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STATE OF MINNESOTA

Evaluation Report Summary / February 2013

State-Operated Human Services

The Department of Human Services should continue to provide some direct services to clients, but with a clearer mission and more effective resolution of ongoing problems.

Key Facts and Findings:

- The Minnesota Department of Human Services (DHS) operates more than 130 residential facilities for individuals with mental illness, developmental disabilities, and chemical dependency.
- State-run human services facilities today house fewer than 1,300 residents, compared with more than 16,000 in 1960.
- The mission of DHS's state-run services is not clear in state law.
- DHS's governance structure for state-run services has been confusing, and its oversight of these services has, at times, been insufficient.
- DHS has provided little useful information to the Legislature and public for evaluating the performance of its state-run services.
- Many behavioral health patients have stayed in state-run hospitals longer than necessary, partly due to inadequate placement options following discharge.
- Inappropriate restraint and seclusion of patients contributed to the closure of one state-run facility and serious sanctions against another. State-run facilities have experienced problems with workplace safety, and reports of physical assaults increased sharply in 2012.
- DHS has struggled to address various challenges at the Minnesota Security Hospital, including inadequate psychiatric staffing, increasing staff injuries, and frequent leadership changes.
- Many individuals enter state-run facilities following civil commitment by courts. But state law has overlapping provisions for some types of commitments and does not ensure periodic court review of all commitments.

Key Recommendations:

- The Legislature should clarify in law that the mission of state-run facilities is to serve individuals who would not be adequately served by other providers.
- The Department of Human Services should ensure the availability of placement options for individuals ready to leave state-run facilities.
- DHS should add security to some state-run hospitals, enabling them to serve challenging patients that other facilities cannot.
- DHS should develop a plan for reducing the number of state-run group homes for individuals with developmental disabilities, and it should prepare a plan addressing the future of the Anoka-Metro Regional Treatment Center.
- The Legislature should amend state law to ensure periodic court review of civil commitments.
- The Minnesota Security Hospital should develop clear standards regarding psychiatric contacts with patients and the amount of treatment provided.

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Report Summary

The Minnesota Department of Human Services (DHS) directly provides many services to individuals with mental illness, developmental disabilities, and chemical dependency. The department's State-Operated Services (SOS) Division employs more than 3,000 staff to provide inpatient and outpatient services. Expenditures for state-run services totaled about $293 million in fiscal year 2012.

State-run residential facilities range in size from group homes that serve a few individuals to the Minnesota Security Hospital's licensed capacity of 408 patients. All SOS facilities are licensed by DHS, the Department of Health, or both.

Some state-run facilities serve unique functions, while others provide services similar to nonstate providers.

The state's role as a direct provider of human services should be clarified.

State law provides limited guidance on what services DHS should directly provide. Many services provided by state-run facilities are also offered by nonstate providers. Overall, state-run facilities accounted for about 3 percent of the beds in all Minnesota facilities with similar types of state licenses in 2012. The Legislature should clarify in law the role of state-run facilities to serve clients who cannot adequately be served by other providers.

Some state-run facilities serve a unique function and should continue. For example, the Minnesota Security Hospital is the only secure facility licensed to provide residential treatment to adults with mental illness. This enables it to serve dangerous individuals who cannot be housed elsewhere. Also, discharge of Security Hospital residents is determined, according to law, by the DHS commissioner based on recommendations from an independent board, and it is doubtful that nonstate facilities would serve patients for whom they had no direct control over discharge.

In contrast, there are viable alternatives to state-run group homes for certain individuals with developmental disabilities. In 2012, 384 beds were in state-run adult foster homes, a fraction of the 17,000 beds in licensed foster homes statewide. State-run homes should be continued for clients whose needs would not likely be met by other providers, but DHS officials and client advocates believe that reasonable alternatives exist for many individuals in state-run homes.

The department operates seven small community behavioral health hospitals for adults, all of which have opened since 2006. Because these hospitals have no security staff, they sometimes do not admit patients with histories of violence or aggressive behaviors. Such patients often remain in nonstate hospitals, which have struggled to provide appropriate services. To better serve as the provider of last resort, SOS should experiment with adding security staff to some of its hospitals.

Oversight and accountability of state-run services have been weak.

State law authorizes the Commissioner of Human Services to govern state-operated services. But in 2000, the commissioner created a "governing board" for these services, resulting in confusing lines of authority and some violations of state law. In 2012, DHS changed the board's composition so that its membership now consists entirely of SOS administrators. However, the need for a governing board remains unclear.

At times, DHS leaders have not given sufficient attention to the internal oversight of state-run services. While it is encouraging that DHS's deputy commissioner provided active

oversight of SOS activities in 2012, state-run services will need sustained, effective leadership to succeed.

DHS has provided the Legislature and general public with little information on the performance of state-run services. In biennial budgets covering a 12-year period, DHS provided data on only two performance measures. Also, DHS's public and internal Web sites have provided limited data for evaluating the performance of state-run services. Department management should ensure greater accountability and transparency for SOS activities.

There has been instability in some high-level SOS positions, partly reflecting personnel decisions within the department. For example, two key positions (chief administrator of the Minnesota Security Hospital and SOS chief operating officer) were filled in 2011 and 2012, respectively, but the hired individuals were replaced months later.

Management has not adequately addressed some persistent service delivery problems.

Many patients have remained at state-run facilities longer than necessary.

State-run hospitals—especially the Anoka-Metro Regional Treatment Center—have had a history of keeping many patients hospitalized longer than necessary. This has partly reflected limited post-hospital placement options. The 2009 Legislature required DHS to develop a plan for the Anoka facility, but DHS's response offered few specifics, and DHS eventually postponed its proposed action indefinitely. As of September 2012, nearly 40 percent of Anoka's beds were occupied by patients who no longer needed hospital care.

A 1999 U.S. Supreme Court ruling said that undue institutionalization of individuals with mental disabilities is discriminatory. DHS did not begin developing a comprehensive plan for complying with the court's ruling until it was required to do so by a 2011 agreement reached in response to a lawsuit. The department's plan is scheduled to be completed in mid-2013.

The department's start-up of small behavioral health hospitals for adults in recent years facilitated the closure of larger institutions. But some have had problems attracting and retaining psychiatric staff. One repeatedly failed to meet the standards required to bill for federal health care payments, costing the state several million dollars in reimbursements. These small hospitals have the potential to serve an important role, but perhaps they should collaborate more closely with nonstate hospitals. Such collaboration may require financial incentives; DHS's previous effort to establish partnerships was unsuccessful.

State-Operated Services has struggled to contain workplace safety problems at state-run facilities. In 2012, the reported number of physical assaults within SOS grew sharply. Also, many state-run facilities have high workplace injury rates. State-Operated Services recently implemented an improved system for documenting and tracking workplace incidents, but SOS policies on incident reporting and follow-up remained in need of clarification.

Inappropriate use of patient restraint and seclusion led to the closure of one facility (Minnesota Extended Treatment Options) and a conditional license for another (Minnesota Security Hospital). Since the Security Hospital restricted the use of these practices in 2011, line staff have felt ill-prepared to deal with difficult patients.

The Minnesota Security Hospital has had ongoing management problems for years. For example, there have been unresolved questions about the balance between security and treatment, and staff reporting relationships have

Addressing workplace safety, providing appropriate treatment, and ensuring an adequate continuum of services remain ongoing challenges.

sometimes been unclear. The facility's current managers are trying to address many problems, but it remains too soon to determine their success. The Security Hospital has had too few psychiatrists for the past year, and the amount of structured mental health treatment it provides for patients is modest.

Many patients have stayed at the Security Hospital for years, partly reflecting a lack of placement options. DHS should, working with the Legislature if necessary, ensure that services exist for individuals ready to leave the Security Hospital and other state-run facilities—whether these options are run by DHS or other providers.

State law should require periodic court review of civil commitments, and DHS should receive court data on commitments to DHS.

Many individuals enter state-run facilities following an involuntary civil commitment by a district court. During a recent 18-month period, the courts committed nearly 4,000 individuals as mentally ill, chemically dependent, developmentally disabled, or mentally ill and dangerous.

Statewide, courts vary in the extent to which they have civilly committed individuals. Annual commitments per 10,000 population have ranged from less than 6 in some judicial districts to about 16 in another.

The statutory definitions of "mentally ill" and "mentally ill and dangerous" used for purposes of commitment overlap with each other. As a result, different judges may make different commitment decisions when faced with similar individuals who pose public safety risks.

Unlike most states, Minnesota allows some commitments to be indeterminate in length, without prescribing time periods for judicial review of the commitment. The Legislature should require the courts to periodically review the commitments of individuals as mentally ill and dangerous or as developmentally disabled.

DHS should be aware of all individuals for which a court has assigned responsibility to DHS. State courts do not currently provide complete information to DHS on such commitments, but they should. To help DHS conduct background checks of applicants for firearms, current law requires courts to inform DHS about individuals committed to non-DHS facilities; often, however, the courts have not done so. DHS uses multiple information sources to conduct firearms-related background checks, but the process does not appear to be entirely reliable.

Summary of Agency Response

In a letter dated February 8, 2013, Minnesota Department of Human Services Commissioner Lucinda Jesson said the report "clearly and accurately identifies the issues facing the department as we work to provide a safe and caring environment for our clients and employees." She said the department supports the report's key recommendations, "which are largely consistent with our own assessments and ongoing efforts to address areas needing improvement." For example, she said the department will work on developing better placement opportunities for clients ready for discharge from its facilities and bring plans to the Legislature regarding the role of certain facilities.

The full evaluation report, *State-Operated Human Services*, is available at 651-296-4708 or:
www.auditor.leg.state.mn.us/ped/2013/sos.htm