well as several specific factual items relating to W.O, and provided testimony before the Court. The Settlement Class opposed DHS efforts to have the Court retroactively approve W.O.'s placement at MSH.

In its Order on the DHS motion, the Court stated:

The parties shall attend a status conference on August 4, 2015, at 9:00 a.m., to provide the Court with an update regarding the status of W.O., including, but not limited to, the following issues: (1) whether W.O. has been moved from the Minnesota Security Hospital; and (2) if W.O. has not been moved from the Minnesota Security Hospital, what placement options have been identified and pursued and what transition plans have been made with respect to W.O. In addition to the parties, the Court invites the Ombudsman for Mental Health and Developmental Disabilities, the county officials involved in the state proceeding, including the Dakota County attorney and defense counsel, as well as W.O.'s social workers and any involved mental health professionals, to the August 4, 2015 status conference.

As the Court indicated at the hearing, it is the expectation of the Court that there will be collaboration between the parties, the Ombudsman for Mental Health and Developmental Disabilities, and the involved county officials with respect to W.O.'s situation. Separately, it is the expectation of the Court that the Department of Human Services will provide an analysis of the names of individuals who are high or frequent users of crisis services, hospitalizations, and inpatient psychiatric units to Plaintiffs and to the Ombudsman for Mental Health and Developmental Disabilities by July 22, 2015. Finally, as the Court has stated in previous Orders, it is the expectation of the Court that the Department of Human Services will seek the input of the Ombudsman for Mental Health and Developmental Disabilities and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities in this process. (See, e.g., Doc. No. 435 ("May 6, 2015 Order") at 9; Doc. No. 340 ("September 3, 2014 Order") at 4.)

Order of .June 24, 2015 at 2-3 (Doc. 464).

DHS expressly requested the Court's involvement and agreed to a Court ordered process in which DHS has been reporting to the Court Monitor, the Consultants, and Class Counsel concerning the status of W.O.'s placement and months-long awaited transition plans. Yet DHS now complains about the presence of the Court after agreeing to the Court's jurisdiction and specifically seeking its involvement with regard to W.O. DHS has clearly has waived any right to object to the Court's jurisdiction over this issue.

Moreover, after seeking the Court's involvement and agreeing to collaborate on W.O.'s situation, it was discovered that DHS was using a mechanical restraint chair on a person with developmental disability at MSH in direct violation of the Settlement and civil rights, more than once. DHS then tried to justify this abuse by stating the Positive Support Rule does not preclude it. *See gen.* DHS April 7, 2015 letter to Court. DHS disregard of a fundamental protection in the Settlement and the Court ordered process of collaboration to protect a minor with a developmental disability, supports the Court's long standing, agreed upon jurisdiction, and active

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monitoring of DHS conduct.⁸ Simply put, the presence of the Court is necessary to enforce the Settlement because DHS refuses to comply with it.

In contrast to DHS recent statements, the Jensen Class Action lawsuit, and the Settlement, were fundamentally predicated on stopping the State and DHS from restraining and secluding people with developmental disabilities. The DHS decision to secretly violate the Settlement to use the mechanical restraint chair despite a Court order to ensure the person's well being and candidly report to the Court about its actions, is simply incredible.

The Settlement Agreement is clear on its intent:

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 techniquesto 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 staffand/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.

* * *

1. Within sixty (60) days upon Court approval of this Agreement, the State shall undertake best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability. No later than July 1, 2011, there shall be no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital. This prohibition does not apply to persons with other forms of commitment, such as mentally ill and dangerous, mentally ill, chemically dependent, psychopathic personality, sexual psychopathic personality and sexually dangerous persons. Nor does this prohibition pertain to persons who have been required

⁸ In another example of its disregard for the Court-ordered process., DHS secretly issued a variance for MSH, effective June 1, to allow for the use of mechanical restraint, without any notice to the Court, Consultants or Class Counsel. DHS communications on this issue have sought to amplify its misguided position that DHS is not required to inform the Court, Court Monitor or Consultants about its variance to

use of mechanical restraint on people with developmental disabilities in this setting.

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to register as a predatory offender under Minn. Stat. § 243.166 or 243.167 or to persons who have been assigned a risk level as a predatory offender under Minn. Stat. § 244.052.

- 2. There shall be no change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.
- 3. No later than December 1, 2011, persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, shall

Final Approval Order for Stipulated Class Action Settlement Agreement at 6, 20 (Doc. 136).

This clear intent was not lost on the Independent Court Monitor:

This settlement provision is clearly intended to prevent individuals with developmental disabilities from institutionalization at the Minnesota Security Hospital, a secure facility for individuals committed as mentally ill and dangerous.

Independent Court Monitor STATUS REPORT ON COMPLIANCE at 140 (June 11, 2013) (enclosed).

In addition, the Court Monitor comprehensively reviewed the Settlement Agreement, Rule 40 Advisory Committee reports, DHS adoption of the report and findings, and DHS statements and policies, including the DHS Respect and Dignity Practices Statement, in relation to the Minnesota Security Hospital, stating:

The initial impetus for this litigation was the excessive use of mechanical restraints at the Minnesota Extended Treatment Option (METO) at Cambridge, MN. In addition to closing METO, the 2011 court-approved settlement in this case prohibited all but emergency restraints; mechanical restraints and seclusion became things of the past.

The Settlement Agreement did more than forbid non-emergency restraints and seclusion at Cambridge. Referencing the 1987 rule which permitted aversive treatment such as restraints and seclusion, the State of Minnesota declared that "its goal is to utilize the Rule 40 Committee" process "to extend the application of the provisions in this Agreement to all state operated locations serving people with developmental disabilities with severe behavioral problems or other conditions that would qualify for admission to METO, its Cambridge, Minnesota successor, or the two new adult foster care transitional homes." Settlement Agreement, ¶7, Recitals.

Under the settlement, the State is 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

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development of an 'Olmstead Plan'" consistent with the U.S. Supreme Court's decision in Olmstead v. L.C, <u>527 U.S. 582</u> (1999).

In response to the *Rule 40 Advisory Committee Recommendations on Best Practices and modernization of Rule 40* (July 2, 2013) (<u>Dkt. 219</u>), the Department of Human Services committed to establishment of a plan to eliminate seclusion and restraints:

To that end, DHS will prohibit procedures that cause pain, whether physical, emotional or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department. It is our expectation that service providers, including state operated services, will seek out and implement therapeutic interventions and positive approaches that reflect best practices.

The settlement also requires the State to develop and implement a plan to comply with the requirements of the Americans with Disabilities Act as enunciated in the Supreme Court's 1999 decision in Olmstead v. L.C.4 The Rule 40 Advisory Committee cites Olmstead as among current "best practices" incorporated into the settlement.

Accepting the Advisory Committee report, the Department adopted the principle for services which are licensed or certified by the Department that "[p]rohibit[s] techniques that include any programmatic use of restraint, punishment, chemical restraint, seclusion, time out, deprivation practices or other techniques that induce physical, emotional pain or discomfort." The principle is to be implemented by December 31, 2014.

In June 2013, the Department adopted a DHS Respect and Dignity Practices Statement (attached to this report) which similarly endorses the prohibition of techniques including restraint and seclusion and "other techniques that induce physical, emotional pain or discomfort." The Statement commits DHS to "seek the inclusion of these concepts in the State Olmstead Plan and its implementation."

As indicated in the settlement agreement, and detailed in the Advisory Committee's report, the ban on seclusion and restraints is not established in a vacuum. Careful and compassionate treatment planning, addressing behavioral and other needs through best practice supports and person centered planning are among the conditions which sustain the Department's move away from once common aversive measures.

Anoka Regional Treatment Center and Minnesota Security Hospital are within the scope of the changes in restraint and seclusion policy and practice described above

* * *

The Court has recognized that "[t]he Rule 40 modernization and the Olmstead Plan, and other elements of the settlement agreement, will affect all persons served at state operated locations other than MSHS-Cambridge, including Anoka Regional Treatment Center and Minnesota Security Hospital among others." Direction Letter to the Court Monitor (Aug. 5, 2013) at 1 (Dkt. 220). The Monitor is to review compliance with regard to MSH and Anoka, and the Court expects Defendants to "provide full access" to the records of the residents of those institutions. Id.

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Restraint Chair and Seclusion Use at AMRTC and MSH: Phase I Review (October 17, 2013) at 4-7 (Doc. 236).

In addition, the Comprehensive Plan of Action (CPA) (<u>Doc. 284</u>), agreed upon by DHS, and approved by the Court, contains enforceable Evaluation Criteria. CPA Evaluation Criteria 99 to 104 correspond to the Systemwide improvements section of the Settlement, including DHS obliations to modernize Rule 40, the administrative rule governing the use of aversive and deprivation procedures on people with developmental disabilities. The CPA further states that "unresolved issues may be presented to the Court for resolution by any of the above, and will be resolved by the Court." CPA at EC 103.

As part of the implementation of the Settlement, the Positive Support Strategies and Restrictive Interventions (PSR) was publically adopted. Importantly, the PSR expressly prohibits mechanical restraint. *See* Ch. 9544.0060. DHS, in its public positions supporting the Positive Supports Rule, also stated that mechanical restraint is precluded at state operated facilities:

[T]he Minnesota Legislature, in connection with the terms of the Jensen Settlement Agreement, directed the Department to adopt rules that would govern positive support strategies and would ensure the applicability of the prohibitions and limits in chapter 245D to all of its licensed services and settings when serving a person with a developmental disability or related condition." "To fulfill the settlement agreement obligation and legislative directives, the Department is now proposing a rule that governs positive support strategies for all licensed settings and services and, for providers not already governed by chapter 245D, applies the prohibitions and limits of that chapter to those non-245D licensed services. The rule accomplishes the latter by incorporating the pertinent requirements of chapter 245D by reference. As a result of the proposed rule, no Department-licensed service or facility will be permitted to use outdated and unacceptable practices for persons governed by the statute and rule."

* * *

Item H reflects the principle that any use of an aversive or deprivation procedure diminishes the quality of life of a person. This is consistent with fulfilling a major focus of the Jensen Settlement Agreement. Consistent with current best practices, aversive or deprivation procedures are now generally considered to be a form of abuse. It is necessary and reasonable that the rule recognize the broad objective of eliminating aversive and deprivation procedures in Minnesota licensed social services.

DHS Statement of Need and Reasonableness, Proposed New Permanent Rules Governing Positive Supports, and Prohibitions and Limits on Restrictive Interventions at 2, 16. Since August 31, 2015, all facilities licensed under Minn. State 245D, including MSH under 245A, have been required to comply with the PSR and its prohibition against mechanical restraints. *See* Minn. R. 9544.0010, subp. 2; 9544.0060, subp. 2(V).

In a letter to DHS licensing on the DHS use of mechanical restraints at MSH., the Minnesota Disability law Center stated:

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Deputy Commissioner Johnson's letter raises significant concerns regarding the implementation of the PSR at both MSH and other DHS licensed facilities. MSH or any other facility could justify the use of an otherwise prohibited procedure by stating that the purpose for the procedure's use was different than one of the four purposes laid out in the PSR. In the incidents involving [], MSH cited "security" as its purpose. MSH or other licensed providers could create other "purposes" to justify the use of any of the procedures listed in Minn. R. 9544.0060, subp. 2 to subvert the intention of the PSR. This type of "purpose-based" exception has the potential to render the entire "Prohibited Procedures" portion of the PSR null and void.

* * *

Deputy Commissioner Johnson writes that a report should he made to the Licensing Division if there is "concern about a potential violation" of the PSR. Nevertheless, the letter then goes on to state that the use of mechanical restraint on [] on two occasions "was not a violation of the PSR." It does not appear that the Licensing Division conducted an investigation into these two incidents. If this is the case, it raises concerns about the Licensing Division's adherence to its own procedures.

May 18, 2016, letter to DHS Licensing Division. The Licensing Division responded on June 10, 2016, stating, "The Positive Supports Rule applies to more than 20,000 DRS-licensed programs, across 12 distinct service classes when serving a person with a developmental disability or related condition, as defined in Minnesota Rules, part 9544 0020, subpart. 11." However, it did not provide the requested criteria and guidance that DHS is required to provide under the law, see Swenson v. State, Dep'I of Pub. Welfare, 329 N. W.2d 320, 324 (Minn. 1983) (DHS "must either follow its own regulations or amend them in accordance with statutory rulemaking procedures"); Troyer v. Vertlu Mgmt. Co./Kok & Lundberg Funeral Homes, 806 N. W.2d 17, 24 (Minn. 2011). DHS failure to clarify and provide guidance by its internal enforcement division points up a critical danger to people with developmental disabilities in this state, leaving facilities, and families, without clear, direct guidance needed to avoid misinterpretation about the PSR, increasing the risk the using of prohibitive abusive procedures on vulnerable citizens. This DHS inaction further supports Court involvement and active monitoring to ensure that the CPA is properly implemented, and the PSR properly enforced by DHS.

In 2016, just as in 2008 when the Ombudsman issued the *Just Plain Wrong* report, there can be no excuse, delay, waiver, variance or anything else preventing the immediate protection of our vulnerable loved ones. As we have repeatedly stated to DHS, the State, the Court, Court Monitor, and Consultants, we do not support or condone any conduct, proposed plan provision, interpretation of any provision, process or protocol that allows for the use of restraint or

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⁹ "Documents in individual records revealed that people were being routinely restrained in a prone face down position and placed in metal handcuffs and leg hobbles. In at least one case, a client that the metal handcuffs and leg hobbles were secured together behind the person, further immobilizing the arms and legs, reported it to the Ombudsman staff. Some individuals were restrained with a waist belt restraint that cuffed their hands to their waist. An individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall. Others were being restrained on a restraint board with straps across their limbs and trunk."

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seclusion on people with developmental disabilities, whether as part of a "transition," "waiver," "exemption," "exception," "conditional use," "variance," "temporary use," "study period," or any other excuse. The continued use of restraint and seclusion directly violates the civil rights of people with developmental disabilities. We object to any such conduct, proposed provision, interpretation or ignorance that seeks to allow for the continued use of restraint and seclusion. This has been the repeated, reiterated position of the Settlement Class throughout the pendency of this matter. Such provisions are not best practice, do not protect anyone, have no positive or redeeming qualities, and would directly contradict the Settlement, CPA and PSR's elimination of restraint and seclusion. The effort should be on best practices that focus on Positive Behavioral Supports of individuals with developmental disabilities rather than restraining and secluding them in violation of their rights. See also Settlement Class Counsel July 14, 2014, letter to Court (Doc. 332) at 13; Gas Aggregation Servs. v. Howard Avista Energy, LLC, 458 F.3d 733, 739 (8th Cir. Minn. 2006) (finding party acted in bad faith when it concealed and misrepresented terms of settlement).

We note here, as we did in opposition to original DHS motion, that DHS placed W.O. at MSH without prior disclosure of this information to the Court, Court Monitor, Consultants or Settlement Class Counsel despite knowing that the issuance of the variance and transfer of the W.O. to MSH would violate the Court's Final Approval Order. *See* Mem. in Opp. to DHS Motion for Relief from Judgment at 5 (Doc. 454). We said then, and again here, had DHS simply disclosed the information to the Ombudsman, there would have an opportunity to discuss and develop an alternative to MSH, including possible transition home placement for crisis stabilization, or the use of Life Bridge, a successor to MSHS Cambridge which, in turn, is a successor to METO. However, contrary to the Court's Order and expectations of collaboration, DHS did not notify anyone about the situation, and repeated its secrecy in using a restraint chair on a person with a developmental disability.

The protection and proper treatment of people with disabilities are at the heart of the issues before the Court. DHS has great responsibility to act to ensure the safety of people with disabilities and help them "to be loved, appreciated, respected and productive." See MN DHS Guidelines to the Investigation of Vulnerable Adult Maltreatment, Appendix V Common Courtesies when Interacting with People with Disabilities at p. 196 (Dec. 2010); see gen. Settlement Agreement; November 17, 2014 class counsel letter to court (Doc. 362). Under the Settlement, CPA, PSR and pursuant to the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 582 (1999), DHS has been required to transition W.O. to the most integrated setting. DHS is obligated to arrange appropriate residential placement, and follow the Court's Orders to inform of changes in that transition. Instead, DHS has repeatedly violated the Settlement concerning W.O. The DHS history of non-compliance over many years, coupled with recent DHS positions advocating for variances and misguided views to support the use of abusive procedures on vulnerable citizens, long ago rejected by our society and precluded by the Settlement, CPA, PSR, as well as DHS statements and policies, and moral common sense, support the immediate need for ongoing Court jurisdiction and comprehensive involvement to independently monitor DHS conduct to ensure compliance and to protect people with disabilities from abuse and neglect.

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We respectfully request that the Court deny the DHS reconsideration request in its entirety.

Thank you.

Respectfully submitted,

O'MEARA, LEER, WAGNER & KOHL, P.A.

/s/ Shamus P. O'Meara

Shamus P. O'Meara SPO:tlb

cc: DHS Counsel

Dr. Colleen Wieck Ms. Roberta Opheim