State ombudsman's office rooted in court case, tragedy

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Roberta Opheim was recently honored by The Arc Minnesota for her outstanding service as Minnesota's State Ombudsman for Mental Health and Developmental Disabilities. It's hard to image the days before Minnesota had that kind of a watchdog office in place. But it took a legal case and an unrelated tragic death for state officials to make the ombudsman's office a reality.

Willmar State Hospital resident John Dragoo died in October 1985 while being restrained face down by staff at Glacial Ridge Treatment Center. The institution's death investigation sought to establish a true cause of death that would close the door on the matter, stating that he died of natural causes or from a seizure. It was also stated that a manual hold procedure had been appropriately authorized and properly administered. But in response to an investigation by Legal Advocacy for Developmentally Disabled Persons in Minnesota, Minnesota Department of Human Services (DHS) appointed an independent review panel that concluded Dragoo died "from an acute cardiac arrhythmia brought about by psychological stress of the manual hold procedure."

In other words, the manual hold procedure killed John Dragoo. Both the institution's initial response regarding the cause of death and the failure to follow up by questioning the effectiveness of the procedure itself dictated the need for an established external review process.

At about the same time DHS wished to conclude the court monitor for the Welsh case consent decree. From 1980 to early 1987 monitors for the decree found on numerous occasions that DHS failed to comply with decree requirements, particularly those that related to provision of services that appropriately met individual needs.

The consent decree was slated to end in the summer of 1987. Starting in February 1987 DHS and attorneys for the plaintiff class in Welsh negotiated a settlement that, among other things, required various quality review processes to be established. One was creation of an external monitoring system, with power to investigate deaths and serious injuries and the adequacy of services in both the state operated and community services

Those events led to 1987 and 1988 legislation in establishing what was initially known as the Office of the Ombudsman for Mental Health and Mental Retardation. The court monitor's office was then terminated.

Anne Henry of the Minnesota Disability Law Center said the formation of the ombudsman's office was a very important step for Minnesotans with disabilities. "We needed to have a state funded office, yet we needed it to be an independent office, able to look at issues and complaints," she said.

Shirley Hokanson was the first ombudsman, followed by Bruce Johnson. Opheim is the third person to hold the post. She and her staff were instrumental in the recent investigation and report on the former Minnesota Extended Treatment Options program, which showed that use of restraint and restrictions is not only illegal but also ineffective.

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