

**UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA**

James and Lorie Jensen, as parents, guardians,
and next friends of Bradley J. Jensen; James
Brinker and Darren Allen, as parents,
guardians, and next friends of Thomas M.
Allbrink; Elizabeth Jacobs, as parent, guardian,
and next friend of Jason R. Jacobs; and others
similarly situated,

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

v.

ORDER

Minnesota Department of Human Services,
an agency of the State of Minnesota; Director,
Minnesota Extended Treatment Options, a
program of the Minnesota Department of
Human Services, an agency of the State of
Minnesota; Clinical Director, the Minnesota
Extended Treatment Options, a program of
the Minnesota Department of Human Services,
an agency of the State of Minnesota; Douglas
Bratvold, individually and as Director of the
Minnesota Extended Treatment Options, a
program of the Minnesota Department of Human
Services, an agency of the State of Minnesota;
Scott TenNapel, individually and as Clinical
Director of the Minnesota Extended Treatment
Options, a program of the Minnesota Department
of Human Services, an agency of the State of
Minnesota; and the State of Minnesota,

Defendants.

Mark R. Azman, Esq., and Shamus P. O'Meara, Esq., O'Meara Leer Wagner & Kohl, PA,
counsel for Plaintiffs.

Aaron Winter, Scott H. Ikeda, and Anthony R. Noss, Assistant Attorneys General, Minnesota Attorney General's Office, counsel for State Defendants.

Samuel D. Orbovich, Esq., and Christopher A. Stafford, Esq., Fredrikson & Byron, PA, counsel for Defendant Scott TenNapel.

INTRODUCTION

This matter is before the Court on the Court Monitor's October 17, 2014 *Behavioral Intervention Devices and Practices: Achieving Compliance in Community Programs* Report to the Court ("Behavioral Intervention Report"). (Doc. No. 347.) For the reasons set forth below, the Court approves the Behavioral Intervention Report and adopts in part the recommendations therein.

BACKGROUND

In June 2011, the parties in this class action litigation reached a Stipulated Class Action Settlement Agreement ("Settlement Agreement"). (Doc. No. 104.) Pursuant to the terms of the Settlement Agreement, Defendants were required to provide class members with "transition plans, protections, supports, and services consistent with such person's individualized needs, in the most integrated setting." (*Id.* at 13.) Defendants were also required to foster each class member's "self-determination and independence" by "us[ing] person centered planning principles at each stage of the [planning] process to facilitate the identification of the [class member's] specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs." (*Id.* at 14.) Defendants were further required to "immediately and permanently discontinue" the use of restraints, seclusion, and other aversive procedures and techniques. (*Id.* at 6.)

Less than one year after the parties agreed to the terms of the Settlement Agreement, the Court was informed of Defendants' non-compliance with certain aspects of the Settlement Agreement. (Doc. No. 157, Ex. 5; Doc. No. 158 & Exs. 1-2.) In response to these reports of non-compliance, the Court appointed a Court Monitor to address non-compliance issues and to make recommendations to the Court. (Doc. No. 159 at 12-13.) Since his appointment, the Court Monitor has filed numerous reports and recommendations with the Court regarding Defendants' compliance with the terms of the Settlement Agreement, including the most recent Behavioral Intervention Report that is now before the Court. (Doc. No. 347.)

DISCUSSION

I. Recommendation No. 1

In the Behavioral Intervention Report, the Court Monitor first addresses the failure of the Department of Human Services ("DHS") to transition class member Andrew L. "to the most integrated setting" in accordance with the Settlement Agreement provisions. (*See id.* at 15-36.) Although DHS previously reported to the Court that Andrew L. had "transitioned to the community" (Doc. No. 193 at 68), albeit over a year after the deadline, this report was later disputed and proved to be incorrect (*see, e.g.*, Doc. No. 217 at 143 (reporting DHS' "non-compliance" with respect to Andrew L.'s transition); Doc. No. 299, Ex. 67 at 4 (confirming that Andrew L.'s transition was "not completed with a person-centered plan or Olmstead analysis"); *see also* Doc. No. 193, Ex. 121 (supporting a finding of non-compliance with the Settlement Agreement's transition requirements)).

The Court Monitor reports that DHS “continues to be in non-compliance with the Settlement Agreement with regard to Andrew L., a 27 year old individual who lives in restrictive isolation in a modified industrial building [“pole barn”], without a person-centered plan and without meaningful activities in his daily life.” (Doc. No. 347 at 15.) According to the Court Monitor, Andrew L. spends the vast majority of his time alone indoors in a confined area enclosed by chained partitions. (*Id.* at 33-34.) The Court Monitor further reports that although Andrew L.’s program costs \$2,740 per day, Andrew L.’s life is “starkly barren of aspects many people take for granted, such as relationships, meaningful daily activities, a job and educational opportunities.” (*Id.* at 29, 36.)

To address these concerns, the Court Monitor recommends that DHS “secure additional expertise, including expertise external to DHS and approved by the Court Monitor, to develop an age-appropriate, community-based, person-centered vision that includes positive behavior supports in which Andrew L. is a contributing member in his chosen community and lives in a new location in the most integrated setting.” (*Id.* at 54.)

The Court adopts the Court Monitor’s recommendation regarding Andrew L. with certain modifications. First, the Court finds that a new person-centered plan for Andrew L. must be designed to comply with the terms of the Settlement Agreement. The planning process shall include the identification and evaluation of Andrew L.’s “specific interests, goals, likes and dislikes, abilities and strengths as well as support needs” to foster his “self-determination and independence” in accordance with the Settlement Agreement provisions. The planning process must involve Andrew L.’s guardians and shall be overseen by the Office of the Ombudsman for Mental Health and Developmental

Disabilities. The plan shall be finalized within two months from the date of this Order. Second, the Court directs DHS to promptly communicate the requirements of the Settlement Agreement to Andrew L.'s provider and any individuals involved in the planning process. Finally, the Court requires DHS to provide support and follow-up assistance related to compliance with the plan.

II. Recommendation No. 2: Karen H.

The Court Monitor next addresses the use of restraints against Karen H. as an example of a prohibited behavioral intervention device and practice pursuant to the terms of the Settlement Agreement. (*See id.* at 37-51.) According to the Court Monitor, Karen H. “has been in a restraint chair regularly, sometimes daily” for years. (*Id.* at 38.) On at least one occasion, Karen H. was confined to a restraint chair for nearly nine hours and denied bathroom breaks and food. (*Id.* at 38, 42.) The Court Monitor further reports that, although Karen H. was one of the select class members that DHS identified for intensive monitoring, “key offices within DHS with deep knowledge and responsibilities for implementation of the Court’s orders knew of the restraint chair use for Karen H. for years and either approved or took no action.” (*Id.* at 46.)

The Court Monitor recommends that DHS “secure additional expertise, including expertise external to DHS and approved by the Court Monitor, to (a) discontinue the use of the restraint chair as soon as possible based upon best practices; and (b) develop an age-appropriate, community-based, person-centered vision that includes positive behavior supports in which Karen H. is a contributing member of her chosen community and a plan for its achievement and implementation.” (*Id.* at 55.)

The Court adopts the Court Monitor's recommendation with respect to Karen H. with some modifications. First, the Court orders the immediate discontinuance of the use of restraints against Karen H. pursuant to the terms of the Settlement Agreement. Second, the Court finds that a new person-centered plan for Karen H. must be designed to comply with the requirements of the Settlement Agreement. The planning process must include a comprehensive positive behavioral supports analysis and shall be overseen by the Office of the Ombudsman for Mental Health and Developmental Disabilities. The plan shall be finalized within two months from the date of this Order. Third, the Court directs DHS to promptly communicate the requirements of the Settlement Agreement to Karen H.'s provider and any individuals or agencies involved in the planning process. Finally, the Court orders DHS to provide support and oversight to ensure compliance with the Settlement Agreement provisions and protections with respect to Karen H.

III. Recommendation No. 3: Community Oversight and Accountability

According to the Behavioral Intervention Report, DHS' community oversight function is currently "scattered among several offices within DHS" that "communicate inadequately or untimely." (*Id.* at 53.) As a result, "there is no single locus of responsibility and authority for providers, clients and family." (*Id.*) The Behavioral Intervention Report identifies the need for "a single, central clearinghouse and action vehicle" so that DHS' efforts are integrated and coordinated with regard to client- and provider-specific situations. (*Id.* at 56.)

The Court Monitor recommends that DHS "immediately develop an enhanced community oversight and accountability function" with state-wide coverage. (*Id.* at 55.)

To accomplish this function, the Court Monitor recommends increased staffing, “secured via external consultants, approved by the Court Monitor, from time to time and where necessary, to: (a) provide resources and assistance to community-based providers and clients as needed or upon request; (b) have the authority to give direction to counties and providers with regard to supporting clients; (c) recommend sanctions and enforcement action for practice[s] that [are] not consistent with best practices or under the Court’s orders; and (d) serve as a single point of accountability and communication on a client-specific and provider-specific basis.” (*Id.*)

The Court adopts the Court Monitor’s recommendation for increased community oversight and accountability within DHS. However, rather than order DHS to secure additional staff or external consultants to accomplish these functions, the Court directs DHS to reassess its existing organization, communication methods, and functionality to improve its community oversight, its communication with providers and counties, and its accountability for shortcomings. In addition, the Court orders DHS to use all available communication methods to provide information about the Settlement Agreement to counties, case managers, providers, guardians, and advocacy groups. The Court also directs DHS Office of the Inspector General staff to continue to attend meetings with the Court Monitor in order to stay apprised of accountability issues. Finally, the Court reminds DHS of its obligations to utilize best efforts to require counties and providers to comply with the Comprehensive Plan of Action “through all necessary means” within DHS’ authority, “including but not limited to incentives, rule, regulation, contract, rate-setting, and withholding of funds.” (Doc. No. 104 at 19; Doc. No. 289 at 9.)

IV. Recommendation No. 4: Training Consortium

The Court Monitor references numerous examples in the Behavioral Intervention Report where DHS staff and providers were unaware of the basic terms of the Settlement Agreement. For example, the Court Monitor observes that “DHS’ Jensen-related units had not provided DHS Licensing with the names of the class members or [with] training.” (*Id.* at 37.)

The Court Monitor recommends that DHS “immediately create and support a training consortium charged with developing a comprehensive, coordinated state-wide training plan to include all levels of training but especially applied subjects such as creating ‘home,’ eliminating the use of mechanical restraints and other aversive devices and practices, valued social roles, customized employment and other topics, especially topics nominated by direct care providers, consumers and families.” (*Id.* at 56.)

The Court adopts the Court Monitor’s recommendation for the establishment of a training consortium. The Court directs the Court Monitor to review and discuss the training consortium proposal at a future monthly meeting with the parties, the Ombudsman for Mental Health and Developmental Disabilities, and the Executive Director of the Governor’s Council on Developmental Disabilities to determine its feasibility and assess current training efforts.

V. Recommendation No. 5: Jensen Implementation Office

Finally, the Court Monitor addresses the lack of effective communication channels between DHS, counties, and providers. According to the Court Monitor, these communication shortfalls have hindered cooperative efforts for implementation of the

Settlement Agreement provisions and investigative efforts in response to specific instances of non-compliance. (*Id.* at 40.)

The Court Monitor recommends that DHS increase the staffing of the Jensen Implementation Office “to address specific client and provider situations which raise concerns at the compliance level.” (*Id.* at 53.) Specifically, the Court Monitor recommends additional staff to serve as “trouble-shooters” and to “gather information and to respond” to specific instances of non-compliance. (*Id.* at 54.)

The Court acknowledges the need for proactive measures by DHS to implement the Settlement Agreement provisions and for prompt responses by DHS to specific instances of non-compliance. However, the Court also recognizes that, as a multi-billion dollar agency, DHS does not lack the resources or staffing capacity to perform these functions in accordance with the terms of the Settlement Agreement. Therefore, the Court instead directs DHS to reassess the organizational and functional effectiveness of its Jensen Implementation Office, including an evaluation of training needs and assignment of staff.

The Court sadly observes, as it has in numerous prior orders, that a meaningful survey of individuals with disabilities and their families would likely challenge the notion that any true improvement in the quality of care, treatment, and lives of Minnesota citizens with disabilities has occurred since the Court approved the Settlement Agreement more than three years ago. The Court is committed to ensure that the Settlement Agreement is not an empty promise and that meaningful progress is realized across the State. Justice requires no less.

ORDER

In consideration of the Court Monitor's Behavioral Intervention Report, **IT IS HEREBY ORDERED THAT:**

1. The Court approves the Court Monitor's *Behavioral Intervention Devices and Practices: Achieving Compliance in Community Programs* Report to the Court (Doc. No. [347]) and adopts in part the recommendations therein as specified in this Order.
2. Should DHS fail to timely comply with the terms of this Order, the Court reserves the right to impose monetary or other sanctions.
3. The Court reserves the right to address other non-compliance issues by separate order.

Date: December 5, 2014

s/Donovan W. Frank
DONOVAN W. FRANK
United States District Judge