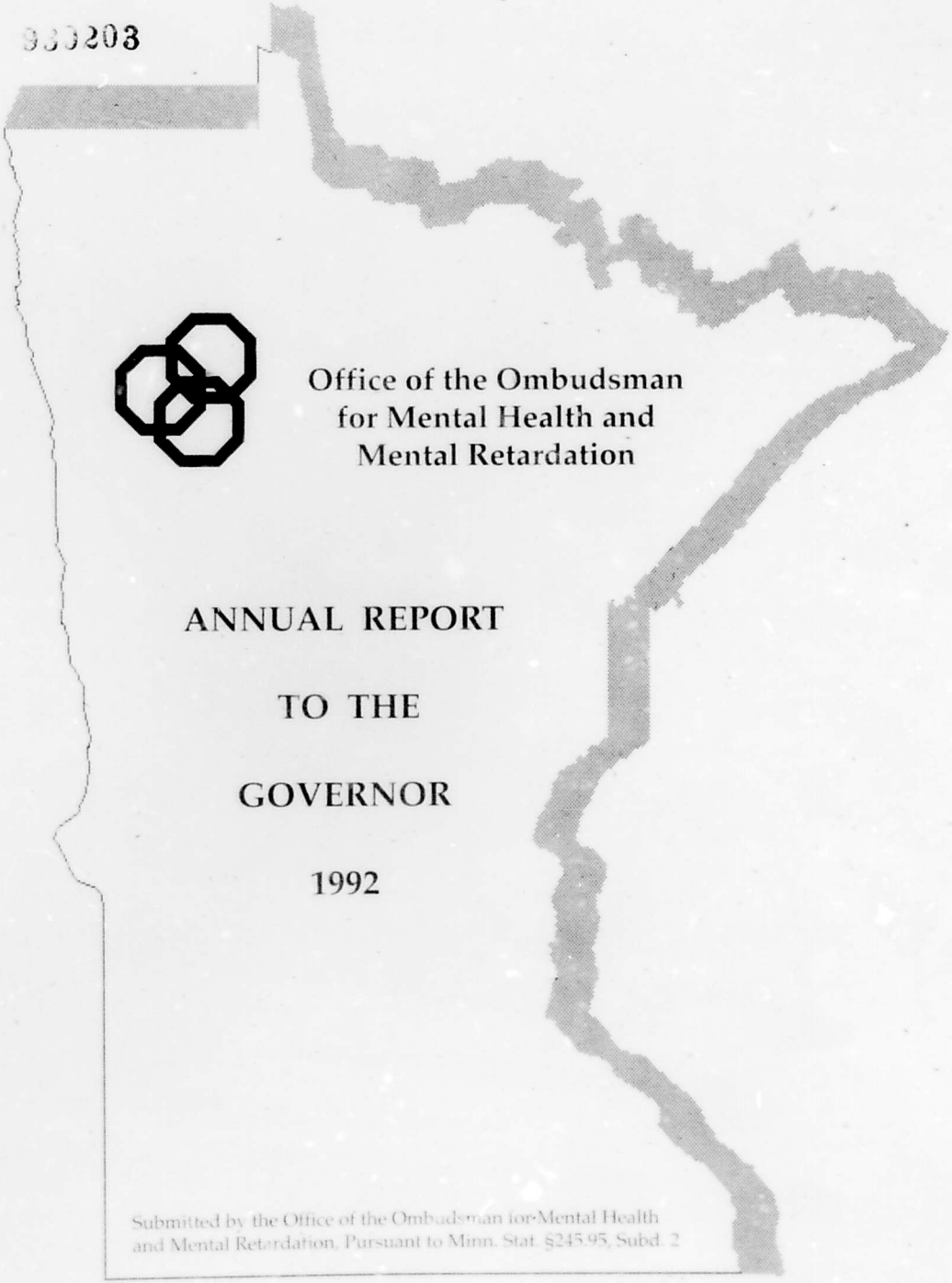


Office of the Ombudsman
for Mental Health and
Mental Retardation

ANNUAL REPORT

TO THE

GOVERNOR

1992

Submitted by the Office of the Ombudsman for Mental Health
and Mental Retardation, Pursuant to Minn. Stat. §245.95, Subd. 2

STATE OF MINNESOTA
OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION
Suite 202, Metro Square Building, St. Paul, MN 55101
612-296-3848 or Toll Free 1-800-657-3506

January 27, 1993

Dear Governor Carlson:

The accompanying report summarizes the activities of the Office of the Ombudsman for Mental Health, Mental Retardation, Chemical Dependency, and Emotionally Disturbed Children from January 1992 to December 1992.

We have endeavored to present this information in a manner that would enhance your understanding of the office operations, the compilation of data on issues and complaints, and strategic plans for the future. In addition, we have included the relevant state statutes.

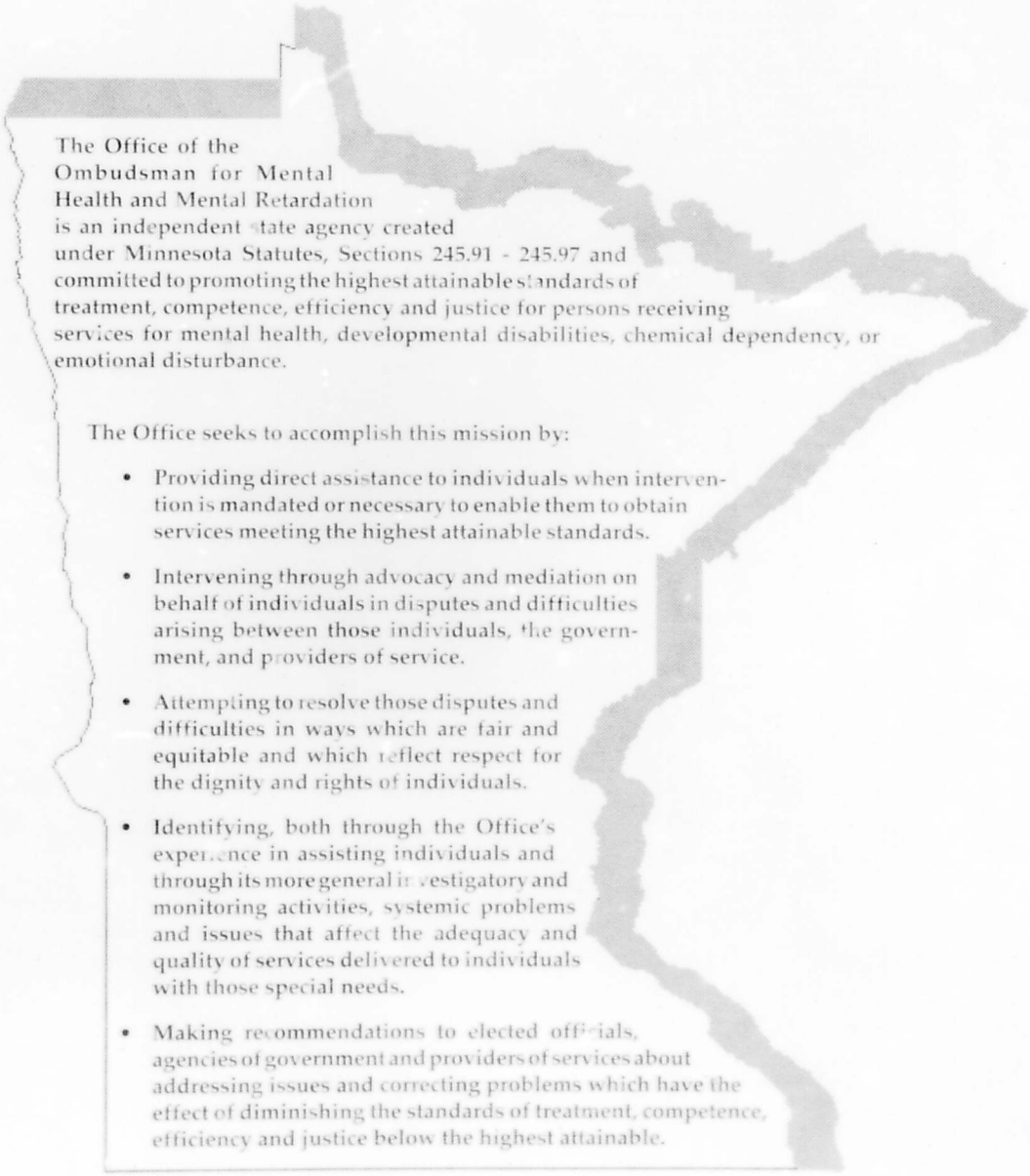
This information is integral to sound decision making as it relates to the lives of persons with disabilities. We hope it proves beneficial as you continue to administer public policy for those individuals our office serves.

Respectfully,

The 1992 Annual Report to the Governor Committee

Members: Jean Koonce, Chairperson
Sandra Newbauer
Sharon Peterson
Aimee Belfiori
Kathy Dohmeier
Claudia Hulleman

Ombudsman Office Mission Statement



The Office of the Ombudsman for Mental Health and Mental Retardation is an independent state agency created under Minnesota Statutes, Sections 245.91 - 245.97 and committed to promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

The Office seeks to accomplish this mission by:

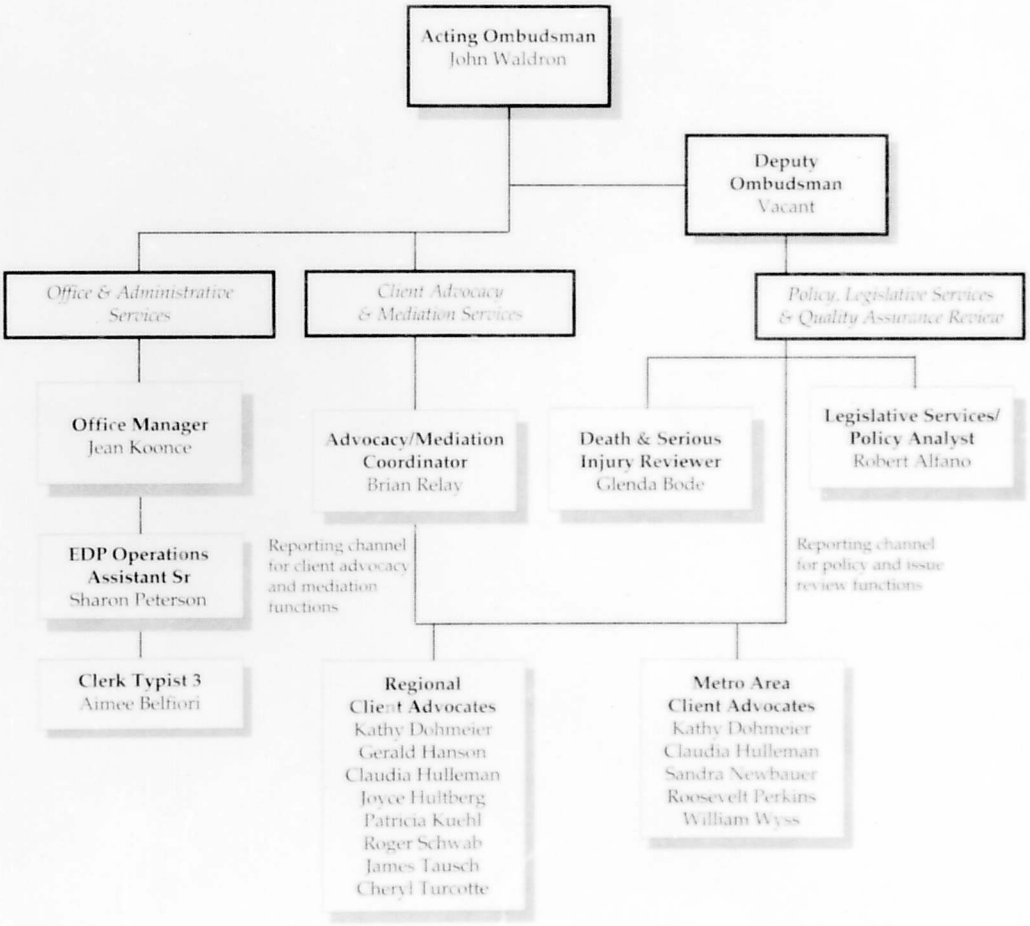
- Providing direct assistance to individuals when intervention is mandated or necessary to enable them to obtain services meeting the highest attainable standards.
- Intervening through advocacy and mediation on behalf of individuals in disputes and difficulties arising between those individuals, the government, and providers of service.
- Attempting to resolve those disputes and difficulties in ways which are fair and equitable and which reflect respect for the dignity and rights of individuals.
- Identifying, both through the Office's experience in assisting individuals and through its more general investigatory and monitoring activities, systemic problems and issues that affect the adequacy and quality of services delivered to individuals with those special needs.
- Making recommendations to elected officials, agencies of government and providers of services about addressing issues and correcting problems which have the effect of diminishing the standards of treatment, competence, efficiency and justice below the highest attainable.

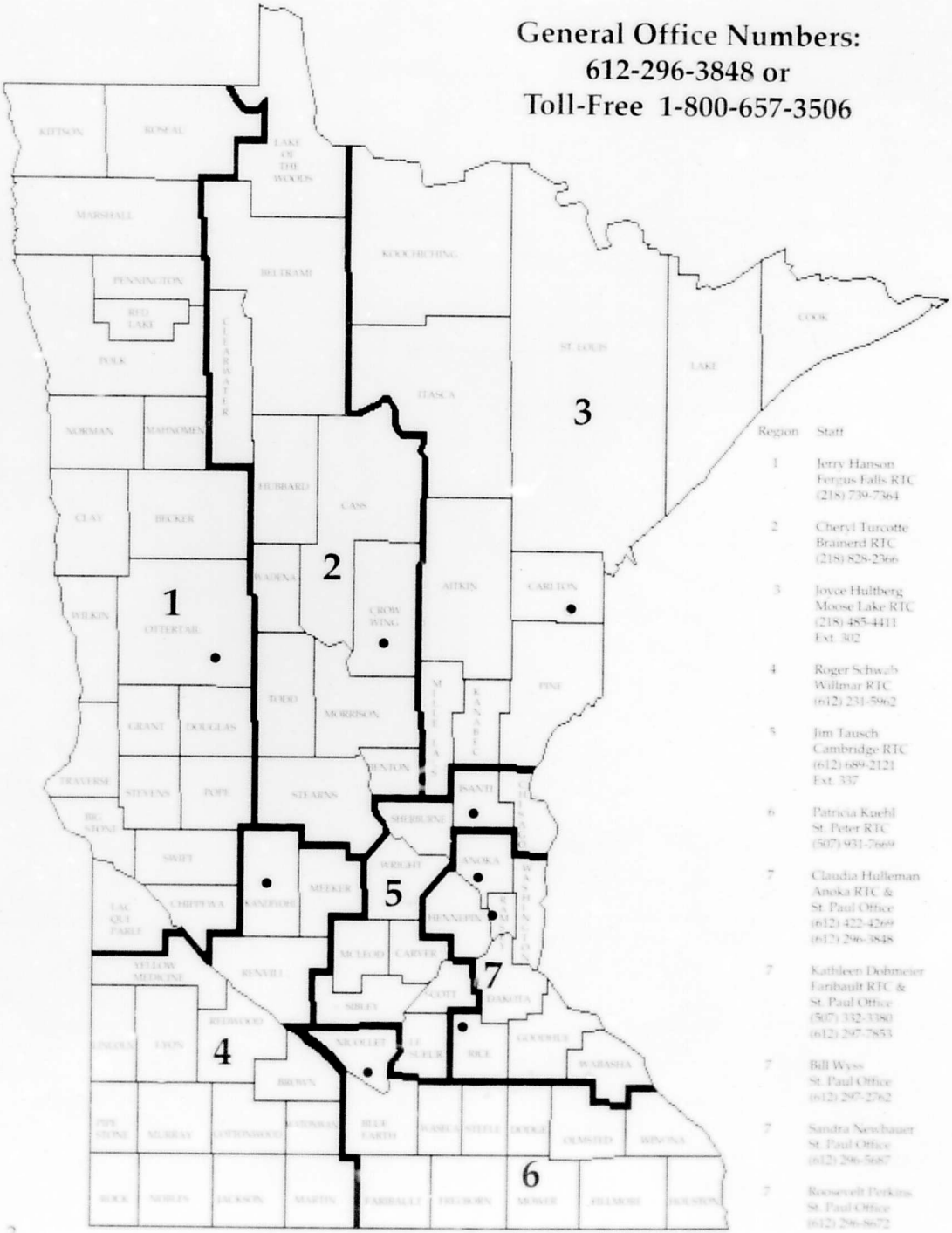
Table of Contents

Office of the Ombudsman
for Mental Health and Mental Retardation
Suite 202, Metro Square Building
St. Paul, Minnesota 55101
612-296-3848
1-800-657-3506

Ombudsman Organizational Chart

as of January 27, 1993




General Office Numbers:
612-296-3848 or
Toll-Free 1-800-657-3506
KITTSON
ROSEAU
LAKE OF THE WOODS
MARSHALL
BELTRAMI
KOOCHICHING
PENNINGTON
RED LAKE
POLK
ST. LOUIS
LAKE
COOK
ITASCA
3
NORMAN
MAHNOMEN
HUBBARD
CASS
CLAY
BECKER
WADENA
2
AITKIN
CARLTON
WILKIN
1
OTTERTAIL
CROW WING
PINE
TODD
MORRISON
GRANT
DOUGLAS
BENTON
TRAVERSE
STEVENS
POPE
STEARNS
SHERBURNE
ISANTI
SWIFT
WRIGHT
ANOKA
MEEKER
5
CHIPPEWA
RANDOLPH
HENNEPIN
LAC QUI PARLE
MCLEOD
CARVER
YELLOW MEDICINE
RENVILLE
7
SCOTT
DAKOTA
SIBLEY
LINCOLN
LYON
REDWOOD
NICOLLET
LE SUEUR
RICE
GOODHUE
4
WABASHA
BROWN
COTTONWOOD
BLUE EARTH
WATONWAN
FARIBAULT
MARTIN
JACKSON
NOBLES
ROCK
6
MOWER
FILLMORE
HOUSTON
Region Staff
1 Jerry Hanson
Fergus Falls RTC
(218) 739-7364
2 Cheryl Turcotte
Brainerd RTC
(218) 828-2366
3 Joyce Hultberg
Moose Lake RTC
(218) 485-4411
Ext. 302
4 Roger Schwab
Willmar RTC
(612) 231-5962
5 Jim Tausch
Cambridge RTC
(612) 689-2121
Ext. 337
6 Patricia Kuehl
St. Peter RTC
(507) 931-7669
7 Claudia Hulleman
Anoka RTC &
St. Paul Office
(612) 422-4269
(612) 296-3848
7 Kathleen Dohmeier
Faribault RTC &
St. Paul Office
(507) 332-3380
(612) 297-7853
7 Bill Wyss
St. Paul Office
(612) 297-2762
7 Sandra Neschauer
St. Paul Office
(612) 296-5687
7 Roosevelt Perkins
St. Paul Office
(612) 296-8672

Advocacy and Mediation Activities

The State of Minnesota, as part of public policy, has for two decades, supported protection and advocacy for the most vulnerable of our citizens. These Minnesota citizens are often disfranchised from the mainstream of society, and without any real voice to make choices, or raise issues to state policy makers.

Since the creation of the Ombudsman's Office in July 1987, statistical data has been reported. However, the statistics, graphs, and charts do not express the real impact advocates have on the clients they serve. Statistics only show a moment in time. Client advocates take time during that moment to empower their clients so that they can advocate for themselves.

Many mentally disabled people live in environments which rob them of the ability to make decisions affecting their lives. Institutionalized people often lose the will, freedom or skill to make rudimentary choices about factors that concern them. Persons in such situations frequently succumb to dependency; are isolated from general information about the community; lack the knowledge, confidence and resources to advocate on their own; and to an alarming extent, are subject to a pattern of regular, systematic and institutionalized violations of their legal, civil and human rights.

Empowerment does not occur when an advocate solves a client problem alone and takes credit alone. Empowerment involves building capabilities; leaving new skills or knowledge with the client; providing tangible information (perhaps an applicable law or regulation, telephone number); conveying intangible attitudes (confidence, support, appreciation, pride); active involvement by the client in finding and implementing a solution to the problem.

Empowering mentally disabled persons requires patience, good communication skills, developing basic trust, and establishing rational and realistic expectations. On a basic level, the empowerment process begins by allowing, encouraging, and even requiring increased decision-making by clients in concerns related to their lives. For this to be effective, the advocate must demystify the law and carefully explain its connections to a client's particular situation. Detailed, specific alternatives need to be presented in a comprehensible way. The client must understand the potential impact and outcome of particular choices as well as the relative advantages and disadvantages of each course of action.

Each advocate, representing the Ombudsman's Office, is assigned to one of seven regions (see page two). During this past year, the regional structure has been significantly changed to better utilize our available staff and resources, while meeting the needs of clients. In regions one through six, one regional advocate maintains an office located at a Regional Treatment Center (RTC) and is responsible for complaints from clients at the RTC and in communities throughout the region. In region seven (metro area), five advocates cover an eight county metro area which includes responsibility for two RTC's.

Advocates serve as educators, facilitators, motivators, mock antagonists and technical advisors to clients representing a wide range of issues and complaints. They attempt to find lasting solutions to problems while still creating and nurturing self-advocacy skills.

The graphs and charts on pages six through nine provide a statistical analysis of the issues presented to this agency. However, the lasting goal is the ongoing process of empowerment. Sharing power with users/consumers of services combats helplessness. It replaces the question: "What can I do?" with, "What can I do next." It establishes a sense of involvement and responsibility on the part of clients and challenges the accountability of both government and service providers.

Client Advocate Anecdotal Cases

A developmentally disabled client who resides in a group home has a chronic degenerative medical condition. As the condition progressed, the client faced the likelihood of total loss of ambulation, mobility, and eventually being confined to bed for the balance of the clients life and requiring total nursing care. The Office of the Ombudsman was initially contacted to provide meditation from a client-centered perspective. The client advocate's role soon became one of both consultation and client-centered advocacy.

Although the client's guardian initially refused mediation and further discussion of the issue, the mission and authority of the Ombudsman Office mandates continued involvement to "promote the highest attainable standards of treatment, competence, efficiency, and justice. . ." (Minnesota Statute 245.92). A major factor in this case was a concerned, committed, and actively involved residential team. After two years, and as a result of continued client-centered advocacy by many persons, the guardian authorized the procedure necessary to stabilize the client's condition. Continued residence in a home-like community setting, opportunities to enjoy inclusive activities of choice, and the chance to discover new areas of enjoyment are all a part of this client's future. This is in stark contrast to what would otherwise, through failure to act, have been a future of continued deterioration in status and quality of life.

After repeated attempts to solve the problem, a facility social worker requested intervention by the Office in obtaining the county's assistance in discharge placement. The client, whose commitment of chemical dependency was almost over, had received maximum benefit from in-patient treatment. Nursing home placement was needed because of ongoing medical problems and an appropriate home had been found by the facility. The client's application for medical assistance had been denied even though the client was a recipient of the program immediately prior to the client's facility admission. The county's stand was that this client would have to remain in the facility because the client wasn't eligible for assistance. With the Office's encouragement, the county social worker investigated and found that the property, which made the client ineligible, was in fact not really owned by the client even though the tax statement was in the clients name. With a lot of last minute work, this was verified, the client was found eligible, and admitted to the nursing home of the client's choice.

A fifty-two year old woman with developmental disabilities contacted the Ombudsman's Office because her request to change residence was being ignored by the case manager. The county worker felt her reasons to move did not make any sense. After several meetings with the team and the subsequent revision of the individual service plan and program, the client did move and is now participating in an independent living training program. The advocate helped to keep the focus of the team on what the client was requesting and was instrumental in designing plans that were truly client-focused.

A client receiving treatment at a facility contacted an advocate for assistance in obtaining chemical dependency treatment in the least restrictive environment. The client advocate contacted the client's psychiatrist to schedule a team meeting to discuss the client's treatment plan. After discussion with the treatment team and the medical director, a decision was made to refer the client's desire for community chemical dependency treatment to the county of responsibility for an assessment. Based on the county assessment and input from the client's psychiatrist, it was determined that the client would not benefit from further treatment. The client was released from the facility and received services in the community.

A facility, in the quest for improved quality of care/consumer satisfaction, sent a "satisfaction questionnaire" and in so doing, inadvertently informed a former patient's relative of the client's brief hospitalization. The relative's name had been given by the client, to be contacted in case of emergency. The client and family member were both dismayed and angry at this breach of confidentiality. The client, who had always had difficulty standing up for herself, recognized that she needed to address this for her own mental health and contacted the Office for assistance. With our help, a grievance was filed. The facility responded quickly and compassionately by both phoning and writing the client; in addition they made immediate procedural changes to ensure no similar incident would occur in the future. The client indicates that this experience resulted in increased confidence and self-advocacy skills.

A thirty-two year old women was committed to a facility. She was not having problems with her treatment at the facility, but with County Child Protection.

This client had a ten year old son who was living in a foster home. The child's case manager had been unresponsive to the client and her social worker's calls. The client was supposed to see her son one hour per week and this was not happening. Sometimes she would go two or three weeks without seeing her son, and the visits were a half hour to 45 minutes. There was also an upcoming hearing to terminate parental rights. She had no idea who her attorney was or what she needed to do to defend herself.

The advocate contacted the child protection worker and asked to have a meeting the following week with the client, her social worker and herself. At this meeting, they were able to convince the child protection worker that the client was doing very well in treatment and she was more than willing to continue her treatment. The child protection worker agreed to drop the termination of parental rights action and to increase visitation. He would continue to monitor her progress and was somewhat hopeful that someday she and her son could live together.

The advocate attended the court hearing with the client and talked to the client's attorney, the county attorney, and the child protection worker, and they all agreed this plan would be the best for all concerned. This information was presented to the judge and the hearing proceedings were stopped.

This situation began when a case manager contacted an advocate regarding a developmentally disabled adult. The client and her family had moved to Minnesota approximately 18 months prior. For the past 12 months they had been attempting to arrange day habilitation services, however, because of where they lived, no one was willing to pay the additional cost of transportation to the Day Activity Center (DAC).

After reviewing the situation, the advocate suggested that the family file an appeal. The advocate's position was that by statute, rule and contract, the DAC was responsible for the transportation. The advocate represented the client at the hearing and the Appeals Referee agreed with their position. The client began receiving services approximately six months after the client advocate first became involved.

A fourteen year old African-American was removed from a facility by his mother because of concerns regarding medications and racial remarks directed towards her son. The county responded by issuing a warrant for his arrest and informing the family that the only treatment this adolescent could receive would be back at the facility.

The Office of the Ombudsman got involved to ensure that appropriate and culturally sensitive treatment would be provided. An advocate worked with the family over the course of a year. He is currently receiving comprehensive services that include family, school, and community involvement. (He recently won a chess championship; the first time his school has won.) The mother, once identified as problematic, was recently requested to be on her County Children's Mental Health Advisory Committee. They have identified being together as a major component of their recovery and stabilization.

Complaints by Issues

The graph on the following page demonstrates the types of issues that comprise the complaints or concerns brought to the Ombudsman Office. It can be observed that some categories have consistently increased or decreased in number; that some have remained fairly consistent in number; and that some have fluctuated dramatically from year to year.

Each of these areas can offer various insights or pieces of information. Those that fluctuate significantly are probably the least helpful in making comparisons, as they are based on many variables and specific concerns that arise.

Those remaining fairly constant in number can lead one to assume that this is a fairly accurate reflection of the degree of the problem in the service system.

For those revealing a consistent change in number, it is helpful to explore the data further. As an example, look at the DISCHARGE category. What is observed is a consistent decrease from 385 in Fiscal Year 1990 (FY '90) to 276 in FY '92. However, if the data is broken down by Regional Treatment Centers (RTC's) and Community, we see that the discharge issues within the RTC's did decrease from 333 in FY '90 to 287 in FY '91, to 189 in FY '92. At the same time, the discharge issues within the community settings increased from 52 in FY '90, to 65 in FY '91, to 87 in FY '92.

This further breakdown of the data supports the overall transition occurring within the Ombudsman Office. This process involves increasing involvement in community settings throughout the state. This expansion of service area, without increased staffing, is the primary explanation for the decrease in the total number of issues dealt with in FY '92. It is also a trend, if all resources remain constant, that will probably continue until some balance point is reached.

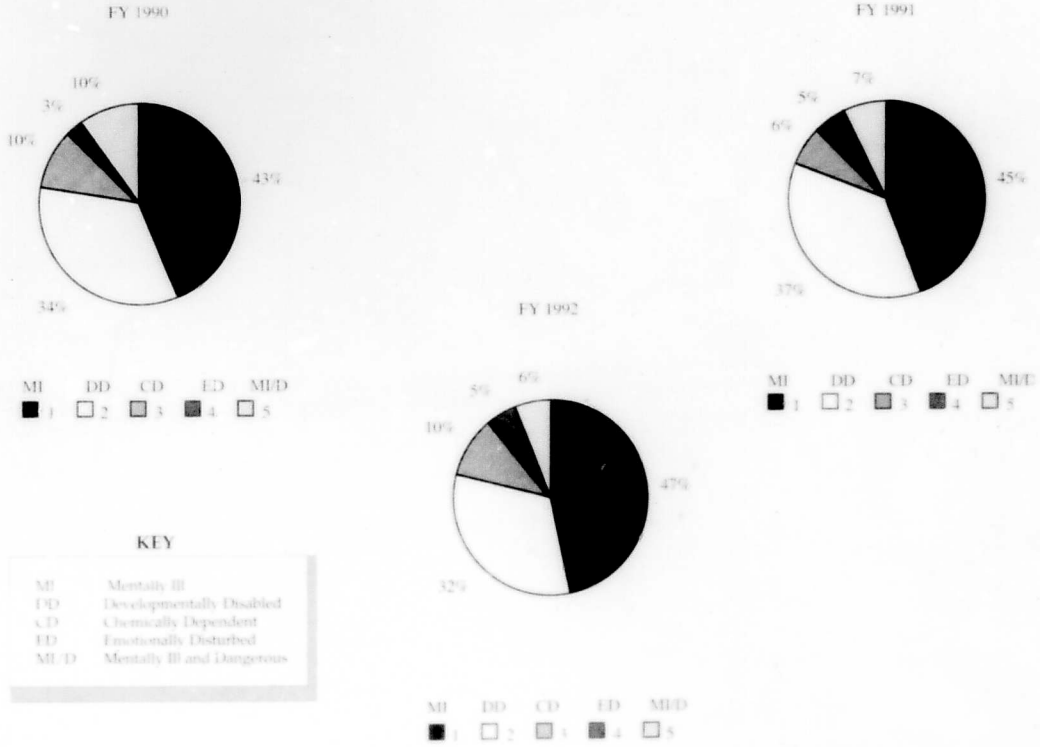
ISSUE	FY 1990	FY 1991	FY 1992	TOTALS
ADMISSION	42	78	55	175
DISCHARGE	385	352	276	1013
TRANSFER	105	112	88	305
COMMITMENT	116	118	104	338
DENIAL OF SERVICES	96	111	92	299
DELAY OF SERVICES	58	41	34	133
TREATMENT/PROGRAM PLANS	302	392	289	983
RESTRAINT/SECLUSION	40	76	42	158
AVERSIVE/DEPRIVATION PROGRAM	25	59	89	173
RESTRICTIONS : MOVEMENT/POSSESSIONS	101	122	86	309
MEDICAL/HEALTH	122	136	138	396
PSYCHOTROPIC MEDICATIONS	165	106	97	368
ECT	3	4	5	12
PSYCHOSURGERY	0	0	1	1
DATA PRIVACY	45	19	35	99
PERSONAL PRIVACY/ DIGNITY	34	35	16	85
PHONE/MAIL/VISITORS	43	50	26	119
MONEY/FUNDING	159	134	148	441
CIVIL/CRIMINAL CODE	84	63	90	237
LIVING CONDITIONS	82	77	75	234
STAFF ATTITUDE/RESPECT	109	95	75	279
CLIENT INTERACTIONS	64	39	58	161
ABUSE	122	106	73	301
NEGLECT	65	72	54	191
OTHER	261	296	219	776
TOTALS	2628	2693	2265	7586

Complaints by Disability

These graphs demonstrate a fairly consistent pattern in regard to the individual disability groups receiving services from the Office of the Ombudsman. Although the annual percentages may vary slightly, it could be assumed that individuals receiving services for mental illness will continue to be the primary service recipients. One reason for this may be the overall lack of a comprehensive continuum of mental health services. These gaps in the service delivery system result in increased consumer complaints. It should also be noted, this is the only group that consistently increased each of the three fiscal years.

Another observation, and fairly safe assumption, is that individuals with developmental disabilities will continue to be the second largest recipients of Ombudsman Office services. Although the annual percentage for this group may fluctuate, they will continue to receive extensive attention.

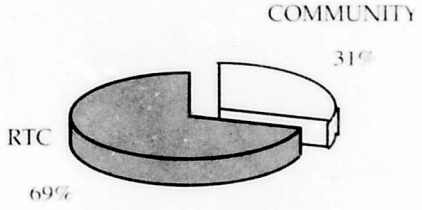
The group with the largest potential for increased involvement is children and adolescents with emotional disturbances. This growth could develop through increased education about, and involvement with, the Ombudsman Office by the parents of these children and adolescents.



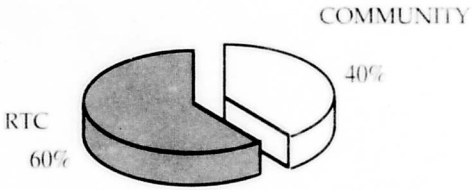
Complaints by Regional Treatment Center or Community

These graphs demonstrate that the Office of the Ombudsman has continued to achieve its goal of increased community involvement. When the office was created in 1987, almost all of the case load was generated within the Regional Treatment Center System (RTC). During the first year, a systematic approach was developed to begin educating the community service providers and service recipients about the Ombudsman Office. This education process is continuing and, as shown in the graphs, the expanded awareness is resulting in an increased utilization of the Office's services by community providers and recipients.

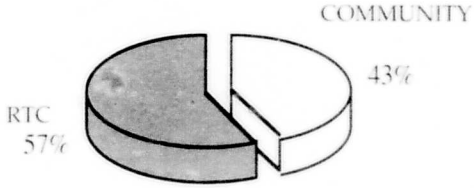
FISCAL YEAR 1990



FISCAL YEAR 1991



FISCAL YEAR 1992



Ombudsman Advisory Committee

The Ombudsman Advisory Committee consists of 15 members appointed by the governor to staggered three-year terms. All members of the committee have a special knowledge of and interest in facilities, programs, and services for persons with mental illness, developmental disabilities, chemical dependency, and children and adolescents with emotional disturbance. Current members include a consumer, representatives from advocacy organizations, physicians, and professionals from health and human services.

The Advisory Committee has played an integral role in assisting the Ombudsman in reviewing systemic problems, in providing the Ombudsman and staff with expert knowledge on promoting the highest attainable standards of treatment and care for clients, and providing insight and critique on public policy regarding how the system of care and funding should operate to promote integration of clients into the community.

In the past, the Advisory Committee has worked on issues such as the planning process for movement of clients from the Regional Treatment Centers into community facilities and case management services. Current activity for the Advisory Committee is to look at how detox services are being provided in Minnesota.

Member	Appointment Date
Janis Amatuzio	January 1993
Gary Berg	January 1990
James Dahlquist	January 1990
Dr. George Dorsey	May 1992
Charles Fields	November 1992
Melvin Goldberg	January 1990
Jane Klingle	May 1992
Dr. Jennifer Olson	May 1991
Rodney Otterness	January 1990
Scott Raberge	November 1992
Terry Schneider	January 1990
Lori Squire	November 1992
Marilyn Vigil	November 1992

(Four vacancies and chair to be appointed in early 1993.)

Advisory Committee meetings are open to the public and meeting times and dates are published in the State Register. Anyone interested in serving as a member should contact the Open Appointments Division of the Minnesota Secretary of State's Office at (612) 297-5845.

Advisory Committee Meeting

Medical and Clinical Review Function

The Medical Review Subcommittee (MRS) is part of the Ombudsman Advisory Committee and consist of five members: Dr. George Dorsey, Psychiatrist, Chair; Dr. Jennifer Olson, Internal Medicine; Dr. Janis Amatuzio, Pathologist; Melvin Goldberg, Attorney; and, Lori Squire QA, St. Joseph's Children Home.

The MRS meets on a monthly basis to review the causes and circumstances surrounding the deaths of clients. The MRS makes a preliminary determination as to whether a death is unusual or appears to have resulted from other than natural causes. The MRS works closely with the Ombudsman Medical Review Coordinator in an effort to improve the quality of care and prevent deaths under similar circumstances.

Cases are chosen for review based on nine indicators established in July, 1992, by the members of the subcommittee and staff assigned to the medical review function. The indicators are as follows:

1) A death attributed to suicide while receiving services.

2) A person who dies while receiving services and for whom Clozaril is currently prescribed.

3) A death of a person with a diagnosis or probable diagnosis of Neuroleptic Malignant Syndrome.

4) A person who dies of an acute* process in a non-acute setting.

5) A person who dies in a detoxification unit.

6) A death of a person receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.

7) A death that may be related to abuse/neglect.

8) A sentinel case: Any death where the circumstances of the case do not meet the indicators for review but review is appropriate.**

9) Any death of a child.

* Acute examples: Bowel infarctions, pneumonia, heart disease, end-stage Chronic Obstructive Pulminary Disease, blood dyscrasias, etc.

** Review requested by family members or other sources; concerns by the Ombudsman Office staff or others, etc.

When a client death meets one or more of the above indicators the case is reviewed by the Medical Review Subcommittee. Ombudsman staff get involved in the process. They are asked to gather and summarize additional information, make recommendations and list their concerns. The information provided by the staff member is analyzed and put into a summary format for review. In addition to the cases that meet the indicators, the aggregate data is accumulated and generated for the committee to identify patterns and trends. This information can be utilized by the committee to issue reports and make recommendations to each affected agency or facility in an effort to improve the quality of client care.

Glenda Bode, who has been a member of the advocacy staff and is a registered nurse, has assumed the responsibilities of Medical Review Coordinator. She is being assisted by Joyce Huitberg and Bill Wyss.

Glenda Bode, Medical Review Coordinator

Medical Review Subcommittee Case Reviews

The death of a client who committed suicide and was receiving community residential services for mental illness meets the criteria for review by the Office's Medical Review Subcommittee. The committee will review the circumstances and issues surrounding the death of the client. If particular concerns are identified that affect the quality of care, the committee may communicate these concerns to the provider for review to improve the quality of care and treatment to clients who receive community residential treatment.

As a result of the client death, the local police, the county adult protection agency, the Department of Human Services, and the Office of Health Facility Complaints are also involved to examine the circumstances and issues related to the client death.

This case caught the public eye and was captured in a front page article last summer in the St. Paul Pioneer Press. The article talked about the client's mental illness and how it affected the client's family.

The Department of Human Services conducted a review of the facility which has resulted in the facility being placed on probation.

A client at a Day Activity Center (DAC) died while eating lunch. The Client's Individual Habilitation Plan required that he not be given shelled food, such as peas, corn, etc., unless they were mashed. It also required that he be supervised while eating, as he ate so fast that he was at risk of choking.

The residential home sent along whole grapes in the client's lunch and the DAC cut them into small pieces. The client started choking on the grapes as he had eaten them too fast to swallow them. The DAC staff and ambulance personnel tried to clear the airway without success. The emergency room staff were also unsuccessful at clearing the airway and the client died of aspiration.

The advocate reported the incident under the Vulnerable Adult Act because the residential facility and DAC failed to follow the client's eating program and the DAC failed to provide the level of supervision required.

A client receiving mental health services at a RTC sustained serious injuries as a result of jumping off a building located on the RTC campus. Due to the injury type, the injuries were reported to the Ombudsman Office as required by the Office's mandatory reporting law.

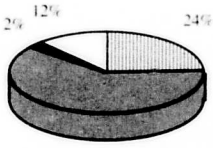
The injuries to the client occurred June of 1992 with active involvement by an advocate to address both the circumstances of the serious injury and to also provide active advocacy services to address both the changing medical and mental health quality of care issues.

Because of the many medical and mental health issues related to this case, many different types of services and agencies were and continue to be involved to meet the needs of the client.

This case represents how complex and involved advocacy services can become when advocating for quality treatment and care for clients.

Serious Injuries by Disability

Fiscal Year 1991



Total Number
705

MI	DD	CD	ED
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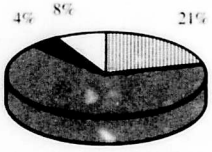
167	440	14	84

Fiscal Year 1990



Total Number
680

MI	DD	CD	ED
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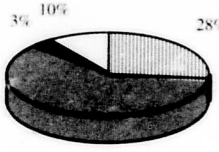
145	451	28	56

Fiscal Year 1992



Total Number
666

MI	DD	CD	ED
1	2	3	4
184	398	20	64

KEY

MI	Mentally Ill
DD	Developmentally Disabled
CD	Chemically Dependent
ED	Emotionally Disturbed

The reporting of serious injuries is a function and responsibility received by the Medical Review Coordinator. The current thrust of this function is to focus more attention on the aggregate of the available data rather than individual case review. By reviewing and analyzing the aggregate of the data, the intent is to identify trends and patterns and develop an action plan that will address these concerns. We believe that focusing in on the bigger picture will produce the best results for improving the quality of services for persons with disabilities.

The data collected on reports of serious injuries for years 1990, 1991, and 1992 remain fairly stable (as shown in the above graphs) in terms of the percentage of serious injuries that correspond to persons with developmental disabilities, mental illness, chemical dependency, and emotional disturbance. They also illustrate that persons with developmental disabilities sustained the largest number of injuries of all the disability groups, and persons receiving services for chemical dependency sustained the smallest number of injuries.

Serious Injuries
Incident Involved

INCIDENT INVOLVED	FY 1990	FY 1991	FY 1992	TOTALS
FALL	256	235	256	747
CLIENT TO CLIENT ACCIDENTAL	8	20	11	39
SPORTS/ACTIVITY RELATED	38	60	30	128
UNKNOWN ACCIDENT	108	114	105	327
OTHER ACCIDENT	151	149	118	418
SUICIDE ATTEMPT	24	30	37	91
SELF INJURIOUS BEHAVIOR	55	58	47	160
CLIENT TO CLIENT INTENTIONAL	32	29	39	100
UNKNOWN INTENTIONAL	0	4	7	11
OTHER INTENTIONAL	8	6	16	30
TOTALS	680	705	666	2051

The above graph illustrates the type of injuries sustained by consumers. Falls represent the largest percentage of injury type and remains consistent over the three year span. While the other injury types maintain a certain balance during the three year time frame, suicide attempts have steadily increased. This information will provide the Ombudsman Office the necessary data to focus on developing an approach to improve the quality of care for consumers.

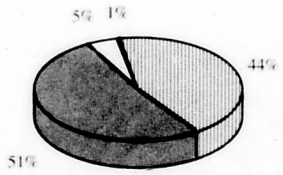
Deaths by Death Type

DEATH TYPE	FY 1990	FY 1991	FY 1992	TOTALS
ACCIDENT	14	9	2	25
HOMICIDE	3	3	2	8
SUICIDE	18	18	15	51
NATURAL	157	136	147	440
UNDETERMINED	7	29	18	54
TOTALS	199	195	184	578

It is encouraging to report that the number of deaths by accident has declined over the past three years. There has been no significant change in the number of deaths by homicide, suicide and natural causes. The increase in the number of undetermined deaths could be a reporting artifact considering the twenty-four hour time limit on reporting and in some cases the cause of death has not been determined within that time period. There is no significant change in the totals over the three year period however; the downward trend is encouraging.

Deaths by Disability

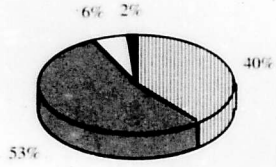
Fiscal Year 1991



Total Number
195

MI	DD	CD	ED
1	2	3	4
85	100	9	1

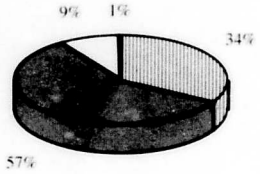
Fiscal Year 1990



Total Number
199

MI	DD	CD	ED
1	2	3	4
79	106	11	3

Fiscal Year 1992



Total Number
184

MI	DD	CD	ED
1	2	3	4
62	105	16	1

KEY

MI	Mentally Ill
DD	Developmentally Disabled
CD	Chemically Dependent
ED	Emotionally Disturbed

There is no significant change in the numbers and percentages of deaths reported by disability. The variations can be interpreted as normal fluctuation given the absence of historical data. The decline in the totals is encouraging.

Strategic and Operation Planning

We have taken a pro-active approach to the challenges facing us by designing and putting into action our strategic plan. At the center of this plan, is our commitment to our mission by constantly being aware and constantly improving on our services to consumers with mental illness, developmental disabilities, chemical dependency, and children/adolescents with emotional disturbance. We have set new sails by creating a new work culture that is based on total quality management principles. We have stayed the course and have come a long way.

The majority of our work on strategic and operations planning is done by self directed work groups made up of various staff members. These work groups have and continue to meet frequently to develop overall plans of actions, including milestones and deadlines in reaching their goals on important administrative and management issues of the agency. Moreover, we have established a participatory management process in almost all matters of agency work by relying on staff to provide input, raise questions or other concerns, or make comment about the direction or operation of the Office.

For example, the drafting of the biennial budget used to be the sole responsibility of management. The 1994-1995 biennial budget, however, was drafted by a work group consisting of management, professional staff, and support staff. We also have a standing budget committee that evaluates our current budget on a monthly basis and makes recommendations to management on how agency funds should be expended.

During this calendar year, much has been accomplished by the Office in reaching its stated goals as outlined in its strategic plan. The following is a partial listing of our accomplishments:

- Revised the medical/clinical review function, making it more sensible and related to the overall goals of our mission;
- Developed a new data collection system, including the purchase of hardware and software, to provide us with accurate and useful information, which will also be available for public use;
- Created a more harmonious and healthier workplace for our employees, a more open system of communications among staff and the development of team efforts;
- Held a successful Ombudsman Awards Program recognizing state of the art and innovative programs and services for consumers;
- Created a more equitable and fair system for providing training and expending training funds;
- Achieved the goal of having a more diversified staff;
- Created a more open and cooperative attitude with other agencies, both public and private;
- Wrote our mission statement as a basis for all our work.

We will continue to re-examine, to re-evaluate and to re-think how we do our work to insure that the highest quality of service will be provided to the consumers. We are committed to doing the right things to achieve our mandate in promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

1992 Ombudsman Awards for Excellence

Nineteen ninety-two marked the first year of the Ombudsman Awards for Excellence. The Ombudsman recognized services that provided high standards of treatment, competency, efficiency and quality that enrich the lives of Minnesotans who experience developmental disabilities, mental illness, chemical dependency or emotional disturbance.

Over 60 nominations were received and reviewed based on criteria that ensured innovation, quality of care and services, client or consumer satisfaction and the enhancement of the quality of a client's life. There were separate award categories for community and state services.

The Awards Banquet was held on June 25, 1992, at McGuire's Ramada Inn and Conference Center in Arden Hills, Minnesota. Approximately 130 persons observed Lieutenant Governor Joanell Dyrstad present the awards and honorable mentions. Gloria Segal, Minnesota House of Representatives District Number 44B, was the key note speaker.

The Ombudsman Awards celebration was a positive experience for program staff as well as consumers. It afforded the opportunity for state and community programs to note outstanding services in each area. As one participant observed, "It is wonderful to be connecting with other programs doing creative things and not just hearing about what is wrong or negative."

1992 Ombudsman Award for Excellence Winners

The following programs received awards:

Chemical Dependency Services

State Operated: Four Winds Lodge, Brainerd Regional Human Services Center, Brainerd, Mn; Contact: Dorothy Sam, Four Winds Lodge Program Director at 218-828-2396, Gayle Oatey, Administration at 218-828-2389, or James Holien, Program Manager at 218-828-2387.
1
Community: Vinland Chemical Health Programs, Loretto, Mn and Minneapolis; Contact: Greg Jones at 612-479-3555.

Rebuild Resources, Minneapolis, Mn; Contact: Mel Busta at 612-645-7055.

Children's Mental Health Services

Community: PATH: Family Foster Treatment for Children. Contact the Administration Office at 2324 University Avenue West, Suite 101, St. Paul, Mn 55114, 612-641-0455.

Honorable Mention: Project CAASEY, St. Paul Public Schools, St. Paul, Mn; Contact: Alpha Bibbs at 612-293-5911.

Developmental Disability Services

State Operated: Cambridge Pre-Admission and Evaluation Project, Cambridge Regional Human Services Center, Cambridge, Mn; Contact: Josefina S. Colond at 612-689-2121, ext. 292.

State Operated: Rum River Ornamental Products and Services of Cambridge Regional Human Services Center; Cambridge, Mn; Contact: Walter Hartland Jr., Director, 520 1st Ave No, Isanti, Mn 55040, 612-444-9819.

Honorable Mention: Crossroads Day Training Habilitation Services, Willmar Regional Treatment Center, Willmar, Mn, Contact: Ken Spates at 612-231-5364.

Community: Crest SILS, Albert Lea, Mn Contact: Bernie Lea at 507-373-0188.

Honorable Mentions: People First Advocacy of Olmsted County, Rochester, Mn; Contact: Sara Croymans, 507-287-2032, and Southside Services of Minneapolis, Mn; Contact: Carla Lehtinen at 612-721-1696.

Distinguished Service Award

Anne Henry, Attorney; Developmental Disability Law Project of Legal Aid.

Diverse Services

Project Challenge, School District 742, St. Cloud, Mn; Contact: Mary Bauer at 612-251-1733.

Mental Health Services

State Operated: Sibley County Community Support Program. Contact: Ms. Betty Baumberger, Sibley County Human Services, 112 5th Street, P.O. Box 237, Gaylord, Mn 55334, 612-237-5575.

Community: Range Mental Health Community Support Program, Virginia, Mn; Contact: Miller A. Friesen at 218-749-2881.

Twenty-Sixth Street Artists of the Mental Health Association, Minneapolis, Mn; Contact: Pat Young at 612-331-6840.

Honorable Mention: Camp Grandir. Contact: Linda Davidson at 612-331-6840.

** A special thank you to Ellen Forbes of 26th Street Artists, who designed the artwork for the 1992 Ombudsman Award and invitations.*

1987 - 1992 Ombudsman Office in Review

July 1, 1987: Office of Ombudsman created under Minnesota Statute 245.91.

September 1987: Former State Representative Shirley Hokanson appointed first Ombudsman.

October 1987: First meeting of the Ombudsman Advisory Committee is held.

October 1987: Mass mailing to 676 facilities and agencies informing them of the existence of the Office.

November 1987: First meeting of the Ombudsman Medical Review Subcommittee (MRS).

December 1987: Public meetings are held throughout the state to give providers information on the operation of the Ombudsman Office.

December 1987: The Ombudsman Office finds home at the Metro Square Building, St. Paul.

January 1988: The Medical Review Subcommittee (MRS) establishes procedure for the review and investigation of client deaths.

January 1988: Active legislative session for the Office in which the duties of the Court Monitor under Welsch are transferred to the Ombudsman.

May 1988: Office develops policy/action plan which includes legislative initiatives for subpoena power for the Ombudsman; definition of serious injury to clients; and, mandates 24 hour reporting to the Office of serious injuries and deaths of clients.

October 1988: First Ombudsman Newsletter is published.

December 1988: Medical Review Coordinator position established. The Medical Review Coordinator is responsible for the medical and clinical review function of the Office.

January 1989: Ombudsman legislative initiatives approved by legislature Office begins implementation of review and investigations of serious injuries and deaths to clients under the new mandated reporting law.

January 1989: First Annual Report by the Ombudsman is published.

May 1989: Ombudsman Office releases report on the use psychotropic medication with developmentally disabled clients in community residential programs.

October 1989: Ombudsman Office releases public report on Gerard of Minnesota regarding the quality of care for emotionally disturbed children at Gerard.

January 1990: Ombudsman Office assists with drafting legislative language that controls and prohibits certain restrictive techniques and procedures with emotionally disturbed children in residential programs.

April 1990: Ombudsman Advisory Committee releases report on Case Management services in the state of Minnesota.

December 1990: Ombudsman Office releases public report on the delivery of services to emotionally disturbed children in Rule 5 residential programs.

April 1991: Ombudsman Office releases public report on the Quality of Care at Faribault Regional Center (FRC).

November 1991: Shirley Hokanson steps down as Ombudsman.

December 1991: Bruce H. Johnson, Director of Office of Health Facility Complaints, appointed Ombudsman.

January 1992: Office begins reorganization and strategic planning.

February 1992: Office, with assistance of the Management Analysis Division, completes strategic plan and begins implementation of the plan.

May 1992: Office of Ombudsman mission statement completed.

June 1992: New data collection system developed.

June 1992: Office implements policy and procedures on review and assessment of system-wide issues impacting consumers of services.

June 1992: Ombudsman Awards Program attended by approximately 130 people.

July 1992: All Advocacy Staff attended a 24 hour training and certification program in investigative and inspection procedures and techniques sponsored by the National Certified Investigator/Inspector Training Program.

September 1992: An agreement with the Ombudsman Office and St. Peter Regional Treatment Center, DHS to provide additional advocacy services to clients at the RTC through a mobility assignment.

September 1992: Client Advocate regions redefined to ensure adequate advocacy coverage.

October 1992: St. Peter consumers survey and needs assessment developed. It will be adopted to be used in other state hospitals.

November 1992: Death and serious injury review process updated and revised.

December 1992: The Faribault Regional Center monitoring project concluded.

January 1993: Bruce H. Johnson steps down as Ombudsman.

January 1993: John Waldron, Deputy Ombudsman appointed Acting Ombudsman.

Ombudsman Minn. Stat. §245.91

I. OMBUDSMAN FOR MENTAL HEALTH AND MENTAL RETARDATION STATUTE: MINN. STAT. § 245.91-.9.

245.91 DEFINITIONS.

Subdivision 1. **Applicability**. For the purposes of sections 245.91 to 245.97, the following terms have the meanings given them.

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state departments of human services and health, and of designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 3. **Client.** "Client" means a person served by an agency, facility, or program, who is receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, that is required to be licensed by the commissioner of human services, and an acute care inpatient facility that provides services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance.

Subd. 5. **Regional center.** "Regional center" means a regional center as defined in section 253B.02, subdivision 18.

Subd. 6. **Serious Injury.** "Serious injury" means:

(1) fractures;
(2) dislocations;
(3) evidence of internal injuries;
(4) head injuries with loss of consciousness;
(5) lacerations involving injuries to tendons or organs, and those for which complications are present;
(6) extensive second degree or third degree burns, and other burns for which complications are present;
(7) extensive second degree or third degree frost bite, and others for which complications are present;
(8) irreversible mobility or avulsion of teeth;
(9) injuries to the eyeball;
(10) ingestion of foreign substances and objects that are harmful;
(11) near drowning;
(12) heat exhaustion or sunstroke; and
(13) all other injuries considered serious by a physician.

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility, or program. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The

ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

245.93 ORGANIZATION OF OFFICE OF OMBUDSMAN.

Subdivision 1. **Staff**. The ombudsman may appoint a deputy and a confidential secretary in the unclassified service and may appoint other employees as authorized by the legislature. The ombudsman and the full-time staff are members of the Minnesota state retirement association.

Subd. 2. **Advocacy**. The function of mental health and mental retardation client advocacy in the department of human services is transferred to the office of ombudsman according to section 15.039. The ombudsman shall maintain at least one client advocate in each regional center.

Subd. 3. **Delegation**. The ombudsman may delegate to members of the staff any authority or duties of the office except the duty of formally making recommendations to an agency or facility or reports to the governor or the legislature.

245.94 POWERS OF OMBUDSMAN; REVIEWS AND EVALUATIONS; RECOMMENDATIONS.

Subdivision 1. **Powers**. (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility, or program if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, mental retardation or a related condition, or emotional disturbance.

(f) The ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(g) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(h) The ombudsman may attend department of human services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the department of human services; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(i) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding services provided to clients with mental retardation or a related condition.

(j) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(k) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Subd. 2. **Matters appropriate for review.** (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

(1) may be contrary to law or rule;

(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;

(3) may be mistaken in law or arbitrary in the ascertainment of facts;

(4) may be unclear or inadequately explained, when reasons should have been revealed;

(5) may result in abuse or neglect of a person receiving treatment;

(6) may disregard the rights of a client or other individual served by an agency or facility;

(7) may impede or promote independence, community integration, and productivity for clients; or

(8) may impede or improve the monitoring or evaluation of services provided to clients.

(9) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

Subd. 2a. **Mandatory Reporting.** Within 24 hours after a client suffers death or serious injury, the facility or program director shall notify the ombudsman of the death or serious injury.

Subd. 3. **Complaints.** The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in section 626.557, subdivision 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

Subd. 4. **Recommendations to agency.** (a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;

(2) modify or cancel its actions;

(3) alter a rule, order, or internal policy;

(4) explain more fully the action in question; or

(5) take other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

245.95 RECOMMENDATIONS AND REPORTS TO GOVERNOR.

Subdivision 1. **Specific reports.** The ombudsman may send conclusions and suggestions concerning any matter reviewed to the governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, program, or any person, the ombudsman shall consult with the governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the governor that is adverse to an agency, facility, program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

Subd. 2. **General reports.** In addition to whatever conclusions or recommendations the ombudsman may make to the governor on an ad hoc basis, the ombudsman shall at the end of each year report to the governor concerning the exercise of the ombudsman's functions during the preceding year.

245.96 CIVIL ACTIONS.

The ombudsman and his designees are not civilly liable for any action taken under sections 245.91 to 245.97 if the action was taken in good faith, was within the scope of the ombudsman's authority, and did not constitute willful or reckless misconduct.

245.97 OMBUDSMAN COMMITTEE.

Subdivision 1. **Membership**. The ombudsman committee consists of 15 members appointed by the governor to three-year terms. Members shall be appointed on the basis of their knowledge of and interest in the health and human services system subject to the ombudsman's authority. In making the appointments, the governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

Subd. 2. **Compensation; chair**. Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The governor shall designate one member of the committee to serve as its chair at the pleasure of the governor.

Subd. 3. **Meetings**. The committee shall meet at least four times a year at the request of its chair or the ombudsman.

Subd. 4. **Duties**. The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

Subd. 5. **Medical review subcommittee**. At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by subdivision 2. The governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next-of-kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

Subd. 6. **Terms, compensation, removal and expiration**. The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by section 15.0575. The ombudsman committee and the medical review subcommittee expire on June 30, 1993.