UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, et. al, Plaintiffs, vs. Minnesota Department of Human Services, an agency of the State of Minnesota, et. al, Defendants.	Court File No.: 09-CV-1775 DWF/FLN **PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR** **PRELIMINARY INJUNCTION**

Plaintiffs are compelled to bring this action against Defendants' routine and widespread imposition of severe and cruel methods of seclusion and restraint upon people with developmental disabilities, including Plaintiffs and others similarly situated, at Minnesota Extended Treatment Options ("METO"), a program of the Minnesota Department of Human Services ("DHS"), operated in blatant disregard of their civil and constitutional rights. As part of their "treatment and care," Plaintiffs Bradley J. Jensen ("Bradley"), Thomas M. Allbrink ("Thomas"), Jason R. Jacobs ("Jason") and a class of METO residents have suffered irreparable harm from the abusive, inhumane and cruel use of seclusion and restraint while involuntary patients of the METO program. Specifically, Defendants forced Plaintiffs and other METO residents into law enforcement-type metal handcuffs and leg hobbles as a means of behavior modification, coercion, discipline, convenience and retaliation for conduct as benign as touching a

pizza box, spitting, laughing and hand-washing. *See, e.g.*, Answer ¶ 39 [Doc. 24] (admitting to the use of restraints).

Bradley, Thomas and Jason are only three of approximately 300 METO residents subjected to these cruel and inhuman seclusion and restraints in addition to those who will be secluded and restrained during the pendency of this litigation. *See* O'Meara Aff. Ex. 16 (stating case involves review of 300 non-parties – i.e., METO residents). On behalf of Bradley, Thomas, Jason, and all other individuals who were subjected to the use of seclusion and restraints while at METO, Plaintiffs initiated this class action lawsuit under, *inter alia*, 42 U.S.C. § 1983, challenging the Defendants use of seclusion and restraints in violation of their civil and constitutional rights.

Because Defendants have refused to stop the use of seclusion and restraints, Plaintiffs request this Court promptly issue a preliminary injunction immediately enjoining any further use of seclusion and restraints on residents of the METO program, or any successor program, (collectively "METO"), including mechanical restraints, manual restraints, prone restraint, seclusion, individual isolation, electroconvulsive therapy, and chemical restraints.[1]

FACTS

A. State of Minnesota Ombudsman issues "*Just Plain Wrong*" (September 2008)

In April of 2007, the State Ombudsman for Mental Health and Developmental Disabilities (the "Ombudsman") received a complaint about the use of restraints at

[1] Plaintiffs are also moving for class certification, and have submitted a separate memorandum of law in support of such motion.

METO. Amend. Compl. Ex. 1-A [Doc. 3-1]. Over the course of the next year, the Ombudsman conducted a comprehensive investigation of the use of restraints and aversive methods at METO and found that Defendants were involved in a *program wide* practice of restraining residents with metal handcuffs and leg hobbles for such benign behaviors as touching a pizza box, talking about running away, or touching staff, a walkie-talkie or other objects, causing residents to cry, yell and struggle. *See id.* Some residents were restrained hundreds of times. *See id; see also* O'Meara Aff. Ex. 1. Others were placed in a face down, prone position while restrained with metal handcuffs and leg irons, even when they were cooperative and calm. Amend. Compl Ex. 1-A [Doc.3-1]. Some residents would just "assume the position" due to the frequency of restraints used on them. *Id.*

On September 18, 2008, the Ombudsman's Office published a report entitled "*Just Plain Wrong*" detailing its investigation, findings, conclusions and recommendations. *Id.* The Ombudsman found, *inter alia*, the following:

> Documents in individual records revealed that people were being routinely restrained in a prone face down position and placed in metal handcuffs and leg hobbles. In at least one case, a client that the metal handcuffs and leg hobbles were secured then together behind the person, further immobilizing the arms and legs, reported it to the Ombudsman staff. Some individuals were restrained with a waist belt restraint that cuffed their hands to their waist. An individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall, as they would not be able to use their arms or hands to break that fall. Others were being restrained on a restraint board with straps across their limbs and trunk. METO policies stated that a person was not to be restrained for more than 50 minutes. Ombudsman staff found numerous examples of documented incidents where after 50 minutes in a restraint, staff would continue the restraint but document it on a different restraint use form,

> sometimes with no indication that it was a continuation of the previous restraint.
>
> Documentation revealed that in most cases where restraints were used, the person was calm and cooperative about going into the restraint but began to struggle, cry and yell once they were in the restraints. In some cases, clients appeared to be conditioned to "assume the position" for the application of restraints where they would lie on the floor and put their hands behind their back without resistance. One client who was regularly restrained with metal handcuffs and leg irons stated that once the restraints were on he/she began to experience discomfort which led to crying, yelling and struggling against the restraints. The METO policy stated that a person had to be calm for 15 minutes before they could be released from restraints.

Amend. Compl. Ex. 1 at p. 17-18 [Doc. #3-1].

The Ombudsman further reported, in part:

A. METO was a program that was established with a good foundation and lofty goals but had slid into a pattern of practice that used restraints as a routine treatment modality;

B. Generally accepted best practice standards indicated that restraints should only be used in a situation where there is imminent risk to the patients or others and only for as long as the risk is present;

C. Current best practice standards focused on positive behavioral supports, which included assessing the purpose of the behaviors and finding positive alternatives for the individual to employ;

D. Sixty three percent (63%) of METO patients at the time of the review, had been restrained and the majority of those had been restrained multiple times; one patient had been restrain 299 times in 2006 and 230 times in 2007;

E. Reasons for restraining patients included touching a pizza box;

F. No alternatives were attempted to avoid the use of restraints;

G. The length of time some patients were in restraints exceeded METO's own guidelines; and

H. The agencies who had protective obligations for METO patients or responsibility to serve as a checks and balances over the actions of the program, failed to protect the patients or turned a blind eye to the problem.

Amend. Compl. Ex. 1 [Doc. #3-1]. The Ombudsman concluded, *inter alia*, that METO had a *program-wide* practice of routine use of restraints employed as a basic treatment modality, and the use of restraints was anticipated with every admission. *Id.* at p. 44 (emphasis added). Moreover, the Ombudsman concluded that inappropriate use of restraints constituted abuse under Minnesota's Vulnerable Adult Act, and that certain practices at METO violated the human and civil rights of some clients. Amend. Compl. Ex. 1 at p. 45 [Doc. #3-1].

B. The Minnesota Department of Human Services Concludes its METO Program Violated State Law

In addition to the Ombudsman's investigation, the Department of Human Services Licensing Division ("DHS") conducted a self evaluation of METO, following complaints about the use of controlled procedures, in particular, the use of mechanical and manual restraints.[2] On April 4, 2008, DHS issued an *Investigation Memorandum*, concluding, in part, that the emergency use of restraints were not implemented, reviewed, or reported as required by Rule 40, and that staff implemented the use of controlled procedures on an emergency basis without the residents' behavior meeting the criteria for such use (i.e., immediate intervention is needed to protect the person or others from physical injury or

[2] The use of aversive and deprivation procedures on METO residents is monitored by the DHS Licensing Division for compliance with the standards promulgated in Minnesota Rules, parts 9525.2700 through 9535.2810, commonly referred to as "Rule 40." Amend. Compl. Ex. 1-B at p. 61 [Doc. 3-2].

to prevent severe property damage that is an immediate threat to the physical safety of the person or others). Amend. Compl. Ex. 4 at p. 18 [Doc. 3-8]. In response to its investigation, DHS issued a Corrective Order to METO, citing numerous violations of state laws governing the use of aversives and deprivations procedures at METO, including restraints. Amend. Compl. Ex. 5 [Doc. 3-9].

C. The State of Minnesota's Department of Health, Office of Health Facility Complaints Found Violations of State and Federal Law at METO

The Minnesota Department of Health ("MDH") Office of Health Facility Complaints ("OHFC") also conducted an unannounced visit of METO in order to investigate alleged violations of federal law related to the use of restraints. Amend. Compl. Ex. 2 [Doc. 3-6]. As part of its investigation, the MDH reviewed eleven METO residents files and reported that METO utilized manual restraints, physical escort, and the following mechanical restraints: a RIPP restraint board (a client is put on their back and restrained on a board), RIPP straps (straps utilized for restraining a client's extremities), RIPP cuffs (wrist restraints), "arm bar takedowns" (a manual method utilized by two staff, who apply pressure to the client's elbows, with the goal of lowering the client to the ground in a prone position-lying on their stomach), Posey soft cuffs attached to residents wrists, which is then attached to a RIPP belt that is secured around the resident's waist, handcuffs, leg hobbles and other mechanical restraints. *See generally* Amend. Comp. Ex. 2 [Doc. 3-6] for additional mechanical restraints used on METO residents.

Moreover, MDH reported that METO utilized chemical restraints on its residents. For example, after exhibiting aggressive behavior, Client #6, "was given 10 milligrams of

Haldol, 2 milligrams of Ativan and 50 milligrams of Benadryl, intramuscularly (IM), at 10:25 a.m." and "[a]t 11:30 a.m. the client was a sleep." Amend. Compl. Ex. 2 at p. 18 [Doc. 3-6]. Additionally, while being restrained for a total of 170 minutes within a three hour time frame, "Client #1 received Haldo, 5 milligrams, and Ativan, 1 milligram" and yet another "Ativan, 1 milligram." *Id.* at p. 3. Also, "Client #6 was given 10 milligrams of Zyprexa IM" for "pacing, grabbing at staff, walking in office and peers rooms." *Id.* at 8. These are just a few examples of the use of chemical restraints on METO residents.

The following are exemplary incidents of the use of restraints at METO, as documented by the MDH.

> On February 9, 2007, client #1 walked into the resident phone room and touched peer. Client #1 was mechanically restrained [] from 3:09 p.m. to 3:24 p.m. When client was completely released, he touched staff person. He was restrained mechanically, [] from 3:29 p.m. to 4:14 p.m., for a total of 50 minutes.
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> During the time the client was restrained it was noted that he was "screaming, crying and swearing" at staff. At 4:24 p.m. client #1 as restrained per his "Rule 40 on board" again "yelling, crying, screaming and swearing at staff." He was restrained until 5:04 p.m., another 40 minutes. Client #1 was restrained one more time on February 9, 2007. At 5:10 p.m., client #1 was restrained "Rule 40 on board" for "yelling, screaming and swearing." He was released at 5:23 p.m., after 18 minutes. Client #1 also received Benadryl, 25 milligrams, and Ativan, 2 milligrams IM at 5:00 p.m.
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> On July 10, 2007 at 4:13 p.m., client #2 was sitting at a table eating a snack when she "knocked" a glass of water "shoved" a box of crafts off the table. Client #2 was told to "stop" and "lie down" and was restrained for ten minutes. During the time she was restrained she, "did minor SIB" (self injurious behavior), slapping her sides for six minutes.
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> On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directions . . . invading peers/staffs space [with] wheelchair." The client then "slapped" a staff's forearm with an open hand. He was then restrained with leg hobbles and wrist cuffs for 22 minutes.

On May 24, 2007 at 8:43 p.m., client #4 was manually and mechanically restrained for 50 minutes. Prior to being restrained, the client "appeared agitated and had been touching staff for over an hour."

Upon arrival to the facility on the day of admission, May 7, 2007, client #6 was attempting to bite and kick staff. An emergency mechanical restrain was implemented. The client "continued to struggle and attempt physical aggression." The client was in restraints for 30 minutes. In addition to the mechanical restraint, client #6 was given 10 intramuscularly (IM), at 10:25 a.m. At 11:30 a.m., the client "was asleep." Documentation indicated that the client was "scared" and he did not know staff. At 6:20 p.m., client #6 was in the bathroom washing his hands. A staff person cued him to dry his hand with a washcloth. The client stuffed the washcloth in his mouth. The staff pulled the washcloth out of the client's mouth. The client struck the staff person three times with an open hand. The staff implemented a "basic come along take down to prone position, handcuffs, and leg hobble." The client was in restraints for 50 minutes. At 8:50 p.m., client #6 attempted to enter the staff office. Documentation indicates he "was struggling during escort." The client kicked and punched staff. A double arm bar takedown was used and both emergency manual and mechanical restraint were implemented in response to physical aggression. The client was in restraints for 50 minutes.

Client #6 was put in leg hobbles and handcuffs for 50 minutes. During restraint, he yelled and was banging his head on the floor.

At 3:15 a.m. on May 10, 2007, client #6 was trying to swing at staff person's face with a closed fist. The staff person used an arm bar take down to restrain the client. Documentation indicated that at 3:20 a.m. the hobble was removed. The client was agitated and kicking, and the hobble was re-applied. At 3:35 a.m., client #6 was struggling, trying to get cuffs off causing abrasions on his wrists. The cuffs were removed and the client was put in a manual hold. The client was restrained until 4:00 a.m. when he was released due to labored breathing.

On June 2, 2007, indicated that client #6 was restrained at least seven times. At 2:40 pm., client #6 was given 100 milligrams of Seroquel. Client #6 had "four Rule 40 implementations today for physical aggression (no specific behaviors identified) and PICA" (eating inedible objects). A note written as follow-up by nurse indicated client #6's Rule 40 was re-implemented at 4:17 p.m. and the Seroquel was minimally effective. At 7:15 p.m., client #6 was given 2 milligrams of Ativan and 50 milligrams of Benadryl IM. The "precipitating behavior" indicated was "three more Rule 40's for agitation/aggression, each lasting nearly 50 minutes."

On August 11, 2007, at 8:11 a.m. the client "began to come at staff in an aggressive manner." Staff redirected client to room. [Client #6] went in room but came out again within several seconds. [Client #6] then began to grab at staff with force. Staff implemented rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice), by first putting [client #6] in an arm bar. [Client #6] resisted the arm bar and continued to claw and grab at staff. [Client #6] went to his knees but continued to fight. Staff then implemented an arm bar for take down. As staff did this, [client #6] turned away from implementor to another staff, grabbing and clawing. At this moment implementor felt and heard upper arm pop.

Staff called 9-1-1 and notified R.N. A splint was applied and the client was transported to the hospital by emergency medical technicians. Client #6 had a left distal humerus fracture and was admitted to the hospital for pain control after his arm was set and splinted. He returned to the facility on August 13, 2007. He returned to the hospital on August 28, 2007 for surgical repair on his fractured arm and returned to the facility on August 29, 2007.

Client #7 has mild retardation. A review of the "Documentation for Emergency Use of Controlled Procedure" from indicated that on December 12, 2007 at 7:00 p.m., client #7 "had been upset since supper, ignoring staff requests." Staff asked her to go to "home 3" so they could escort other clients. The client "refused shouting when staff stood beside her chair then kicked tried to hit." The staff had tried to "negotiate" with the client for an hour, offered her quiet time in her room and time to talk. An arm bar takedown was implemented and the client was restrained manually for 20 minutes. The client's mood after the restraint was documented as "feeling depressed" and crying.

On December 21, 2007 at 9:10 p.m., client #7 was "arguing w/staff about recovery [programming], when told she had to restart she started screaming at staff [and] kicked the wall very hard." The client was put in manual then mechanical restraints, leg hobbles, and wrist cuffs, for 28 minutes due to property destruction, "kicking the wall." The client "screamed and cried" for 18 minutes before she was calm.

October 12, 2007, at 8:35 a.m. indicated that client #7 was asked to take her bath and medication. The client began yelling and screaming at staff. When staff entered the bedroom, client #7 attempted to hit staff. The client was put in a manual restraint in prone position. After two minutes, mechanical restraints were applied. The procedure ended at 8:55 a.m. Documentation indicated that after the restraint procedure, client #7 was

> "very emotional and crying, stating she can't go to work today." The nurse assessment, at 9:05 a.m., indicated the client was anxious, and was rocking in the rocking chair.
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> On September 9, 2007 at 7:20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is property destruction." As a result, the client ran out of his bedroom and into another "unoccupied" bedroom and slammed the door. The client was handcuffed and his legs were hobbled for a total of 10 minutes.
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> On August 5, 2007 at 8:12 a.m., client #9 "was watching T.V. and laughing inappropriate." The client bit, slapped, and hit himself, "with strong force." . . . The client was cued to calm down and to keep his boundaries. The staff "waited for extra staff before takedown." The client was manually restrained and placed in wrist cuffs and leg hobbles for a total of 50 minutes. The client was noted to be crying and trying to relax, but, "he was being held" in a prone position and the client "attempted to grab staff [and] get up." The leg hobbles and wrist cuffs were reapplied at 12:25 p.m. for an additional ten minutes.
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> On September 28, 2007 at 12:55 p.m. client #9 received Ativan because he was "agitated [and] aggressive."
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> An incident report, dated September 13, 2007, at 9:00 a.m., indicated that after being restrained, client #9 went into his bedroom and banged his head against the wall. He sustained a two centimeter abrasion mid-forehead and a two centimeter abrasion on his right temple.
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> On March 6, 2007 at 7:59 p.m., client #10 "was given a snack." He began spitting on kitchen table. Staff cued the client to stop spitting and to go to his room and calm down. While in his room he began vomiting on his floor and urinated. He was laughing for no reason." He spit and vomited on staff and was restrained for 14 minutes in handcuffs and hobbles.
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> Client #11 was restrained 19 times between August 10, 2007 and November 2, 2007, on an emergency basis.

Amend. Compl. Ex. 2 [Doc. 3-6]

The MDH cited METO for violations of state and federal law related to the use of restraints and aversives. Amend. Compl. Ex. 2 at p. 17 [Doc. 3-8]. It also reported that

METO "failed to ensure that residents were free from unnecessary physical restraints and/or drugs," and "that METO "failed to revise individual program plans as necessary related to behaviors; incorporate alternative interventions in place of restraints, into the client's individual program plan; and utilize restraints in a manner that will reduce the restraint or eliminate the behavior[;] [t]herefore, fifteen federal deficiencies were issued and one state licensing order was issued." *Id.*

D. Independent Experts Retained by METO Officials Recommend Reducing Restraints, Staff Education and Alternative Methods for Behavior Modification

In July of 2008, following the investigations of the State's DHS Licensing Division and the MDH, Defendants engaged a group of national experts in the treatment and support of persons with developmental disabilities to complete a review of the METO program, which lasted three days. *See* O'Meara Aff. Ex. 2. The experts opined "METO should seek alternative approaches to mechanical restraints to assure safety during physical behavioral crisis." *Id.* at p. 2. Additionally, the experts stated that "[t]he use of mechanical restraints is not regarded as best practice in the disability field" and that "[s]eeking alternative approaches to assure safety during physical behavioral crisis is advisable." *Id.* at 5. The experts went on to outline recommendations for METO to consider in its effort to further reduce the use of restraints, especially mechanical restraints, including not teaching restraint to staff and enhancing alternative methods for diffusing dangerous behaviors. *Id.* at 6.

E. METO Continues to Use Restraints and Existing Policies Permit the Use of Restraints

METO continues to use restraints on it residents. Through class certification discovery, the State Defendants have disclosed METO policies that continue to permit the use of restraints. O'Meara Aff., Ex. 4 at Response 15 and Exs. 7-11 (Procedures 3503 *Client Care / Emergency Use of Controlled Procedures (Manual and Mechanical Restraints)* (Effective September 15, 2009); 3504 *Client Care / Use of Controlled Procedures in Behavior Management* (Effective April 23, 2010); 3505 *General Administration / Therapeutic Intervention/Personal Safety Techniques* (Effective April 23, 2010); and 3601 *Client Services / Administration of Psychotropic Medication* (Effective November 29, 2009)).

Procedure 3503 permits the use of manual, mechanical, and chemical restraints, prone holds, and "exclusionary and room timeout procedures" in emergency situations. O'Meara Aff. Ex. 8 at p. 3 ¶¶ B(1)(c), B(1)(d), B(1)(j). "Emergency" is defined as follows.

> Emergency: A situation in which the behavior of a client is actually causing, or almost certainly leading to, significant physical injury. Client refusal to receive / participate in treatment shall not constitute an emergency, unless otherwise defined by court order.

Id. at p. 1 ¶ D.

Procedure 3504 permits the use of "room timeout" and "deprivation procedure" as part of a resident's Individual Program Plan for behavior management. O'Meara Aff. Ex. 9. The policy defines room timeout as follows.

> ROOM TIME-OUT removes a client from an ongoing activity to a specifically designed time-out room. Through a variance to Minnesota Rule 9520.2170, Subpart 35.B (Rule 40), the client may be prevented from leaving the time-out room by an electro-mechanical device that requires constant pressure by a staff member to maintain the mechanism in a locked position. A room-time out procedure must not exceed 60 minutes.

Id. at p. 2 ¶ (N)(1). Although not technically permitted "seclusion" is encompassed within the definition of "room time-out."

> *Seclusion*: The placement of a person in a room from which egress is:
> 1. Non-contingent on the client's behavior; or
> 2. Prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the client from leaving the room.

Id. at p. 2 ¶ (L).

Procedure 3601 permits the use of psychotropic medication under routine circumstances and in emergency situations. O'Meara Aff. Ex. 11. Psychotropic medications may be used as a chemical restraint in emergency situations. *Id.* at p. 5 ¶ (B)(3). An "emergency" is defined as follows.

> Emergency: A situation in which a client's mental health symptoms create:
> 1. An imminent risk of significant physical injury to the client or others, and/or
> 2. Significant psychological / emotional anguish, and
> 3. Non-pharmacological behavioral procedures are ineffective, inappropriate, or not possible for the situation.

Id. at p. 1 ¶ (E).

Finally, Procedure 3505 permits the use of "personal safety techniques (PST), including manual restraints and prone holds when a resident "becomes aggressive" and as part of a resident's approved behavior management program or IPP. O'Meara Aff. Ex. 10 at p. 2 ¶ (B).

The term "personal safety techniques" is defined as follows.

> Personal Safety Techniques (PST): Application of external physical control by employees to clients who become aggressive despite the preventive strategies attempted. Physical control is based on the principle of using the least amount of force necessary to prevent injury and protect life and physical safety when program and other prevention strategies have failed.

Id. at p. 1 ¶ (B). Although not explicitly called a "restraint," PST is the application of physical control, which is seemingly analogous to manual restraint. The policy also allows for the use of prone holds in light of the admitted potential harm that can result from use of such hold.

> Positional asphyxiation is a risk factor when using a prone hold and this hold should only be used as a transitory intervention.

Id. at p. 2 ¶ (B)(4).

F. METO Residents Have Been Discharged and Recommitted to METO

Although the three Plaintiffs are not currently committed to METO, METO residents, in general, have a history of being recommitted, including Plaintiff Jason, whom was already recommitted on one occasion. *See* Answer ¶ 77 [Doc. 24] (Jason was committed to METO on April 23, 2007, subsequently transferred, and then recommitted to METO on December 4, 2007). Additionally, as identified by the State Defendants in its spreadsheet partially documenting the use of restraints at METO, Client 22 was discharged from METO on June 25, 2003, and recommitted on August 5, 2003, wherein he/she was again subjected to use of restraints; Client 34 was discharged from METO on February 27, 2009, and recommitted on August 26, 2009, wherein he/she was again

subjected to the use of restraints; Client 35 was discharged from METO on August 23, 2007, and recommitted on November 19, 2008, wherein he/she was again restrained; Client 45 was discharged from METO on September 26, 2001, and recommitted on January 22, 2002, wherein he/she was again restrained; Client 49 was discharged from METO on October 14, 2002, and recommitted on December 21, 2009, and immediately subjected to the use of restraints again; Client 68 was discharged from METO on June 9, 2008, and recommitted on June 20, 2008, wherein he/she was again subjected to the use of restraints; Client 70 was discharged from METO on November 10, 2004, and was recommitted on January 9, 2005, and again subject to the use of restraints; Client 77 was discharged from METO on June 30, 2005, recommitted on June 25, 2005, and again subjected to the use of restraints; Clients 84 and 88 were committed to METO on three separate occasions and during all three times they were subjected to the use of restraints. *See* O'Meara Aff. Ex. 1. METO residents, including Plaintiff Bradley, have expressed fear about returning to METO.[3] *See* Amend. Compl. Ex. 1-A at p. 24 [Doc. 3-1].

Moreover, group homes serving persons with developmental disabilities threaten to have residents committed to METO. Kenney Aff. ¶ 4. Recently, an individual was committed to METO after having been threatened by his group home staff for the last year that they were going to send him to METO. *Id.* ¶ 5.

[3] Upon information and belief, Plaintiff Bradley is Person #2 in the State Ombudsman *Just Plain Wrong* report.

ARGUMENT

I. PLAINTIFFS AND THE CLASS ARE ENTITLED TO A PRELIMINARY INJUNCTION PROHIBITING THE USE OF RESTRAINTS AT METO

A. STANDARD OF ANALYSIS

"[W]hether a preliminary injunction should issue involves consideration of (1) the threat of irreparable harm to the movant; (2) the state of balance between this harm and the injury that granting the injunction will inflict on other parties litigant; (3) the probability that movant will succeed on the merits; and (4) the public interest." *Dataphase Sys., Inc. v. C.L. Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981) (en banc). These four factors are typically referred to as the "*Dataphase* factors." The burden of establishing the propriety of a preliminary injunction is on the movant. *Baker Elec. Co-op., Inc. v. Chaske*, 28 F.3d 1466, 1472 (8th Cir. 1994). District courts have broad discretion with respect to requests for preliminary injunctions, and their decisions are reviewed on a standard that allows reversal "only for clearly erroneous factual determinations, an error of law or an abuse of that discretion." *United Indust. Corp. v. Clorox Co.*, 140 F.3d 1175, 1179 (8th Cir.1998).

B. PLAINTIFFS AND THE CLASS POSSESS STANDING TO PURSUE A PRELIMINARY INJUNCTION

Upon certification, the Class assuredly possesses standing to seek a preliminary injunction as it includes individuals who are currently residents of METO and subjected to the use of restraints and seclusion. Absent class certification, however, the three named Plaintiffs also have standing to seek a preliminary injunction, as their claims remain justiciable as "capable of repetition, yet evading review."

Although Bradley, Thomas and Jason are not current residents of METO, they remain residents of Minnesota and will forever remain individuals with developmental disabilities, thus the threat remains that they will be recommitted to METO and again subjected to restraints under METO's existing policies and practices. Accordingly, Plaintiffs' claims are "capable of repetition, yet evading review."

In *Honig v. Doe*, the Supreme Court provided an analysis of the "capable of repetition, yet evading review" doctrine, under circumstances similar to those here. In *Honig*, respondent Jack Smith was a developmentally disabled student who was suspended from school indefinitely for violent and disruptive conduct related to his disabilities, pending the completion of expulsion proceedings by the San Francisco Unified School District (SFUSD). Smith alleged that the suspension and proposed expulsion violated the Education of Handicapped Act (EHA) (what is known today as the Individuals with Disabilities Education Act or IDEA), and sought injunctive relief against SFUSD officials and the State Superintendent of Public Instruction.

In rejecting a claim of mootness, the Supreme Court explained:

> Respondent Jack Smith, however, is currently 20 and has not yet completed high school. Although at present he is not faced with any proposed expulsion or suspension proceedings, and indeed no longer even resides within the SFUSD, he remains a resident of California and is entitled to a "free appropriate public education" within that State. His claims under the EHA, therefore, are not moot if the conduct he originally complained of is " 'capable of repetition, yet evading review.' " *Murphy v. Hunt*, 455 U.S. 478, 482, 102 S.Ct. 1181, 1183, 71 L.Ed.2d 353 (1982). Given Smith's continued eligibility for educational services under the EHA, the nature of his disability, and petitioner's insistence that all local school districts retain residual authority to exclude disabled children for dangerous conduct, we have little difficulty concluding that there is a "reasonable expectation," *ibid.*, that Smith would once again be subjected to a unilateral "change in

> placement" for conduct growing out of his disabilities were it not for the statewide injunctive relief issued below.

Honig v. Doe, 484 U.S. 305, 319-18, 108 S. Ct. 592, 601-02, 98 L. Ed. 2d 686 (1988) (footnote omitted). Finding the case was justiciable because it was "capable of repetition, yet evading review," the Court held that the respondent had standing to claim injunctive relief. *Id.* at 601-604.

Similarly, Plaintiffs' aggressive behaviors, which caused them to be committed to METO in the first instance and restrained while at METO, were manifestations of their disabilities, thus it is reasonable that those aggressive behaviors would occur again, subjecting them to recommitment and the use of restraints so long as METO is permitted to restrain its residents. *See, e.g.*, O'Meara Aff. Ex. 12, at pp. 2-3 (noting Bradley's history of displaying physical aggression, property destruction, self injurious behavior, inappropriate emesis, agitation upon attempts to interact with him by others); Ex. 13, at pp. 2-4 (noting Thomas' history of physical aggression, property damage, difficulty with self-control, and elopement); *see also Honig*, at 320 (stating that "[i]n the absence of any suggestion that respondent has overcome his earlier difficulties, it is certainly reasonable to expect, based on his prior history of behavioral problems, that he will again engage in classroom misconduct" which gave rise to this litigation.).

The *Honig* Court emphasized that "for purposes of assessing the likelihood that state authorities will reinflict a given injury, [courts] generally have been unwilling to assume that the party seeking relief will repeat the type of misconduct that would once again place him or her at risk of that injury"; however, "[g]iven the unique circumstances

and context of the[e] case," the Court was willing to assume that a plaintiff whose "very inability to conform his conduct to socially acceptable norms that render[ed] him [developmentally disabled]" would "again engage in the type of misconduct that precipitated th[e] suit." 484 U.S. at 320-21.

Moreover, Plaintiffs have sufficient personal stake to warrant standing in this case. Plaintiffs' allegations of future injury are not speculative. Although none of the three Plaintiffs are currently committed to METO, METO residents, in general, have a history of being recommitted, including Plaintiff Jason, whom was already re-committed on one occasion. *See* Answer ¶ 77 [Doc. 24] (Jason was committed to METO on April 23, 2007, subsequently transferred, and then recommitted to METO on December 4, 2007). Additionally, as identified by the State Defendants in its spreadsheet partially documenting the use of restraints at METO, Client 22 was discharged from METO on June 25, 2003, and recommitted on August 5, 2003, wherein he/she was again subjected to use of restraints; Client 34 was discharged from METO on February 27, 2009, and recommitted on August 26, 2009, wherein he/she was again subjected to the use of restraints; Client 35 was discharged from METO on August 23, 2007, and recommitted on November 19, 2008, wherein he/she was again restrained; Client 45 was discharged from METO on September 26, 2001, and recommitted on January 22, 2002, wherein he/she was again restrained; Client 49 was discharged from METO on October 14, 2002, and recommitted on December 21, 2009, and immediately subjected to the use of restraints again; Client 68 was discharged from METO on June 9, 2008, and recommitted on June 20, 2008, wherein he/she was again subjected to the use of restraints; Client 70

was discharged from METO on November 10, 2004, and was recommitted on January 9, 2005, and again subject to the use of restraints; Client 77 was discharged from METO on June 30, 2005, recommitted on June 25, 2005, and again subjected to the use of restraints; Clients 84 and 88 were committed to METO on three separate occasions and during all three times they were subjected to the use of restraints. *See* O'Meara Aff. Ex. 1.

Accordingly, there is a reasonable likelihood that Plaintiffs will again suffer the deprivation of their civil and constitutional rights that gave rise to this suit, and thus Plaintiffs have standing to seek a preliminary injunction. *See Von Colln v. County of Ventura*, 189 F.R.D. 583 (C.D. Cal. 1999) (holding pretrial detainees, who sought damages from jail officials for being placed in restraining chair in violation of their constitutional rights, had standing to seek injunctive relief; considering fact that all but one of detainees was on probation, combined with their apparent propensity to incarceration in county jail, it was beyond speculation that at least one of the named detainees would be in custody of jail in the near future, and it was not speculative that the detainees would be subject to restraining chair when they were returned to jail since defendants had policy authorizing the use of restraining chair for detainees).

C. THE *DATAPHASE* FACTORS FOR A PRELIMINARY INJUNCTION ARE SATISFIED

"Whether a preliminary injunction should issue involves consideration of (1) the threat of irreparable harm to the plaintiff; (2) the state of balance between such harm and the injury that granting the injunction will inflict on other parties litigant; (3) the probability that plaintiff will succeed on the merits; and (4) the public interest."

Dataphase Sys., Inc. v. C L Sys., Inc., 640 F.2d 109, 114 (8th Cir. 1981). "No single factor is determinative; rather, the probability of success must be examined in the context of the relative injuries to the parties and to the public." *Advantage Media, L.L.C. v. City of Hopkins*, 379 F. Supp. 2d 1030, 1035 (D. Minn. 2005) (citing *Dataphase*, 640 F.2d at 113). Although no one factor is determinative, likelihood of success on the merits is generally the touchstone inquiry. *Id.* "The party requesting injunctive relief bears the 'complete burden' of proving all of the factors." Advantage Media, L.L.C. v. City of Hopkins, 379 F. Supp. 2d 1030, 1035 (D. Minn. 2005) (citing *Gelco Corp. v. Coniston Partners*, 811 F.2d 414, 418 (8th Cir.1987)).

1. Plaintiffs are likely to succeed on the merits

A preliminary injunction may be granted if Plaintiffs can demonstrate a probability that they will succeed on the merits. The "probability of success on the merits" prerequisite does not require that the party seeking such relief prove a greater than 50% likelihood that he will prevail on the merits. *Dataphase*, at 113. Rather, "where the balance of other factors tips decidedly toward plaintiff a preliminary injunction may issue if movant has raised questions so serious and difficult as to call for more deliberate investigation." *Dataphase*, 640 F.2d at 113.

The courts have found that residents at state-operated institutions have a constitutionally protected interest in safe conditions and in freedom from bodily restraint. *Youngberg v. Romeo* 457 U.S. 307, 315-16, 323, 102 S. Ct. 2452, 73 L.Ed.2d 28 (1982); *Messier v. Southberry Training School*, 562 F.Supp.2d 294 (D.Conn. 2008); *see also Society for Good Will to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239, 1243 (2d

Cir.1984). "[L]iberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action" and this interest survives involuntary commitment. *Youngberg*, at 316 (citing *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18, 99 S.Ct. 2100, 2109, 60 L.Ed.2d 668 (1979)). Individuals with developmental disabilities in a state institution have a Fourteenth Amendment due process right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care. *Youngberg*, at 324, 102 S.Ct. at 2462. In contrast, excessive or unreasonable use of restraints violates an individual's due process rights. *See id*, at 321-24.

METO has a long history of excessively and unreasonably subjecting its residents to the use of restraints. *See* Amend. Compl. Exs. 1-A, 2 & 4 [Docs. 3-1, 3-6 & 3-8]. The official State Ombudsman concluded, *inter alia*, that METO had a *program-wide* practice of routine use of restraints employed as a basic treatment modality, and the use of restraints was anticipated with every admission. Amend. Compl. Ex. 1-A at p. 44 [Doc. 3-1] (emphasis added). Moreover, the Ombudsman concluded that inappropriate use of restraints constitutes abuse under Minnesota's Vulnerable Adult Act, and that certain practices at METO violated the human and civil rights of some clients. Amend. Compl. Ex. 1 at p. 45 [Doc. #3-1].

Additionally, following a self-investigation, DHS Licensing Division concluded, in part, that the emergency use of restraints was not implemented, reviewed, or reported as required by state law and that staff implemented the use of controlled procedures on an

emergency basis without the residents' behavior meeting the criteria for such use. Amend. Compl. Ex. 4 at p. 18 [Doc. 3-8]. In response to its investigation, DHS issued a Corrective Order to METO – one of its own programs - citing numerous violations of state laws governing the use of aversives and deprivations procedures at METO, including restraints. Amend. Compl. Ex. 5 [Doc. 3-9].

Moreover, the MDH also conducted an unannounced visit of METO in order to investigate alleged violations of federal law related to the use of restraints. Amend. Compl. Ex. 2 [Doc. 3-6]. The MDH cited METO for violations of state and federal law related to the use of restraints and aversives. Amend. Compl. Ex. 2 at p. 17 [Doc. 3-8]. It also reported that METO "failed to ensure that residents were free from unnecessary physical restraints and/or drugs." *Id.; see also* Amend Compl. Ex. 3 [Docs. 3-7] (MDH summary of deficiencies at METO).

Three State agencies – the State Ombudsman, the MDH and DHS itself – have all found METO residents have been repeatedly and excessively restrained. This excessive use of restraints violated Plaintiffs and other METO residents' due process rights. *See Messier v. Southberry Training School*, 562 F.Supp.2d 294 (D. Conn. 2008); *see also Youngberg v. Romeo* 457 U.S. 307, 323, 102 S. Ct. 2452, 73 L.Ed.2d 28 (1982); *see also* Amend. Compl. Ex. 1 at p. 45 [Doc. #3-1] (It is the opinion of the Ombudsman that certain practices have violated the human and civil rights of some clients). Accordingly, Plaintiffs will likely succeed on the merits of their claims.

2. Failure to prohibit the use of restraints at METO will cause irreparable harm to residents of METO

To warrant a preliminary injunction, the moving party must demonstrate a sufficient threat of irreparable harm." *Dataphase*, at 114; *Iowa Protection and Advocacy Serv., Inc. v. Gerard Treatment Programs,* 152 F.Supp.2d 1150, 1156 (N.D. Iowa 2001) (citing *Adam-Mellang v. Apartment Search, Inc.*, 96 F.3d 297, 299 (8th Cir.1996)). As discussed *supra*, the courts have found the use of restraints to be harmful and in violation of an individual's due process rights. Plaintiffs and all METO residents have a due process right to be free from bodily restraint. *Youngberg*, 457 U.S. at 324, 102 S. Ct. 2452. The use of restraints violates those rights, causing irreparable harm. Each day an individual's constitutional rights are violated, causes irreparable harm. *See Advantage Media, L.L.C. v. City of Hopkins*, 379 F. Supp. 2d 1030, 1035 (D. Minn. 2005) (holding that for each that passes while any citizen is deprived the constitutional right protected by the First Amendment, such a delay establishes the threat of irreparable injury).

The continued use of restraints causes irreparable harm to METO residents by violating their due process rights and causing severe bodily injury. Plaintiffs are subjected to the threat of irreparable harm as nothing prevents them from being recommitted to METO at any time. Plaintiff Jason has already been discharged and recommitted to METO on one occasion, as have several other METO residents. Plaintiff Bradley has expressed fear about being sent back to METO. Amend. Compl. Ex. 1-A at p. 24[Doc. 3-1]. Moreover, group homes serving persons with developmental disabilities threaten to have residents committed to METO. Kenney Aff. ¶ 4. Recently, an individual

was committed to METO after having been threatened by his group home staff for the last year that they were going to send him to METO. *Id.* ¶ 5.

As identified by the State Defendants in their spreadsheet, documenting the partial use of restraints at METO, Client 22 was discharged from METO on June 25, 2003, and recommitted on August 5, 2003, wherein he/she was again subjected to use of restraints; Client 34 was discharged from METO on February 27, 2009, and recommitted on August 26, 2009, wherein he/she was again subjected to the use of restraints; Client 35 was discharged from METO on August 23, 2007, and recommitted on November 19, 2008, wherein he/she was again restrained; Client 45 was discharged from METO on September 26, 2001, and recommitted on January 22, 2002, wherein he/she was again restrained; Client 49 was discharged from METO on October 14, 2002, and recommitted on December 21, 2009, and immediately subjected to the use of restraints again; Client 68 was discharged from METO on June 9, 2008, and recommitted on June 20, 2008, wherein he/she was again subjected to the use of restraints; Client 70 was discharged from METO on November 10, 2004, and was recommitted on January 9, 2005, and again subject to the use of restraints; Client 77 was discharged from METO on June 30, 2005, recommitted on June 25, 2005, and again subjected to the use of restraints; Clients 84 and 88 were committed to METO on three separate occasions and during all three times they were subjected to the use of restraints. *See* O'Meara Aff. Ex. 1.

Moreover, it is not speculative that the Plaintiffs will be subject to unconstitutional treatment if recommitted to METO. METO's use of restraints on its residents is both recurrent and presumptively in violation of the Plaintiffs' constitutional rights. METO

has policies in place authorizing the use of restraints. O'Meara Aff. Exs 7-11. Moreover, METO has a history of using restraints in violation of its own policies governing such use, including in emergency situations. *See generally* Amend Compl. and Exhibits thereto (including Docs. 3-1, 3-8, 3-9). Furthermore, METO has demonstrated a pattern and practice of abusing people with developmental disabilities through the use of restraints. *Id*. As such, "[t]he possibility or recurring injury ceases to be speculative when actual repeated incidents are documented." *Nicacio v. INS*, 797 F.2d 700, 702 (9th Cir.1985).

Furthermore, the ongoing use of restraints not only threatens to cause irreparable harm by violating Plaintiffs and METO residents' constitutional rights, but also by resulting in bodily injury. One such example of the threat of bodily harm that can result from the use of restraints occurred on Christmas Eve of just this past year when a METO resident's elbow was fractured while he was being manually restrained. O'Meara Aff. Ex. 14. Another example of the severe harm the use of restraints can cause is when Plaintiff Jason's arm was broken when he too was being restrained at METO. Amend. Compl. ¶ 93 [Doc. 3]. And yet other examples are the numerous injuries Plaintiff Thomas suffered while being restrained – "[a]s a result of the use of restraints and group takedowns, Thomas suffered several physical injuries, including abrasions on the right and left side of his forehead, cuts on his wrists, and his right ear being banged on the ground resulting in blood in his ear canal." *Id*., at ¶ 84 [Doc. #3]. Additionally, an individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall, as they would not be able to use their arms or hands to break that fall. Amend. Compl. Ex. 1 at p. 17 [Doc. #3-1]. Yet another

individual who was regularly restrained with metal handcuffs and leg irons stated that once the restraints were on he/she began to experience discomfort, which led to crying, yelling and struggling against the restraints. *Id.* These are just a few of the endless examples of the extent of bodily harm METO residents suffer from being restrained – not to mention the emotional harm.

METO residents are systematically restrained, suffering such egregious injuries as broken arms, fractured elbows, cut wrists and bloody abrasions. The severity of harm restraints can cause is horrific and sometimes even fatal. Recently, a 27-year old man with developmental disabilities died after being restrained in a prone position at his state operated workplace. O'Meara Aff. Ex. 14. Such a horrific accident should not have been allowed to occur and emphasizes the extreme importance of eliminating the use of restraints at METO.

There is a staggering number of restraints being used on residents at METO (e.g., "One of the most egregious cases revealed a client had been restrained 299 times in 2006 and 230 times in 2007"; "In 2007, this person was restrained approximately 225 times for a total of over 130 hours." "Of those 225 plus times for 2007, restraints were only used four times for self-injurious behavior and seven times for hitting or scratching staff or a peer." Amend. Compl. Ex. 1-A at pp. *iv* and 22 [Doc 3-1]). The documented abuse of people with developmental disabilities and the examples of bodily harm set forth herein, establish that the opportunity for irreparable harm from the use of restraints is undoubtedly a foreseeable consequence of their continued use. Plaintiffs and other

METO residents face the very real frightening threat of irreparable harm so long as restraints are used at METO.

3. The benefit in granting the preliminary injunction far outweighs the drawbacks the injunction will have on other interested parties

The benefit of enjoining the use of restraints at METO far outweighs any harm or inconvenience it may create. Defendants claim they must continue to use restraints in emergency situations to protect residents and staff from injury. However, the use of restraints is not a best practice in the area of developmental disabilities. "Current best practice standards focused on positive behavioral supports, which included assessing the purpose of the behaviors and finding positive alternatives for the individual to employ." Amend. Compl. Ex. 1-A, p. iii [Doc. #3-1]. Positive Interventions are the generally accepted standard of care for persons with developmental disabilities. Amend. Comp. ¶ 103(A) [Doc. #3]; Amend. Compl. Ex. 1, at p. 44 [Doc. #3-1].

Recently, on July 7, 2009, Dr. Read Sulik, Assistant Commissioner for Chemical and Mental Health Services for DHS, admitted that DHS wanted to eliminate the use of seclusion and restraints on METO residents, that current efforts existed to reduce the use of seclusion and restraints, and that METO could treat patients without using seclusion and restraint. Answer ¶ 49 [Doc. 24] (admitting Paragraph 61 of the Amended Complaint); Amend. Compl. ¶ 61 [Doc. 3].

Moreover, DHS has previously recognized the barbarism associated with the use of restraints when administrators at the Moose Lake State Hospital discontinued the use of restraints and chose to treat patients humanely and therapeutically rather than through

the threat of restraints. Amend. Compl. ¶ 58 [Doc. 3]. Moose Lake State Hospital was a part of the State Operated Services division of the DHS, just as METO is today. Answer ¶46 [Doc. 24]. There is no need to use these types of aversives and deprivation procedures in any true emergency. In fact, the Oklahoma Department of Human Services is an exemplary state where the use of restraints are completely prohibited. O'Meara Aff. Ex. 16.

The hardships imposed on Plaintiffs far outweigh the benefits to the use of restraints by Defendants. Continued use of restraints will cause physical and emotional harm to Plaintiffs and other residents of METO. During their investigations, three State entities - the State Ombudsman, the MDH and DHS Licensing Division - all found many individuals were adversely affected by METO policies and procedures regarding the use of mechanical restraints. The courts have repeatedly held that providing individuals with developmental disabilities a safe, integrated and community-based setting far outweighs the use of restraints for controlling a resident and the treatment provided to persons with developmental disabilities should be in settings that are the least restrictive to the person's personal liberty. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 599, 119 S. Ct. 2176, 2186, 144 L. Ed. 2d 540 (1999); *Youngberg*, 457 U.S. at 327; *see also Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 24, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981).

4. A preliminary injunction is in the public's interest

The final *Dataphase* factor requires the conduct seeking to be enjoined be in the public's interest. Here, Plaintiffs seek to enjoin the use of restraints at METO in

violation of their constitutional rights. "It is always in the public interest to prevent the violation of a party's constitutional rights." 42 Am. Jur. 2d Injunctions § 74 (2010). Likewise, providing persons with developmental disabilities the opportunity to thrive in the least restrictive setting allows such persons to participate more fully in the community and gain the capacity to do things for themselves without total dependence on an institution. *Olmstead*, at 605. The use of restraints will only hinder METO residents' ability to gain independence and contribute to the community as whole. It is in the public's interest to not only protect its vulnerable citizens who can so easily be taken advantage of; but also to encourage their full participation in the community and allow diversity in communities to prosper. Certainly the public's best interest is served through issuance of an injunction to stop the use of restraints at METO.

CONCLUSION

The Plaintiffs respectfully request this Court issue a Preliminary Injunction immediately enjoining the use of mechanical, manual and chemical restraints and seclusion on residents of METO.

Respectfully submitted,

JOHNSON & CONDON, P.A.

s/ Shamus P. O'Meara

Dated: _____

Shamus P. O'Meara (#221454)
Mark R. Azman (#237061)
M. Annie Mullin (# 0389206)
7401 Metro Boulevard, Suite 600
Minneapolis, MN 55439-3034
(952) 831-6544