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Office of the Ombudsman for Mental Health and Mental Retardation

1996/1997 Biennium Report on Agency Activities

Ombudsman Office Embarks on Systemic Review of Early and Periodic, Screening, Diagnosis, and Treatment Programs

There are some low-income children who have significant mental health needs that if not addressed will affect their social and emotional development. The state's Early and Periodic, Screening, Diagnosis, and Treatment Program (EPSDT) offers prevention and treatment services that are necessary to help children and teens develop healthy lifestyles. EPSDT is a state Medicaid program that provides an array of valuable physical and mental health services to Medicaid-eligible children and teens. The Ombudsman Office is interested in learning about how the state's EPSDT program operates to serve the mental health needs of this population. EPSDT mental health services are the focus of this article.

EPSDT is a comprehensive and preventative health care program for Medicaid-eligible individuals up to age 21. This program provides mental health screenings, as well as diagnostic and

treatment services for conditions detected through screenings. The elements of the EPSDT program are designed to do the following:

- **Early:** assess children's mental health status early in life so prevention and treatment services can be made available.
- **Periodic:** assess children's mental health status at recommended intervals to detect any untreated mental health needs.
- **Screening:** the use of tests and procedures to detect any mental health conditions that require further attention.
- **Diagnostic:** the use of tests and procedures to determine the nature and cause of identified mental health issues.

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In Their Own Words

The following is the story of a young adult with autism who had fallen through the cracks of the system for many years. The quotes are from a letter we received from the family. This young adult went from being totally home bound and restrained five or more times per day, to leaving home on a daily basis for school and other programming and almost never requiring the use of behavior restraints. All of this was accomplished in about a year, after many years of failed services. This story continues to evolve and there will be challenges as this young adult transitions. However this story shows what can be accomplished when systems and committed professionals work together for the benefit of the clients.

"We would like to thank the Office of the Ombudsmen (sic) for their excellent diligent help and cooperation for the betterment of our son's life as a disabled individual. Their responses and efforts

in timely, helpful, and appropriate .M6 for his needs. At a very difficult time in M58 our son's life the Office of the 1996/97 man stood with us and helped to establish a team to meet our needs."

The Office of Ombudsman became involved with this case in response to a complaint by another agency alleging an improper abuse/neglect investigation. A few months earlier, two professionals from

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What's Wrong With You?

Aaron's¹ situation came to our office from a former group home direct care staff worker. The worker wanted someone to know that Aaron was suffering and in a lot of pain. The caller also wanted someone to know that Aaron's current staff were encouraging him to die, telling him he would see his parents (already deceased). The caller requested that our office investigate why Aaron was being allowed to die without a diagnosis.

Can you imagine being in pain so extreme that you stop eating because it seems to be the only thing that helped to decrease the pain? Aaron was such a person. He was a middle aged adult with developmental disabilities. He was under state guardianship and had a need for medical attention. He was often found whimpering, crying and holding his stomach from the pain that seemed to be worse after he ate. The staff at his group

In Their Own Words - Continued on Page 6

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Agency Role and Overview

This independent agency was created by the legislature to promote the highest attainable standards of treatment, competence, efficiency and justice for persons receiving care and treatment for mental illness, mental retardation and related conditions, chemical dependency, and emotional disturbance from an agency, facility or program.

When reviewing that broad mission in conjunction with the historic role and function of an ombudsman, along with specific powers and authorities assigned to the office; the agency has interpreted the empowering legislation to allow for a number of actions that the agency MAY engage in, within the limits of available resources, including:

- Monitoring government run, government regulated, and/or government paid for systems to ensure that services are delivered fairly, with dignity and respect, and consistent with the intent behind the empowering legislation of the system;
- Receiving complaints about the quality of those services.
- Investigating/reviewing those complaints.
- Assisting citizens in resolving those complaints.
- Assisting citizens to navigate complex legal and technical systems.
- Lending the technical and professional credibility of the agency to the citizen's issue to help balance the scales of power.
- Being a "trouble shooter" or problem resolver for the system.
- Making recommendations to correct or improve the systems.
- Providing services to individual clients using a variety of powers and authorities provided to the agency.
- Reviewing Deaths and Serious Injuries to look for opportunities to improve the systems.
- Investigating specific agencies, facilities or programs when there is cause to believe there are areas of concern and opportunities to recommend improvements.
- Working collaboratively with other stakeholders in the system through task forces and work groups to anticipate and find solutions for potential problems in an effort to enhance services and prevent complaints.
- Making formal recommendations to policy makers and policy implementers for good quality, cost efficient, citizen sensitive programs.
- Performing the role of whistle blower when necessary.

Because of the number of Minnesota citizens who could qualify statutorily as a client and the large number of facilities and programs, the agency resources are not sufficient to serve every caller, take every complaint or monitor every action of all of the agencies, facilities or programs. Size and design never envisioned the agency to be all things to all people nor to prevent or correct every incident.

The legislature provided direction to the ombudsman as to those matters that should be given priority for review including:

1. unusual deaths or injuries of a client.
 2. actions of an agency, facility or program that:
 - may be contrary to law or rule.
 - may be unreasonable, unfair, oppressive or inconsistent with a policy or order of an agency, facility or program.
- may be mistaken in law or arbitrary in the ascertainment of facts.
 - may be unclear or inadequately explained, when reasons should have been revealed.
 - may result in abuse or neglect of the person receiving treatment.
 - may disregard the rights of a client or other individual served by an agency or facility.
 - may impede or promote independence, community integration, and productivity for clients.
 - may impede or improve the monitoring or evaluation of services provided to clients.

The legislature also instructed the ombudsman to avoid duplicating other investigations or regulatory efforts.

Within those priorities there are more requests for services than can be delivered within the resources of the agency. In addition, needs around the state vary depending upon the number and types of clients that are served and the resources available in any given region. Service systems also vary between urban and rural areas of the state. Regional clients advocates have been given broad discretion to manage the cases within their assigned regions using the legislative priorities as their guidelines along with their professional knowledge of their region's problems, needs and strengths; limitations of their current case loads; and professional discretion. Clients and callers are encouraged to develop the ability to advocate for themselves and, when possible, provided information needed to do that so that resources can be reserved for those most in need of assistance. The agency focus has been on resolving issues and serving the maximum numbers of citizens possible in the most flexible manner. Accordingly, rigid process has been minimized and professional discretion maximized in recognition that each citizen's complaint is unique and may require different tools at different times under different circumstances. Formal reports and process are reserved for the

Due to the broad nature of that mandate, the agency has been configured to promote those standards through some specific services which include:

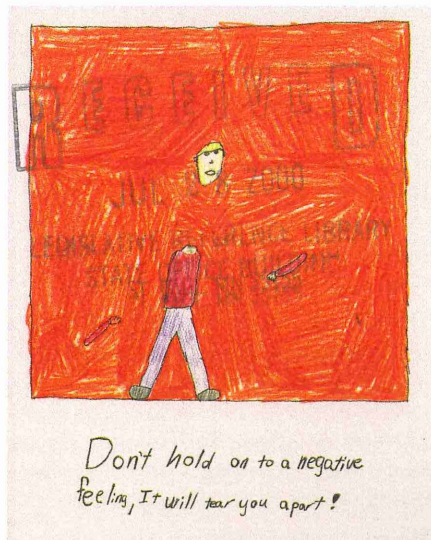
most complex cases/issues or when large sections of the service delivery system can be educated in an efficient manner. This is done in an effort to spare resources and to serve the largest number of citizens.

The agency has been divided into two divisions that both report to the Ombudsman in an effort to organize the work associated with such a broad mission. Those divisions are:

1. The Client Services Division (13 staff members) - To provide direct services to clients and other concerned parties to ensure the fair and just delivery of designated government provided, government regulated or government paid for services for statutorily defined clients.

2. The Public Policy and Administrative Division (7 staff members) - To provide direction in public policy development consistent with the mission and charge of the agency. To provide for administrative, leadership and technical support to the agency in the execution of its mission in accordance with state law and policy.

The Ombudsman relies upon the volunteer services of a 15-member citizen Advisory Committee and a 5-member Medical Review Subcommittee to enhance and compliment the resources of the agency.



Danny Bengtson, Winner
1998 Children's Mental Health Poster Contest

Computerized Case Management System

The Office of Ombudsman began planning for future technological needs in 1995. The computer system in the Office was the Macintosh platform, which was no longer supported by State technology departments. The Macintosh system was not meeting the needs of the Office, and it was decided that a new computer system was needed. An appropriation for Fiscal Year 1998 was made by the legislature to make this project possible.

The prioritized needs of the Office were as follows:

- Case Management and Reporting ability.
- Trend to Systemic Issues (Data Analysis).
- Assessments of Facilities.
- Key Word Information for Drugs.
- Year 2000 Compliance.

The main goals identified for the new system were:

- Improvement of documentation.
- Improvement of data entry and data access.
- Improvement of archiving of client and other system information.
- Providing the ability for staff and management to view cases, case status and advocate workload.
- Allowing real time access, giving advocates immediate access to all cases.
- Providing the ability to perform intake in a variety of locations around the state.

Within these goals, the system needed to be flexible, easy to work with and provide support to the advocates. It must not allow the data capture to

intrude on the ability of the advocate to provide services. Critical success factors were developed and a liaison from the Office was provided to the chosen vendor.

The following four-phase plan was developed:

- Analysis: The identification of functional requirements was followed by visits to regional advocates and an assessment of hardware, network and software needs.
- Design Plan: Prototypes of screen information and views were developed and letter and report requirements were identified.
- Implementation: The Office hired a half-time technical support person, who worked with the vendor's technical people and the agency liaison to assure a smooth transition to the new case management system.
- Support (Training): Tailored training for office staff was developed. This is an area where a decision was made to do full training for all staff, and the outcome was positive. The staff was comfortable with the system when it went "live" on July 1, 1997.

Technical Benefits

The implementation of the new case management system brought several technical benefits to the agency. Access to Internet e-mail and the web for staff has speeded up communications and information procurement. Accounts adhere to the State's domain standards and are administered locally on the office's gateway. To expand citizen access, Client Advocates may be e-mailed directly from the agency web page at:

<http://www.ombudmhmr.state.mn.us>.

The new system contains full SQL reporting capabilities on all information tracked by the agency. This allows for

What's Wrong with You?

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home documented this behavior in his chart but said they did not know what the cause was. This same behavior is repeatedly noted in his chart but for the most part was not addressed. No one tried to investigate the origin of his pain or what they could do to make him more comfortable. Nothing was done and the pain got worse and worse, so Aaron stopped eating almost completely. The group home staff suspected that he may have a hernia but they did not take him in for a medical confirmation. A nurse at the home stated that on at least two days he was placed in a chair, restrained, and was force-fed. This attempt however, was not successful in getting him to ingest food. Aaron dropped to 87 lbs. (down from 129 lbs.) before the group home staff decided that he was in need of medical attention.

By the time Aaron was seen by a doctor, he was medically classified as "severely malnourished." At this point, his frail 87-pound body lay gaunt and dying in a hospital bed. Aaron lay there dying and no one knew why. The only diagnosis in his chart was "mental retardation." He was given pain medication for "comfort." Group home staff began indicating to the medical staff the treatment that they thought should be administered to him. Group home staff requested a DNR/ DNI order.

The DNR (Do Not Resuscitate) is a medical order to refrain from CPR in the case of cardiac arrest or respiratory failure. The DNI (Do Not Intubate) is a medical order to refrain from connecting the patient to a ventilator or respirator to assist a patient's breathing when that person is unable to do so on their own. The physician said that the county case manager had approved the order. After contacting the State Guardianship office, it was found that this order had been issued without anyone following the proper procedure as required by the State Guardianship Office. A county case manager, acting as a guardian, does not have authority for end of life decisions;

only the State Guardianship Office acting under the authority of the Commissioner of Human Services does. The physician stated that the case manager had approved this order. However, when interviewed, the case manager said she had nothing to do with the DNR/DNI order.

DNR/DNI orders are only to be used as end of life options when it is unlikely that any course of treatment will end in anything other than death. They are not a form of medical treatment. They are not options of care. This is especially pertinent when the patient has an illness that is treatable or when the cause is not known. Death is the only outcome suggested or expected by implementing a DNR/DNI order.

Why was there was an order in Aaron's file that would allow his death when the only diagnosis in the chart was mental retardation? It was stated to the advocate that the facility had contacted the case manager over the phone. It was a weekend and the case manager was located in a different city and made no effort to come to see the client. She called from a wedding and gave a verbal OK over the phone.

Regardless of who and why the order was placed, the fact was that Aaron was being denied treatment and the residence staff was encouraging him to let go and die. Due to the DNR/DNI orders the doctor, case manager, and residence staff, Aaron lay there dying without a diagnosis or known cause for his pain. The doctor stated to Aaron's residence staff that Aaron was mentally retarded and that he had Alzheimer's. However, there is no documentation of Alzheimer's in his file.

Further, the staff said Aaron did not have Alzheimer's. The attending nurse suspected that there may be a malignancy somewhere causing the gastritis but she wasn't sure. As a result of the call concerning Aaron's welfare, the Office of the Ombudsman for Mental Health and Retardation conducted an investigation regarding provision of residential, medical, case management

and guardianship services to persons residing at that group home.

The advocate brought to the physician's attention the unauthorized DNR/DNI order in Aaron's file. The physician immediately discontinued this order and wrote new orders to administer IV fluids and nutrients. Further, the Ombudsman's office asked that the physician do additional testing to determine the cause of Aaron's ailment.

The resident coordinator from his group home was interviewed and a request was made for Aaron's file. It was found that the patient's previous files had been destroyed. When asked why the coordinator replied, "We've been doing this since I've been here." The coordinator stated that she told Aaron to just let go and he would be able to see his parents.

The Office made a report of findings to the Commissioner of Human Services regarding the specific services provided for Aaron. The Commissioner then made the following recommendations regarding the provisions of public guardianship services:

- The County will identify an alternative person to perform the duties of the guardian.
- The County will institute emergency guardianship services during non-work hours and guardianship back-up procedures when the designated County staff acting as guardian is unavailable.
- The County will review, update and submit ISP's for all adult wards with mental retardation for whom the county acts as guardian, to ensure that appropriate services, decision making, and adequate protections are in place.

Aaron was finally diagnosed as having acute gastritis, re-nourished, and released from the hospital. He moved to a different facility. A follow up visit to the new facility showed that Aaron recovered from the gastritis and was functioning well in his new setting.

¹ The names in this story have been changed to ensure continued privacy of our clients.

Could This Happen To You?

The Revolution in health care has left many consumers confused. Whose responsibility is it to ensure appropriate health care and particularly care for vulnerable populations? Are there some cases in which no one takes responsibility?

A complaint about the process associated with health care was brought to our office. Unfortunately, this complaint was not brought to the office until after the fact. This story is provided in order to allow the reader to better understand what it is like for a person with a disability, in particular a cognitive disability, who needs to get help from a complex health care system.

This is the story of Mary¹. Her story could have been your mother's, your grandmother's or your own. Mary was a frail 80-year-old woman with a developmental disability. She was from a small town in Minnesota and resided in a foster home. Mary became ill and remained ill for weeks. Previous to this episode of being ill, she had not needed the care of a physician for a long time. Therefore, she was a bit apprehensive about going to a physician but she had been in pain and had unexplained rectal bleeding for weeks. She finally requested to see a physician, but as the complainant relayed to this office, the foster home where she lived did not feel it was their responsibility to take her. She had to wait until the foster home arranged to have one of her family members take her for a physician's visit.

Her initial exam found that she was in need of a colonoscopy to determine the origin and severity of the bleeding. The physician, an internist, told her that he could do the procedure but only at the hospital. Her procedure was set up for the following Monday at 11 A.M. As part of the pre-procedure instructions, she was told that she must abstain from eating for 24 hours prior to the procedure. Due to her developmental

disability, pain from her illness, and the pre-procedure process of drinking of a special liquid, she experienced a substantial amount of stress and confusion. Mary became angry because all she understood was that she was sick and being denied food.

Mary arrived Monday morning at the hospital for her procedure. She was disrobed, gowned and put on the hospital table. She was given an IV and wearily awaited the onset of the procedure. The physician entered the room, looked in her chart and inquired of the charge nurse why there was no documentation of the pre-op physical. It was found that no such physical had been conducted by the clinic and therefore the physician couldn't do the procedure unless they could find a physician to do the physical while she was there. The hospital protocol directed that one physician does the pre-op physical and another physician does the procedure.

The charge nurse suggested that perhaps a physician within the hospital could perform the physical. The charge nurse found available physicians who could do the physical. The next step was to call the clinic to explain the situation and as a formality request prior authorization. The clinic denied the request. The clinic also denied the request to send over one of their physicians to do the physical. The clinic stated that the patient would simply have to re-schedule the procedure for another date and come into the clinic for the physical prior to that date. Therefore the procedure was aborted. The IV was withdrawn; she was taken off the table, given back her clothes, and told to reschedule with her clinic. After returning to the clinic at a later date, it was discovered that she did not need the procedure after all.

Regardless of whose responsibility this was, was there a substantiated lack of quality care given to Mary? Is there anything wrong with making a sick, elderly, and disabled woman lay on a table for four hours only to send her home?

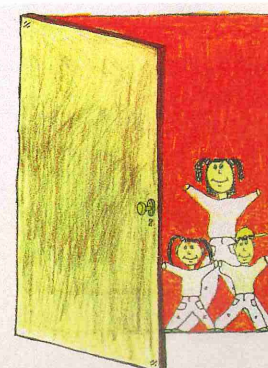
Could the clinic have saved money had the pre-op physical appropriately been performed and determined that the procedure was in fact unnecessary? Was money really saved by denying authorization for the expedited pre-op physical? Who had to pay for all of the costs associated with the aborted procedure?

Did this eighty-year-old woman have any choice in this situation? Was she given any alternatives for her circumstances? Was her best interest determined by whether or not she medically needed this procedure on that day? Who determined what was in her best interest?

Whose responsibility was it to ensure thorough and consistent medical care?

There is no one person or system totally responsible for this. There are many competing interests that caused decisions to be made in the manner they were. But for Mary, the system left her confused, uncomfortable and untreated unnecessarily.

¹ The names in this story have been changed to protect the privacy of our clients.



Don't shut out
Children with
Mental Health Needs

Britany Doty, Winner
New London-Spicer Middle School
1998 Children's Mental Health Poster Contest

In Their Own Words

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the agency were in the home on a one-time basis as consultants to the local educational cooperative. Observing a situation they felt was abusive, they reported it, but felt it had not received appropriate follow-up or outcome. The office's role was to determine whether an appropriate action had been taken by the county agencies responsible for the investigation. Interviews and review of records revealed that both agencies conscientiously investigated and made reasonable, appropriate determinations that did not find abuse or neglect. This would have been the end of our involvement, however during our investigation, it became abundantly clear that there were significant overwhelming problems in the service delivery system for a severely autistic individual and the family.

Recognizing their child's special needs at an early age, this family consistently struggled to meet these needs while keeping their family intact. They sacrificed careers to provide for these needs when they found the system fragmented, non-responsive, and/or inadequate to meet those needs. At one point the family moved out of state to allow the mother to take advantage of a graduate school scholarship in law. Services for their child in the new state proved even more inadequate and they moved back to Minnesota. They continued in their struggles, providing care themselves when the school plan failed. There was no Personal Care Attendant (PCA) provider willing or able to meet the needs although at that time they were eligible to receive over 20 hours per day of PCA services.

The system professionals often pointed to state hospital/regional treatment center placement as the "solution." Although strongly opposed to this option for their child, the family recognized that they could not meet their child's needs alone. They were in constant struggle with the system trying to get sufficient community/home based services. Professionals quickly

identified problems, however failed to develop solutions. A behavior control method developed accidentally by the family appeared abusive to some professionals and, at best, undesirable or unacceptable to others. This method used a device which allowed for movement of the entire body but screened out most vision. One of the characteristics of autism is an inability to tolerate external stimulation. Its use and release were most often self initiated by the client and it was effective in helping the client calm down. It was however forcefully administrated on other occasions. Consultations over the years all identified the need for an alternative, but all fell short of identifying possible alternatives, with the exception of use of a papoose board. This is a device which restrains the entire body, used in State and Psychiatric Hospital settings. That alternative was not acceptable to the family both because of the aversiveness of papoose boards and placement in a state facility, out of and away from the family.

"We were tired, overworked, and worst of all we knew what we were asking for [our child] was simply what was required to meet [our child's] needs. [The advocate] understood that the problems we were having were not with [our child's] behavior patterns but with other people not realizing that they were symptomatic of days filled with inactivity, under stimulation, and over emphasis on destructive behavior. In short, after appraising very wisely [our child's] needs [the advocate] started to work to make [our child's] life better."

At the time of the advocate's involvement, the family was receiving minimal services, clearly not adequate for their needs, from social services, the educational cooperative, and the community support. Team members were certainly making efforts to identify needs and provide adequate service. However, systems were having a

difficult time working together. Communications were strained. It is understandable that agencies and other service providers felt uncomfortable trying to provide services in the community because of the unusual needs, problematic behavior, and unique complexities of this situation. All involved tried to be helpful; however, the problems were overwhelming. There was perhaps a natural tendency to dwell on problems, and a reluctance to "put one's neck out," in an attempt to protect one's own agency; to point fingers at others, rather than to focus on creative problem solving.

A major key was to open communications – to focus on how resources could be combined to meet needs, in spite of obstacles. The advocate was able to help facilitate a team that became able to go beyond their traditional roles and look for ways to make happen what needed to happen. Often the services we identified as necessary were not forthcoming because of unavailability in the area. For example, the identified need for PCA services occurred, a provider agency was found, but the group was unable to come up with actual people to provide the necessary service. Eventually the county was able to secure a "waivered services slot" and with diligent effort was able to put together services that are making tremendous difference in the life of this client and the family.

The complexity of identifying needs and possible means of meeting those needs was a tremendous task. However, there is more to this story. Complicating the challenges presented by this situation were continued efforts by the agency initially referring the case to the Ombudsman's Office. Unsatisfied with the county's and the Ombudsman Office response to the original abuse investigation, agency staff continued to raise questions in several arenas. Their actions included referral to a private agency, alleging licensing violations, by one professional, to a licensing board based on that professional's report on this case (this allegation was eventually found to be untrue, but created much

stress and financial expense for the professional), and referral to a federal agency requesting additional investigation.

These actions had the result of making individual team members wonder when and if their own licenses would be placed in jeopardy. It was difficult for team members to come together and concentrate on creative problem solving rather than "watching over their shoulders." In pursuing this there were data privacy violations, which strained the family's newly developing trust in "the system." Indeed the job for our Office became one of "deflecting" crises in the aftermath of actions of the other agency. We assume these actions were out of concern for our client, however the methods used were not helpful in resolving problems, only in complicating them.

"Most importantly, [the advocate] helped organize a team of professionals and us concerned with [our child's] welfare. She worked, and worked, and worked. [The advocate] is available, always listens, and genuinely cares about our [child's] welfare."

The key in this case was to find ways of working together. This is being accomplished due to diligent efforts of the team led by the county case manager and others including (but not limited to) parents, a community support program, and the school district. The team is large, and ever changing, depending upon the client's changing needs. At times the meetings have over fifteen participants. This team is now usually able to function like a team should. "Hats" worn by individuals get tossed aside and all participants address issues attempting to problem-solve for the client's benefit. **There are still complex problems and obstacles, but the emphasis is now on "how can we do things" rather than on "we can't because..." or "that's someone else's job."**

In the background has been strong support for the case manager, and the

rest of the team, from his director and supervisor. Active participation by the school superintendent made a real difference in finding creative ways to meet some of the educational needs and in ways for school, county, and community support to join hands. The family has graciously welcomed other team members into their home, in spite of the fact that doing so had earlier resulted in their being accused of abuse. The parents are truly team members; their knowledge and expertise regarding their child is respected and valued, as is that of other members. Together, approaches have been tried and changed.

Our client is quite adept at letting us know what works and what does not, the challenge is for us to learn how to listen to the client and to understand. One and one half years ago, the client was homebound, sometimes receiving educational services a few hours per week. The client's behavior led to the family's frequent use of the "restraint." Other times the client self-initiated it's use most of the waking hours, rarely tolerating change. The client was unable to ride in a vehicle without mechanical restraint; **now none is needed.** Medical and psychiatric services identified and are treating migraine headaches; this seems to ward off many of the behavioral problems. Additional community support and educational services were

put in place until the client was able to tolerate travel to school (several miles each way) and attend school, in the school building, several hours each day. Tailored community support services focus on being in the community and

"Our appreciation of the Office of the Ombudsman is beyond bounds. In several times of crisis they have had professional extremely competent people assist us in all types of problems. If they didn't have the answer they went the extra mile to get it."

the client is now also spending part of the day in sheltered work. **The client no longer brings the "restraint" along and in fact hasn't used it for months.**

Change continues to be very difficult, but with services, the client has been able to work through changes in staff, changes from school to other programming, and changes in environment. The client still needs, and is receiving high intensity service and the progress is remarkable. Much of the credit goes to the family, the individuals who work directly with the client, and to the team's creativity and tenacity in addressing the pertinent issues. We expect the client will continue to progress and enrich the lives of those involved in the client's life.



Scott R. Woizeschke, Winner of the 1998 Children's Mental Health Poster Contest

EPSDT

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- **Treatment:** the identified services to address mental health needs.

Each of these components makes EPSDT the most comprehensive health care program available to Medicaid-eligible children and teens today. Other EPSDT elements of the program include outreach and information, scheduling of appointments, and case management. State Medicaid programs are required to conduct outreach campaigns and activities to inform and recruit eligible individuals. Some state Medicaid programs advertise the importance and availability of EPSDT services on radio and TV, in newspapers and through toll-free telephone numbers to call for information.

In addition to outreach efforts, states are required to inform all Medicaid-

eligible recipients of EPSDT services within 60 days of their Medicaid eligibility determination. Medicaid-eligible recipients are to receive information about the program including information that emphasizes the importance of preventative mental health care.

Schools can help to inform eligible children and families about the benefits of the EPSDT program. The major advantage that schools have is daily access to students, which other programs do not have. Schools can encourage families to participate in EPSDT services. Additional requirements include assisting families in scheduling screening appointments, offering and providing transportation to appointments, and providing case management activities.

The Federal Government's Health Care Financing Agency (HCFA) monitors the performance of states' EPSDT programs. State Medicaid

programs are required to submit data to HCFA that shows how they are complying with federal EPSDT program and administrative requirements. One of the most significant requirements is that state Medicaid programs should screen 80% of EPSDT eligible recipients. This requirement ensures that low-income children and teens are offered screening, diagnostic assessments, and treatment services to help with mental health needs.

The Ombudsman Office has received concerns about the state's EPSDT program and plans to conduct a review of this program. The purpose of the review is to evaluate whether the Office can offer recommendations to improve the delivery and performance of EPSDT mental health services to Medicaid-eligible children and teens. If you have questions about this article or would like to share information, please call Bill Wyss at (612) 215-1331 or 1-800-657-3506.

Civil Commitment Process

Many people felt the Minnesota Commitment Act was outdated and was put together piece-meal over the years. In 1994, the Mental Health Association of Minnesota pushed for legislation to have a Task Force set up to review the Commitment Act. The legislature agreed that the law should be reviewed and updated. The legislature passed legislation mandated a Task Force be set up by the Minnesota Supreme Court.

Roger Schwab, Region 6 and 8 Client Advocate, of the Office of the Ombudsman for Mental Health and Mental Retardation was appointed to the Task Force.

Originally there were approximately 25 members of the Task Force, but through the process more people were added when it was realized a few areas of interest were not represented. Eventually, there were approximately 40 members on the Task Force representing consumers, advocates, service

providers, law enforcement and court personnel. Justice Sandra Gardebring was appointed Chairperson to the Task Force.

The Task Force started meeting in August of 1994. It set up the process it would use, which consisted of focus group discussions, site visits and subcommittees. The Task Force decided on public hearings in St. Paul, Owatonna, Willmar, Duluth and Thief River Falls. Along with each public hearing was a site visit to a mental health provider, which included visits with consumers.

Focus groups spoke to the Task Force at its Friday meetings and included County Attorneys, Defense Attorneys, Advocates, Consumers, Psychiatrists, Psychologists, Nurses, State and County Mental Health Agencies, Parents/Family of Consumers, Judges, Law Enforcement and County Social Workers. There were also speakers from other states on their system and Veterans' Affairs.

The Task Force decided on setting up four subcommittees to focus on specific aspects of the Commitment Act. Those were: Judicial Process; Treatment; Funding and Systems; and Advocacy and Patients' Rights. In areas that overlapped, the subcommittees would work jointly for continuity.

The Task Force met one Friday per month, with most subcommittees meeting at least the Thursday before; and, as time went on, more frequently.

The Ombudsman's Office was represented at all Task Force meetings and participated in the Judicial Process, and Advocacy and Patients' Rights subcommittees. In addition to these, Brian Relay, Client Services Supervisors, presented, along with other advocates, at the Focus group on advocacy. Roger Schwab also assisted in planning the site visit in Willmar, as well as setting up the Task Force meeting with Willmar RTC clients.

When the Task Force finished and came up with its final recommendations, the Ombudsman's Office continued to be involved. The office worked with Senator Don Betzold in reviewing and writing legislation to present during the 1996 Legislature. When opposition to the legislation arose, the Ombudsman's Office participated in negotiating regarding concerns until the legislation was pulled from the 1996 calendar. The office continued to participate in negotiations until Task Force members decided to go forward with the legislation, despite opposition.

The Ombudsman's Office assisted with presentations on the Task Force recommendations to providers, MSSA, County Social Services, and others in preparation for the 1997 legislative session.

The Ombudsman's Office followed the legislation through the House and Senate. Roberta Opheim and Roger Schwab testified at the Senate Judiciary Committee and were present at the other committees that reviewed the legislation.

The Ombudsman's Office has also been involved with Senator Betzold's "clean-up bill" to be presented to the legislature this year. This bill will clear up areas which didn't flow with the legislation or were confusing or conflicting.

The Task Force came up with five major recommendations, along with cleaning up the previous bill.

Early Intervention

The first recommendation was Early Intervention. The Task Force kept hearing about how difficult it was to get individuals into treatment when they were opposed to it. It meant waiting until the individual deteriorated to the point where they were a danger to themselves or others. The Task Force debated this issue for some time. Some felt the Task Force should make it easier to commit; but consumers, advocates and defense attorneys were opposed to making it easier to commit. The Task Force reached a compromise with this recom-

mendation. It loosened the standard on individuals who have been committed two times in three years and are at a point where historically they will eventually be committed, or they have made it known they would choose treatment when they were competent (e.g., Advanced Mental Health Declaration). This also put an emphasis on treating early and in the individual's community.

Medication

The second recommendation was for a new Neuroleptic Medication Administration Process. The Task Force heard testimony about how protracted the process is for administration of neuroleptics to persons who refuse to take them or those who agree to take but lack capacity for informed consent. The Task Force reviewed the law and the Supreme Court decision on *Jarvis v. Levine*. The Task Force concluded that it could not do away with *Jarvis* but could speed up the process by having the Courts rule regarding capacity to give consent at the Probable Cause or Commitment hearings. There were also ways to avoid "Jarvis" hearings on clients who occasionally refuse medications. The Task Force also came up with clear criteria for what constitutes a lack of capacity and what substitute decision makers should use for giving consent. This has never been done before.

Provisional Discharge

The third recommendation was to change/strengthen the Provisional Discharge process. The Commitment Act had set up two different ways to revoke a Provisional Discharge, depending on how long the client had been out of the treating "facility." The new process made it the same for everyone. It also gave the "court" the authority to revoke. The new process requires the county to do the reports to the court when the person is in the community, as well as the authority to initiate the revocation process. It made it clear that courts can recommit for purpose of extending a Provisional Discharge and requires a copy of the Provisional Discharge be sent to the client's attorney.

Incompetent Consenter

The fourth recommendation is for consent to treatment for incompetent consenters. The Task Force heard that RTC's were refusing to voluntarily admit individuals who lacked capacity to give informed consent to admission based on a lawsuit in Florida. The Task Force decided that if a person was willing to go into treatment but lacked capacity to consent, the County could consent for him/her. It also set up the right to seek judicial review if there was a question of voluntariness.

Training

The fifth recommendation was for a Training and Resource Center which would be set up/overseen by the Ombudsman for Mental Health/Mental Retardation. (Please see the article on this.) The legislation passed and implementation is underway. Much credit goes to Justice Garderbring and the dedicated members of the Task Force.

Civil Commitment Training and Resource Center

The Court Advisory Task Force on Civil Commitment recommended in their task force report that a statewide civil commitment training and resource center be created to provide interdisciplinary training and information regarding the civil commitment process and related topics. The Office of Ombudsman for Mental Health and Mental Retardation received funding in the 1997 Omnibus Health and Human Services Act to develop and implement the training and resource center.

Our Office has contracted with Hamline University School of Law and the Minnesota Attorney General's Office to provide the training component of the Center. Starting in March, 1998 through

CCTRC

Continued from Page 9

June, 1999, Hamline and the Attorney General's Office will provide a minimum of eight statewide, interdisciplinary training seminars on the Civil Commitment Act and related law.

The first five training seminars will provide a step-by-step overview of civil commitment in Minnesota, with a special emphasis on the 1997 amendments. These seminars will also provide detailed, specialized training on individualized topics in civil commitment, including pre-petition issues, post-petition issues, neuroleptic medications and substitute decision-making, and more effective advocacy. The training locations include Mankato,

Bemidji, St. Cloud, St. Paul, and Minneapolis.

The second set of training seminars will focus on two narrower topics in greater depth. For each of the two topics selected, a detailed, stand-alone training package will be developed that can be easily replicated throughout the state. One training package will be designed for substitute decision-making, the other topic will be decided following evaluation of the first year of training. These two training packages would each be tested at a minimum of two sites.

The Office is currently developing the resource component of the training and resource center. The Office is currently developing a general brochure that will provide information on the

training and resource center. The resource center will also provide informational fact sheets, brochures and pamphlets on the civil commitment process and related topics.

The Office is also currently developing a case law library of key civil commitment cases and training intake staff on the civil commitment law and other civil commitment resources to assist callers. The Office will also continue to provide advocacy and support for persons going through the civil commitment process. The focus of the resource center will be on consumers and their families, but the Office can assist any and all persons who want more information regarding civil commitment. Please call Boyd Brown of the Ombudsman's Office at 612-215-1332 for more information.

Computer System

Continued from Page 3

advanced data querying, graphing and relationship modeling. These features will assist in the agency's reporting abilities.

The computer hardware and software systems are Year 2000 compliant.

Staff Benefits

The new computer system was designed to assist regional staff and management to provide more efficient client services. We have been doing fine-tuning on the system since going "live" to enhance user friendliness of the system.

Our staff gain many benefits from our computer system. A primary benefit is on line, real time computer access to any case file, whether open or closed. Every activity done on behalf of a client is date stamped with a detailed narrative of what actions were taken. Staff can view all case files in the system to insure that another staff person is not already involved with the client. Staff can work jointly on complicated cases and always have current knowledge of the case status. Staff can track clients over time because all reports of contact, client reviews, serious injury reports or even a death review are

stored in one computer file under the client name.

This computer system increases staff productivity in several ways. The system allows staff to attach word processing documents to client files or E-mail messages. The system will generate form letters for timely and effective communication with clients. The system also allows staff to communicate via the Internet with clients, state agencies, and other sources of information to provide needed information to clients and their families. Within the system, all staff have computer calendars that allow them to know when peers or managers are available. The calendar feature also provides a reminder of appointments.

Management Benefits

Managers have the ability to review work in progress from all staff, allowing the analysis of workflow and workload. Managers can review the length of time that cases are open and provide reminders to staff when cases are over 30 days old. This system allows management to not only track client issues as they move within the system, but also track complaints, serious injury reports, or deaths relative to specific programs,

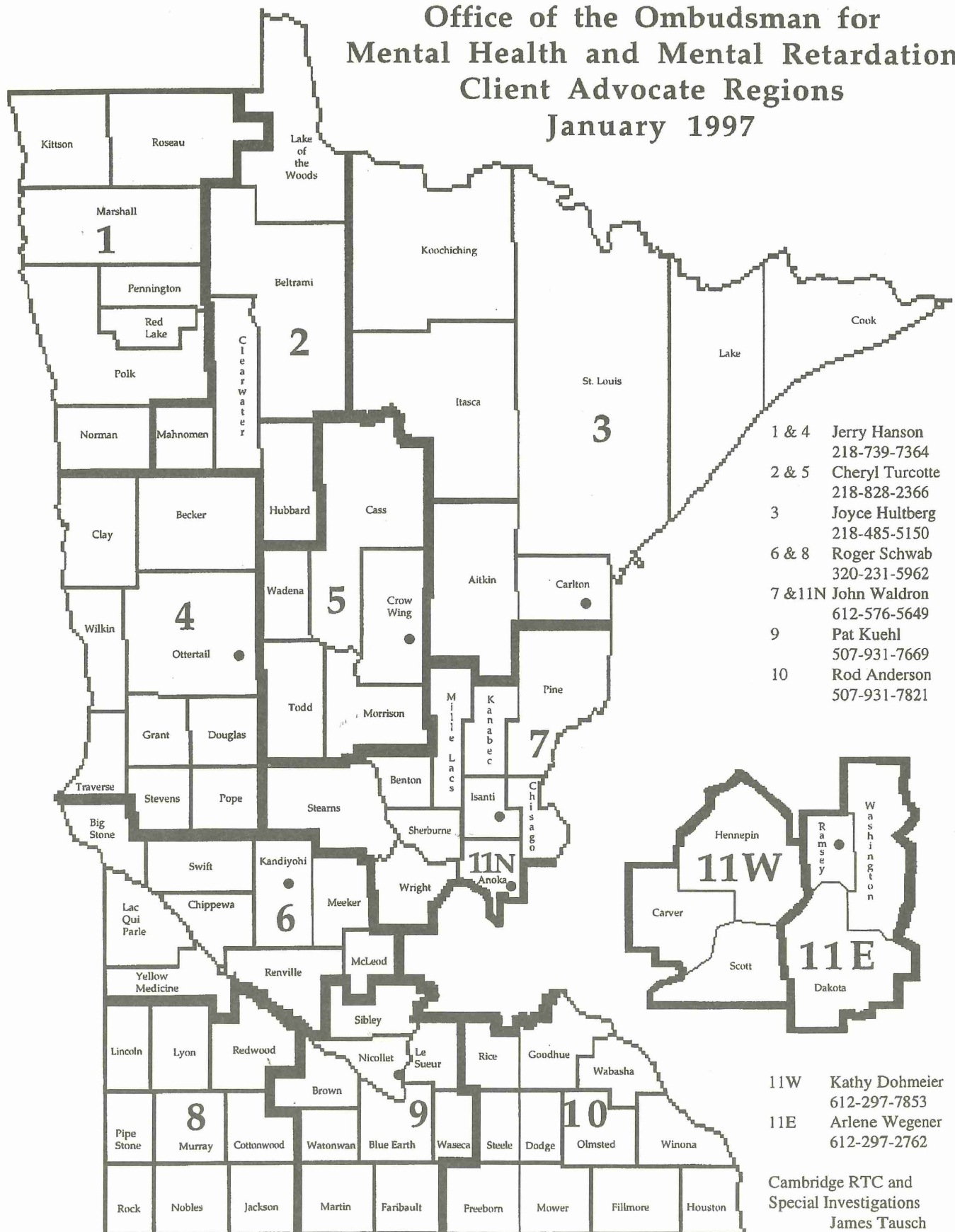
facilities or their parent corporations. This is helpful where one corporation manages multiple facilities or programs. The system has some mandated data fields that will help us analyze collected data in the future. We are only beginning to understand and utilize the data in ways that will benefit our clients and policy makers.

This system also allows managers to provide quality assurance. If a client has a concern about how a staff person provided a service, we can quickly determine what has been done for the client and try to resolve the concern. Computer calendars allows managers to know where staff are at any specific time. This allows us to provide clients with the best information possible.

The computer allows managers to communicate quickly and effectively statewide with staff, set up meetings and assign client referrals and projects. Managers can also communicate with other state agencies and gain access to needed information quickly and effectively via the Internet.

As we learn more about the system through experience we will be able to capture additional benefits for future use and improvements.

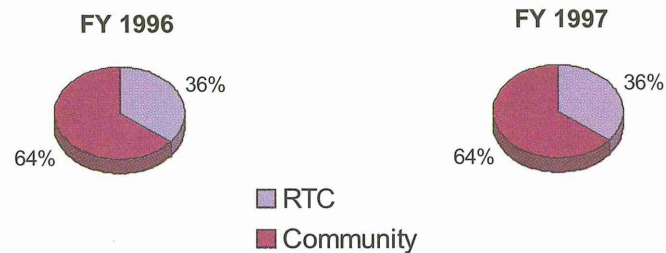
Office of the Ombudsman for Mental Health and Mental Retardation Client Advocate Regions January 1997



Contacts: RTC and Community

The comparison of workload between clients served at Regional Treatment Centers and the community was historically constant with a near 50/50 split. This was to be expected because the Regional Treatment Centers served many of the most severely disabled. Larger numbers of disabled individuals were concentrated at RTC's and clients

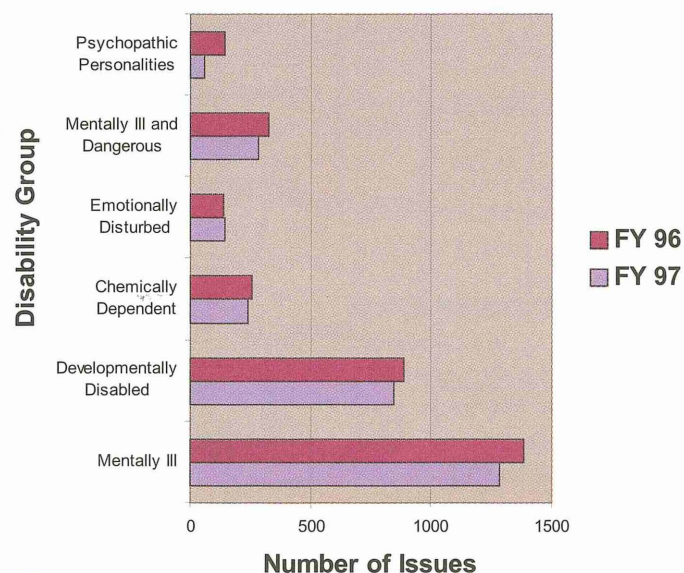
had almost immediate access to a regional advocate. However, during the last several years the workload has moved beyond a 60/40 split. This was expected as some Regional Treatment Centers closed and others downsized. Most Regional Treatment Centers have Patient Representatives that greatly help to lessen the load on our staff and allow more focus to be placed on individuals in the community and systemic issues on a regional or statewide basis.



Contact by Disability Group

Disability group access is fairly consistent. Persons experiencing mental illness utilize our services more often than other disability groups. These numbers continue to be higher due to the level of institutionalization for persons with mental illness, the level of involvement with the court system, problems with housing, public services and societal stigma concerning mental illness.

Persons with developmental disabilities are our second largest group of contacts. Due to deinstitutionalization few developmentally disabled persons live in Regional Treatment Centers. Most have moved to licensed community facilities with home like environments. We monitor this population through contacts from staff, parents, guardians, interested third parties and through serious injuries reports.

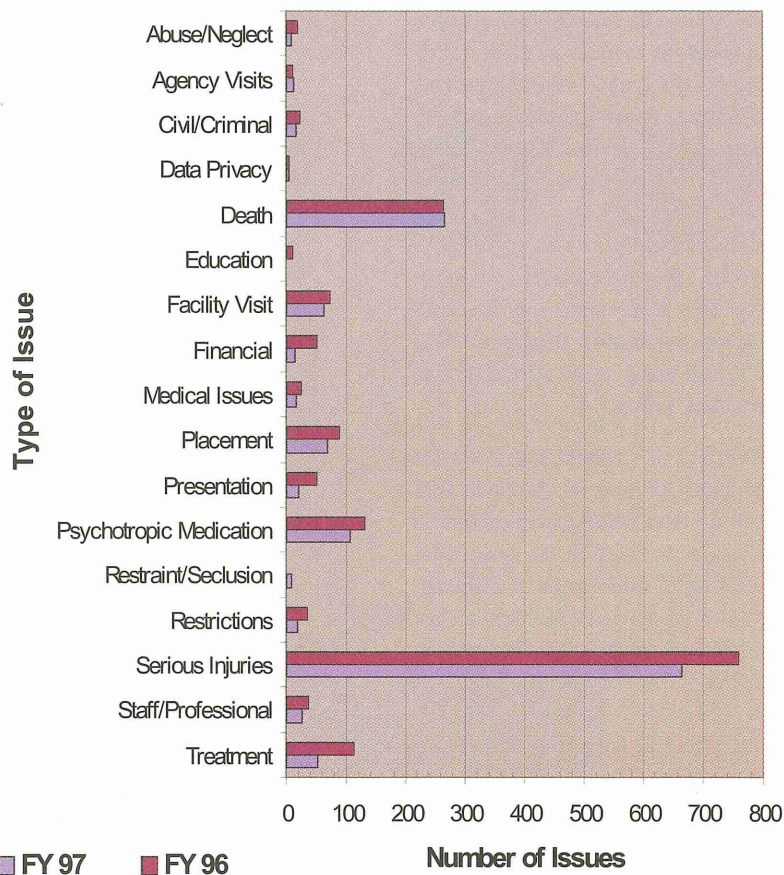


The chemically dependent person and children with an emotional disturbance are almost equal in their access to our services. Persons experiencing chemical dependency treatment tend to be in short term programs and often advocate well on their own behalf. As for children, most of our contacts come through parents/guardians or other interested third parties. As children become more aware of our services and we have greater involvement with the schools we will see an increase in this contact area.

Contact by Issue

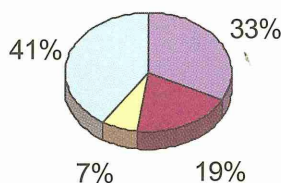
Most of the advocacy work done by this agency can be included in one of four major categories: Individual Client Issues, Serious Injury, Death Reviews and Consultation. Numbers alone can not paint a complete picture because each item varies with a time commitment from several minutes for an information and referral call to an investigation that takes months to complete. There will be greater detail later in this report on death and serious injury reviews.

After death and serious injury is removed you will note an almost 40/30 split between specific individual client issues and consultative contacts. Individual client issues encompasses one advocate representing an individual to resolve a specific issue or issues. This area is generally where the most commitment of time and resources are utilized. Regional staff attempt to resolve complex issues that require investigation, specific actions, and often follow-up. Some examples of this level of review are detailed within this report. As the graph indicates, the most common issues concern: psychotropic medications, placement, and general treatment.

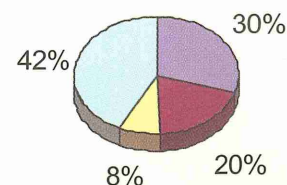


Consultation covers information and referral, crisis calls, facility visits, agency visits, presentations and training, and providing direct consultation to families, social service professionals, policy makers, state agency managers and the legislature.

FY 1996



FY 1997



■ Individual Client Issues
 ■ Serious Injury Review
 ■ Death Reviews
 ■ Consultation

Medical Review Subcommittee

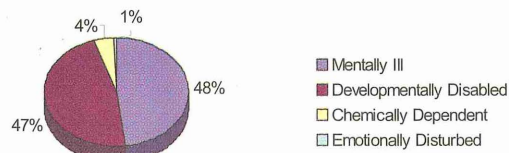
The Medical Review Subcommittee (MRS) meets on a regular basis. The addition of two new members has rounded out the areas of needed expertise and made discussions much more informative. One new member is currently providing in-patient psychiatric treatment. The other new member has pharmaceutical expertise with a special interest in medications used to treat psychiatric illnesses. The MRS is functioning as an efficient and well-informed group.

The Office of Ombudsman does not do an in-depth review of all cases that are reported. The MRS has established certain indicators such as suicides, accidental deaths, and deaths of children, that are used to determine when a case of death needs to be prepared for review by the MRS. The purpose of the MRS reviews is always to look for opportunities to improve the care delivery system. The MRS does not have a punitive focus. There are other governmental agencies such as OHFC and DHS Licensing that do very detailed investigations and have sanction authority. If the MRS finds a situation that needs that kind of investigation it is referred to the appropriate agency or agencies. The MRS will then work collaboratively in order to avoid duplication of efforts.

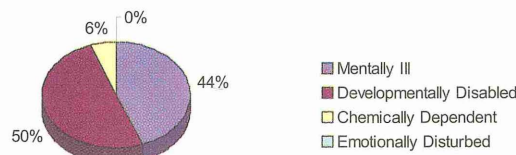
The MRS reviews information regarding deaths and serious injuries looking for patterns and trends. If a situation repeats itself the MRS will take a closer look at the circumstances to see if there is an opportunity to make recommendations to improve the service delivery system. Many times the information that the MRS needs to communicate comes in the form of Medical Updates. Over the past biennium these Medical Updates have included topics such as: Heat Stroke; Swimming Precautions; Winter Hypothermia; and Frostbite. The MRS hopes that by learning from our data and

Death by Disability Group

FY 1996



FY 1997



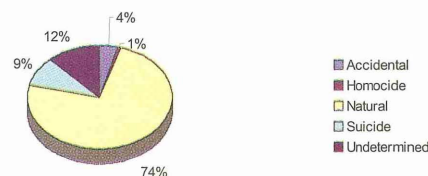
reviews that the MRS can help providers to avoid the same problems in the future.

There were 264 deaths reported to the Medical Review Coordinator in FY 96 and 266 deaths reported in FY 97. Sixty percent were closed immediately, and 16% cases required a full review by

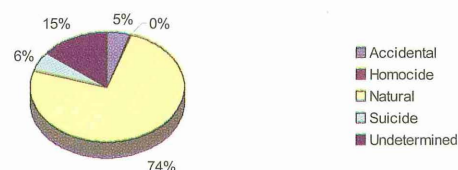
the MRS. The remaining 24% cases were opened for a Limited Review and were closed after additional information was made available to and was reviewed by the Medical Coordinator.

Death by Death Type

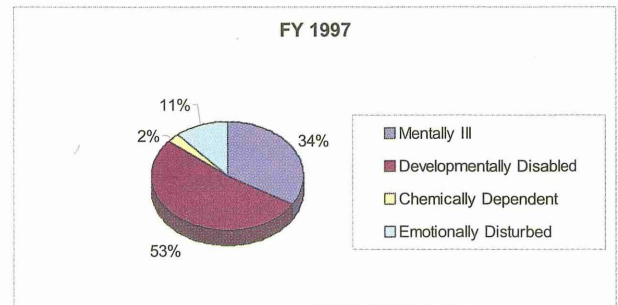
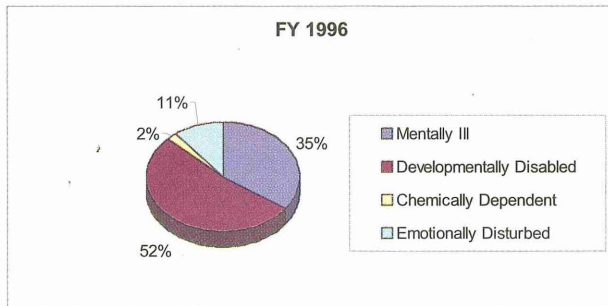
FY 1996



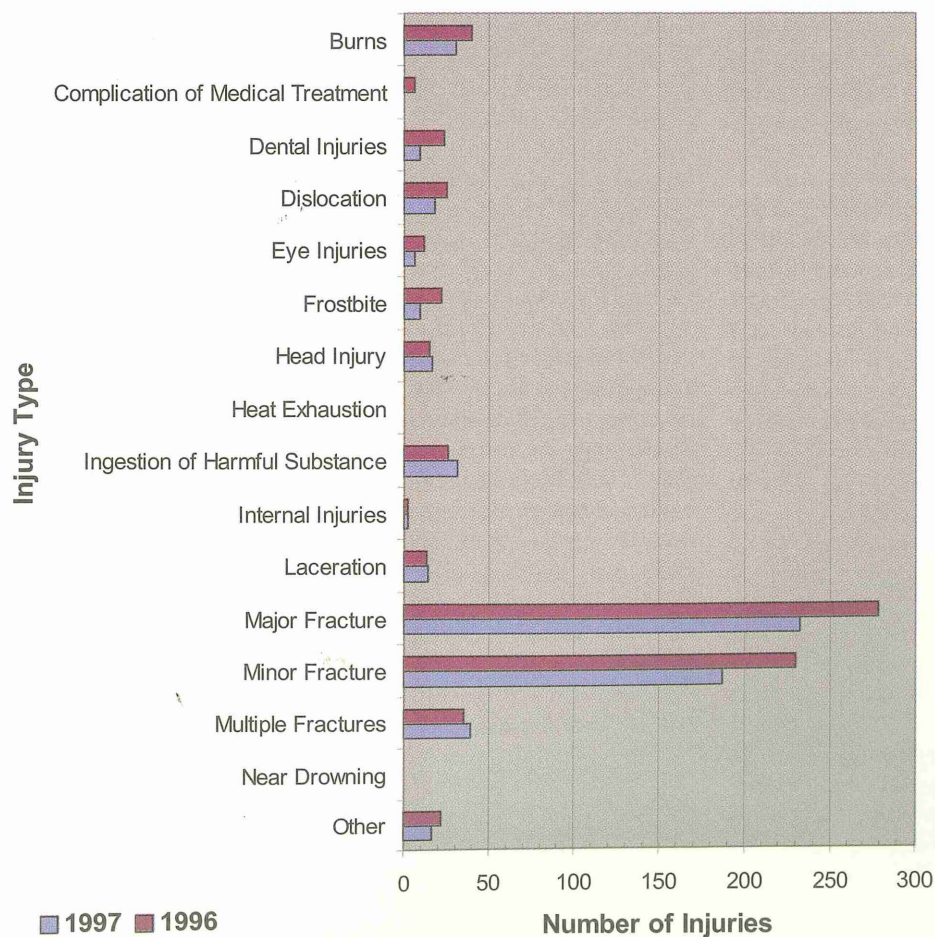
FY 1997



Serious Injury by Disability



Serious Injury by Type



One Child's Foster Care Journey

On August 30, 1996, a foster parent contacted a regional client advocate with the Office of Ombudsman for Mental Health and Mental Retardation (hereinafter referred to as the "Ombudsman Office"), stating that a foster child in his/her care would like to speak to an advocate regarding their rights as a foster child. In addition to foster care, the child was receiving mental health services paid for by LeSueur County. The foster child stated to the advocate that s/he was concerned that Le Sueur County may remove him/her from the present foster care home and the local school s/he attended for many years. The reason stated was that the county had a policy that foster children cannot drive a car under any circumstances, even if they have a license or permit. The foster child was driving his/her foster parent's car with the foster parent in the passenger seat. The foster child felt that s/he was a part of this home, felt secure there and s/he was doing better in school. S/he felt that if s/he was moved that s/he was being punished for a mistake that someone else made.

On September 3, 1996, the first day of school, the foster child's child protection worker from Le Sueur County came to the school and told the foster child that s/he would be immediately (that afternoon) moving to a new foster home. The foster child was moved to a new foster care home in a neighboring town and attended the school in the neighboring town the next day. In the evening of September 4, 1996, the foster child was taken to the emergency room at Queen of Peace Hospital and later transferred to Immanuel St. Joseph Hospital in Mankato due to continuous vomiting. During the hospital visit, the initial foster parent was denied visitation with the foster child. The foster child's initial diagnosis by the emergency room personnel was stress induced gastritis. However, it was later revealed that the foster child overdosed on pills on September 3, 1996. The foster child told our investigators that s/he wanted to harm him/herself when taking the medications because all of his/her

supports had been taken away from him/her.

Several months after this incident, the foster child was placed in an adolescent alcohol treatment center for thirty-eight days. Presently, the foster child lives in a foster group home licensed by the Department of Corrections.¹ S/he has stated to the advocate that if s/he could have the final say that s/he would have liked to return to the original foster home and return to his/her original school but realizes that is not likely to happen. During the initial process, the foster child stated the following in responding to a question raised by the Ombudsman's Office on how we could help:

a) to be allowed to return to the original foster home and return to his/her former school; or

b) if s/he can not return to the original foster home, that s/he be allowed to stay with the new foster family but get transportation to his/her former school and be allowed to keep the initial foster parent as part of his/her life because s/he looks at that person as his/her "parent" (These preferences were stated before the chemical dependency treatment and subsequent placement in a corrections licensed group home.)

The foster child had decided, given all the barriers, not to continue to pursue returning to his/her previous foster home or attending the original school at this time. However, s/he continues to desire visitation and phone contact with his/her initial foster parent. As of November 2, 1996, the county has allowed the foster child to have visits and phone contact with the initial foster parent. The Ombudsman Office will continue to monitor this situation and provide advocacy as needed.

The Ombudsman Office decided to deal with this case on two levels. The first level was one of advocacy on behalf of the foster child and the other was an investigation into the behavior of the county in this case regardless of the outcome of the advocacy.

There are four key issues at stake in this case:

- Whether the county actions in removing the foster child from his/her foster care home constituted a respectful and humane process, and if the county took into consideration the mental health needs of this child.
- Whether the manner in which the removal of the foster child was handled could exacerbate existing mental health issues for this foster child and contribute to the foster child's actions on September 3, 1996, when s/he attempted to harm him/herself.
- Whether the initial foster parent and the new foster parents were given adequate background information and a service plan to meet the foster child's needs.
- Whether the county acted within the law and state and county policy when removing the foster child from his/her initial foster care home.

As a result of our review, the Ombudsman Office concluded that while the county does have the legal authority to move this foster child, the process used lacked sensitivity to both the foster child and both foster families and was in violation of the legally binding foster care parent agreement and practice issues. In addition, the county's actions could have led to very serious harm of this child entrusted to their care. The recommendations of this agency include the following:

1. Le Sueur County review its policy and procedures regarding the movement of children in foster care; specifically Le Sueur County should develop criteria that takes into account the need for a dignified and respectful process and the need for transitioning services for the foster parents and children. The Ombudsman Office also recommends that Le Sueur County,

¹ It is important to note that even though the foster child has been placed in a corrections licensed group home, s/he has not been adjudicated for any crime.

unless a true emergency exists, refrain from communicating sensitive information at school or in any environment whereby the child would not have a support person in attendance;

2. The county develop a process to improve communication between the county and its foster parents including providing the foster parents important information such as medical and psychological care issues, active involvement of the foster parents in the foster child's case plan and a process for resolving differences between the county and the foster care parents;

3. The State of Minnesota Department of Human Services conduct an in-depth review of Le Sueur County foster care practices to determine if these practice issues go beyond this single case;

4. Some form of oversight of the foster care system be developed by either the Department of Human Services or the legislature, that will provide some due process review for the foster child and the foster parents. The Ombudsman Office specifically recommends that the Department of Human Services or the legislature review the Nebraska Foster Care Review Boards statute;

5. Le Sueur County provide training to staff on issues relating to: impact of change on foster children, the importance of transitioning services for foster children, sensitivity to children's mental health issues, and accurate, complete and timely documentation;

6. Le Sueur County review or develop policies and procedures regarding investigations, documentation and follow through and ensure that county workers are following the policies and procedures implemented; and

7. The Department of Human Services investigate and provide possible resolutions to the issue of foster children being restricted or denied the opportunity to learn and practice driving.

For a copy of the full report contact Paula at the Office of the Ombudsman for Mental Health and Mental Retardation at (612) 296-3848 or 1-800-657-3506.

Looking Forward

As we move into the 1998/1999 biennium, the Office faces new opportunities and challenges, including the following:

Schools - During the 1997 legislative session the legislature added language to our empowering statute that included The Department of Children, Families and Learning and Local School Districts to the definition of Agency in MN Stat. § 245.91. This would allow the Ombudsman and staff members to work with children who have mental illness, mental retardation and related conditions, chemical dependency and emotionally disturbance, in the school setting.

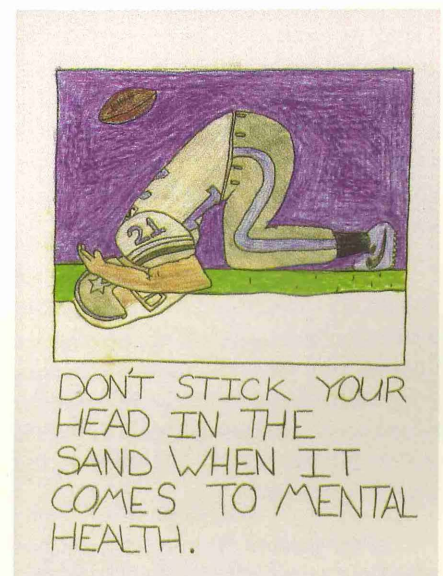
The Office staff learned that when working with the treatment needs of children, it was difficult, if not impossible, to address their social service and treatment needs without addressing their educational needs in a coordinated way. Schools and the need for an education are one constant in the life of every child. Many of the children the agency worked with were multi-system children who may have had an ISP (Individual Service Plan) done by the social service case manager and an IEP (Individual Education Plan) done by the school. There was little or no coordination between the two systems. Some children were also involved with the juvenile justice system. These systems did not always talk to each other and since each system had different rules or desired outcomes, it was confusing to the child and in some cases even caused more problems. Parents were very frustrated.

Since the Children's Mental Health and the Family Services Collaboratives have been established, we see great improvement in cooperation between systems both in individual case work and in the various organizations' openness to collaboration. However some cases still benefit from the assistance of an advocate. Because the resources of the office did not increase with the authority, the Office has established policies that make multi-system children our highest priority.

Maltreatment of Minors Act -

Also during the 1997 legislative session, the Office, while working an issue with ARC of Minnesota, discovered that there was much confusion about the Maltreatment of Minors Act (MN. Stat. § 626.556) as it relates to abuse or neglect when it takes place in a school setting. As a result, we sought and received legislation that would convene a work group led by the Department of Human Services (DHS), to make recommendations for changes in the Act. The Ombudsman has made this issue a high priority for the next biennium.

Demonstration Project - One other project that is in development calls for providing external advocacy for all persons in the Demonstration Projects for Persons with Disabilities. This is an effort by DHS and selected counties to move disabled Medicaid recipients from a fee for service model to a managed care model that will be administered by the county. Members of the various work groups felt that it was important that advocacy services be provided by an agency that was not directly involved with the either the purchase of, provision of or regulation of services. For purposes of the Demo Projects, clients will include persons with all disabilities including physical, mental or cognitive. The Ombudsman will be meeting with various groups in an effort to develop appropriate advocacy services.



Louie Pirrotta, Winner
1998 Children's Mental Health Poster Contest

Systemic Issue Study: State Hospital Review Boards

Since the creation of Minnesota's Office of the Ombudsman for Mental Health and Mental Retardation (hereinafter referred to as the "Ombudsman Office"), there have been several requests for the Ombudsman Office to participate in and assist with discussions regarding possible changes in the role, function, and administration of the State Hospital Review Boards (HRBs). Additionally, the Ombudsman Office has taken note of changes in the way individual HRBs function, changes in the environment in which they operate, and changes in how their administrative agency views the HRBs and interacts with them. This report provides an overview of these issues and also offers some conclusions and recommendations.

This report includes the input of multiple individuals representing a variety of perspectives on the past, present, and possible future of HRBs. Great effort was taken to be sure the broadest possible spectrum of viewpoints and positions was considered. Those interviewed included administrative and professional staff from the Department of Human Services (DHS); current and former HRB members; professional, paraprofessional, and peer advocates from Advocacy and Disability services; former recipients of services at state regional centers, and staff from the Ombudsman Office. Documents offering the opinions and input from former statewide HRB coordinators and others involved with these issues were also considered and included.

In considering the wide variety of opinions and options identified in this report, the Ombudsman Office evaluates these factors from its primary perspective. This perspective can be summarized in two essential questions: 1) What is best for the client? 2) What is the right thing to do?

In the case of Minnesota's institutionalized population, the government - through the civil commitment process -

assumes responsibility for the life of a person while they are under the terms of the commitment order. When the government assumes this responsibility, there is a greater level of accountability that must be maintained.

With Minnesota's Civil Commitment Statute (including the HRB statute) scheduled for review during the 1997 legislative session, the Ombudsman Office presents this public report to assist with the full and careful consideration of proposals which could significantly impact some of the state's most vulnerable citizens.

This report includes six possible options for the future of HRBs and HRB type services in Minnesota. Virtually everyone who had input into the report identified one or more of these six options. Those options include:

- 1) Maintain the "status quo."
- 2) Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from the DHS Licensing Division.
- 3) Transfer the HRB functions to another agency with the goal of providing the type and quality of services the HRBs have offered.
- 4) Continue with and augment current HRB services for DHS' mentally ill and dangerous and psychopathic personality populations, while developing a new model for clients in community based services and short-term institutional placements.
- 5) Transfer HRB functions to another agency with the goal of developing a new model of service.
- 6) Modify the existing statute and abolish the HRB.

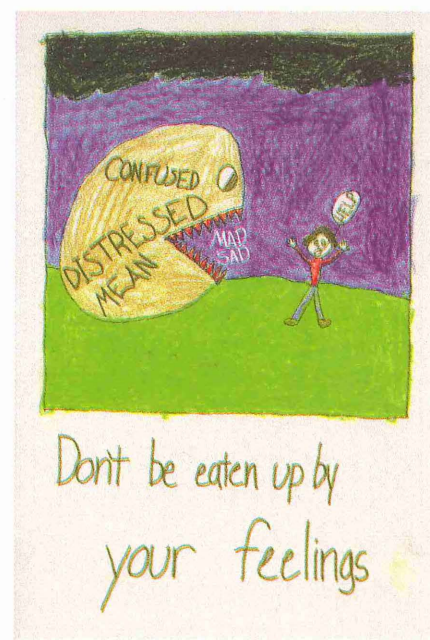
Of the six options, the Ombudsman Office has identified three of them as having the most viability to be success-

fully implemented in the near future.

It is the recommendation of the Ombudsman Office that DHS pursue one of the following three options:

- Continue with and augment current HRB services for DHS' mentally ill and dangerous and psychopathic personality population, while developing a new model for clients in community based services and short-term institutional placement;
- Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from DHS Licensing Division; or
- Transfer HRB functions to another agency with the goal of developing a new model of service.

Please give the Ombudsman Office advance notice if you need reasonable accommodations for a disability, such as wheelchair accessibility, an interpreter, Braille, or large print materials.



Andrew Vogt, Winner
1998 Children's Mental Health Poster Contest

Summer Alert

Update 97-01

The Medical Update is based on the work of our Medical Review Subcommittee and should be posted prominently. We will make an effort to take an active role in improving the services provided to people with disabilities by communicating important issues found in the Medical Review Subcommittee's review of deaths and serious injuries. We want to thank you for your prompt reporting of deaths and serious injuries. You are helping us meet our mission.

MEDICAL UPDATE



This Medical Update provides information on conditions that may cause serious injuries and, in some cases, death. These conditions may result in cases that are reported to our office during the summer season. Our hope is that this Medical Update will be a reminder to you to be alert and informed, therefore able to avoid potential problems.

HEAT

- Check the electrical capacity of the facility to evaluate whether air conditioning can be added.
- For the elderly, plan rest stops to allow for necessary fluid intake.
- Refer to HEAT STROKE Update 97-02.

WATER SAFETY

- Develop policies based on water safety rules from the American Red Cross (Refer to WATER SAFETY Update 97-03).
- Provide inservice on policies for all staff prior to the swimming season.
- Know what hazards to look for in the specific water environments you'll be in, whether it's the beach, water park, pool, river or lake.
- Review individual abuse prevention plans prior to outings.
- Know each individual's vulnerabilities and provide adequate supervision to ensure the safety of everyone.

SUN

- Some medications, such as neuroleptics and antibiotics, put clients at particular risk for sunburn.
- Use a sunscreen with a high sun protection factor (SPF), such as 15.
- Use sunscreen on all exposed skin prior to sun exposure and reapply frequently (every 60 to 90 minutes) and especially after swimming.
- Reduce exposure to the sun with umbrellas, hats, long sleeved summer clothing, etc.
- Limit the amount of direct sunlight you receive between 10:00 A.M. and 2:00 P.M. This is the time of day when UV rays are most harmful.
- Protect eyes with sunglasses that are labeled to absorb at least 90 percent of UV sunlight.

MEDICAL UPDATE



MEDICAL UPDATE



INSECTS

- Check buildings for holes in screens and other spots where insects can get in.
- Apply insect repellants prior to being outside when possible.
- Wear long-sleeved shirts, long pants tucked into socks, and closed shoes when in woods or grassy areas.
- Check for ticks after being outdoors.
- Shower as soon as possible after coming indoors. Ticks take several hours to attach themselves to the skin; in the meantime, they can be washed away.

STATE OF MINNESOTA



**OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH
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April, 1997

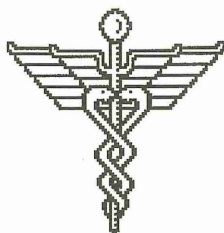
P L E A S E P O S T

Heat Stroke

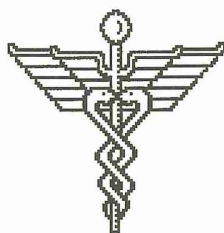
Update 97-02

The Medical Update is based on the work of our Medical Review Subcommittee and should be posted prominently. We will make an effort to take an active role in improving the services provided to people with disabilities by communicating important issues found in the Medical Review Subcommittee's review of deaths and serious injuries. We want to thank you for your prompt reporting of deaths and serious injuries. You are helping us meet our mission.

MEDICAL UPDATE



MEDICAL UPDATE



MEDICAL UPDATE



MEDICAL UPDATE



The heat and humidity put all people at risk for heat stroke or heat exhaustion. We have received reports of clients suffering from heat stroke because they live in very hot buildings or because they made some choices that caused their body temperature to rise to very dangerous levels. Certain medications may also be a factor.

Recipients of mental health treatment may be at added risk:

- Because of living at a facility or other environment that has no air conditioning and/or poor air circulation.
- Because of the need to take medications that inhibit perspiration or increase fluid loss, such as diuretics.
- Because of being reluctant to drink adequate amounts of fluids.
- Because of the incapacity to make decisions that would reduce the risk, such as wearing appropriate summer clothing and eating light meals.

In order to reduce the risk it becomes the responsibility of facility and/or program staff to:

- Keep the environment as cool as possible.
- Review restricted fluid intake programs and provide extra fluids, including water, milk, fruit juice or soda at meal times.
- Encourage fluid intake.
- Know what medications put clients at particular risk, such as neuroleptics.
- Make rounds and observe conditions at regular intervals during the day in order to ensure the health and safety of clients.
- Review activities for their appropriateness during hot weather. If appropriate, reduce, suspend, or conduct the activities in cool places or during a cooler period of the day.
- Limit intake of coffee, tea and alcohol as these beverages can increase fluid loss.

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April, 1997

Update 97-03

Water Safety Guidelines

The Medical Update is based on the work of our Medical Review Subcommittee and should be posted prominently. We will make an effort to take an active role in improving the services provided to people with disabilities by communicating important issues found in the Medical Review Subcommittee's review of deaths and serious injuries. We want to thank you for your prompt reporting of deaths and serious injuries. You are helping us meet our mission.

MEDICAL UPDATE



MEDICAL UPDATE



MEDICAL UPDATE



MEDICAL UPDATE



Prior to the swimming season providers should make sure that all staff involved in taking clients on water activity outings know and understand the following Water Safety Guidelines from the American Red Cross.

The following are safety steps you should take before starting any activity in or near water:

- Learn about swimming, boating, and first aid, and be sure that others in your group also are informed. Contact your local American Red Cross chapter for information about swimming and first aid courses. Check with the Coast Guard and other organizations about boating and other aquatic courses.
- Know what to do in case of a water emergency.
- Choose a safe place for water recreation.
- Use Coast Guard-approved life jackets when boating.
- Look for potential water hazards.
- Know local weather conditions and how to find out what is forecasted.
- Know how to prevent, recognize and care for hypothermia.
- Know how to prevent, recognize and care for heat emergencies.

Ensure that clients use these basic safety tips whenever they swim in any body of water:

- Never swim alone.
- Swim only in supervised areas.
- Never drink alcohol and swim.
- Enter feet first rather than head first if you do not know the depth.
- Swim in a pool only if you can see the bottom at the deepest point.
- Know your swimming limits and stay within them. Don't try to keep up with someone with stronger skills or encourage others to keep up with you.
- Keep an eye on weaker swimmers.
- Watch out for the "dangerous too's"—too tired, too cold, too far from safety, too much sun, too much hard playing.
- Stay out of the water when you are overheated.
- Do not chew gum or eat while you swim; you could easily choke.
- Learn the correct way to dive, and know when it is safe to dive.
- Use common sense about swimming after eating. In general, you do not have to wait an hour after eating before you may safely swim. However, if you have had a large meal, it is wise to let digestion start before beginning strenuous activity like swimming.

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April, 1997

1997/98 Winter Alert Update 97-11

Each year the Ombudsman's Office receives several serious injury or death reports that are directly related to winter conditions. In this Medical Update, the Office is providing you with a list of reminders to help avoid those injuries or deaths. As the cold weather approaches please make sure your facility abuse prevention plans and policies contain the elements that will assure a safe winter. Be sure to discuss them with staff and clients.

Medical Update



HAVE A PLAN OR POLICY AND MAKE SURE ALL STAFF KNOW THE PLAN

Establish a marker wind chill temperature when everyone stays indoors.

Know when to suspend any travel. Is the travel really necessary?

Have a plan about what to do if stranded away from home in adverse weather. Discuss the plan with both staff and clients.

GET READY FOR WINTER

Stock extra batteries for radios and flashlights.

Consider an alternate heat source and a supply of fuel.

Install a UL-approved carbon monoxide (CO) detector in your home, which will sound an alarm when unsafe levels of CO are present.

Have all fuel-burning appliances safety checked in the fall. This will not only reduce the risk of CO poisoning, it will also promote energy efficiency.

Make sure smoke detectors are installed and working. Check all fire extinguishers to make sure they are ready to be used.

Try to avoid using space or portable heaters. They can create a fire hazard.

Medical Update



KEEP SIDEWALKS CLEAR OF ICE AND SNOW

Keep a supply of salt or cat litter.

Make sure that there is snow removal equipment available.

Pay special attention to stairs, porches and areas where clients are getting in and out of vehicles.

Heart attacks are a major cause of death during and after winter storms. Shoveling snow or freeing stuck vehicles can be extremely hard work. Don't overdo it; pace yourself and get help.

COMMUNICABLE DISEASES

Get a flu shot.

Don't share drinking glasses and cups.

Encourage good and frequent hand washing. Regularly clean and disinfect articles touched by many people such as phones, doorknobs and faucets.

Provide disposable paper tissues and a proper place to dispose of them.

Medical Update



HYPOTHERMIA & FROSTBITE

Hypothermia and frostbite can quickly become life and limb threatening. See other Alerts for more details.

The very old, the very young and persons who are in poor health are most at risk.

STAY OFF OF THIN ICE

Stay away from ice-covered ponds and streams.

Many persons have died when they fell through ice they thought was safe. Lake ice should be at least four inches thick before it should be walked on.

Medical Update



WINTER TRAVEL

Know what the weather forecast is. Before travel call for road conditions. The metro number is 612-405-6030 or toll free 1-800-542-0220.

Keep a winter survival kit that contains candles, matches, high calorie food, and a HELP sign in your car along with an extra blanket, boots, cap and mittens.

If your vehicle becomes stranded, stay with it until help arrives. Do not try to walk for help during a blizzard.

Keep your car "winterized" with fresh antifreeze, winter weight oil and a tune up. Use snow tires.

Always use your seat belt!

RECREATIONAL HAZARDS

Every winter we get a number of serious injuries reported that have been the result of snow sliding. Make sure the path is clear of any obstacles, then have fun.

PLEASE POST



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Frostbite

Update 97-11

Each year the Ombudsman's Office receives several serious injury or death reports that are directly related to winter conditions. In this Medical Update, the Office is providing you with a list of reminders to help avoid those injuries or deaths. As the cold weather approaches please make sure your facility abuse prevention plans and policies contain the elements that will assure a safe winter. Be sure to discuss them with staff and clients.

Frostbite is classified into three categories:

Medical Update



First degree: Affects only the top layer of skin. It causes temporary discomfort but is not a serious injury.

Second degree: Affects the top layer and the next layer of skin. It is characterized by a waxy white color and skin is cold to the touch. Clear blisters form up to 36 hours later. This needs medical attention and is a serious injury.

Medical Update



Third degree: Affects the top layer of the skin and the tissue and muscle beneath. The flesh is hard, cold to the touch and bluish gray in color. There is no pain. As the tissue warms, the person experiences pain and swelling. The appearance of multiple, large blood-filled blisters indicates severe and deep tissue injury. This is very serious and needs immediate medical attention.

Report second and third degree frostbite to the Ombudsman Office as a Serious Injury.

PREVENTION

Medical Update



Wear several layers of warm clothing and protection against dampness and wind.

Cover exposed skin. In cold weather, cover as much of the face as possible, allowing for good vision.

Keep your hands and feet dry and make sure boots and mittens do not restrict circulation.

RECOGNITION

Skin is white and feels numb.

Most typically seen on cheeks, earlobes, fingers and toes.

Medical Update



TREATMENT

Do not rub a frozen body-part, that can cause more damage.

Rewarm the area gently and slowly, by blowing warm air on it or placing the area against a warm body part (stomach or armpit).

Put frozen part into a warm water bath of 105-110 degrees F. for 25 to 40 minutes

Refreezing after rewarming causes extensive tissue damage and may result in loss of tissue.

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Hypothermia

Update 97-11

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Medical Update



Hypothermia occurs when the body's core temperature drops below 95 degrees Fahrenheit or 35 degrees Celsius. This happens when the rate of heat loss exceeds the rate of heat production. Hypothermia can quickly become life threatening.

CONDITIONS LEADING TO HYPOTHERMIA

Cold temperatures
Improper clothing
Wet clothing
Fatigue, exhaustion or chronic illness
Dehydration – Moisture is lost with each breath and also from sweating. There is a strong connection between fluid loss and heat loss.
Poor food intake
Little or no knowledge of hypothermia
Alcohol intake - causes blood vessels to dilate, thereby releasing more heat
Certain drugs (such as phenothiazines and barbituates) can prevent the normal body responses to cold temperatures.

Medical Update



PREVENTION

Review the attached wind chill chart and stay inside when there are dangerous wind chills.
Wear layers of clothing
Wear a hat. Up to 70% of body heat is lost through the head.
Stay dry.

Medical Update



RECOGNITION

Watch for the “-Umbles” – stumbles, mumbles, fumbles, and grumbles
Slurred speech
Violent shivering
Irrational behavior – person may take off clothing, unaware s/he is cold. They may actually think they are too warm.
Always call the designated health professional as soon as possible when you recognize hypothermia.

Medical Update



TREATMENT

Warm the person slowly and seek immediate medical help.
Warm the person's trunk first.
Conserve and reduce loss of heat by adding layers of clothing, making sure clothing is dry. Increased physical activity and shivering helps the body produce more heat.
Put the hypothermic person into a sleeping bag with someone who is not hypothermic.
Provide shelter from wind and drafts.
Provide warm food and fluids high in carbohydrates and sugars such as dissolved Jello.
Avoid caffeine, alcohol and tobacco/nicotine.

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