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LEGAL SERVICES FOR THE INSTITUTIONALIZED MENTALLY ILL: AN EXAMINATION OF THE KALAMAZOO STATE HOSPITAL OMBUDSMAN PROGRAM

by

Steven J. Hathaway

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Doctor of Education

Western Michigan University
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Accomplishing a project of this nature requires the cooperation and assistance of many people. In particular, Dr. Uldis Smidchens, Chairman of the Doctoral Committee, was an invaluable source of guidance and expertise throughout the course of the project. Dr. Morvin Wirtz and Dr. Thomas Gossman provided many valuable suggestions while serving on the Doctoral Committee. To each member of the committee is extended sincere appreciation for their encouragement and patience.

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Last, but not least, thanks to my wife, Kathy, for saying the rights things at the right time.

Steven J. Hathaway
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Mental patients have historically been among the most
discriminated against, least represented segments of American
society. Numerous authorities have described the debilitating and
dehumanizing effects of institutions on patients. This phenomenon
called institutionalization is characterized by the reinforcement of
helplessness, deviancy, and dependency, and a general non-
responsiveness which is markedly evident in the area of legal
services. Some states provide court appointed attorneys to repre-
sent involuntary patients involved in commitment or release pro-
ceedings in probate court. Many patients, however, require legal
assistance with everyday legal problems such as divorce, real
estate matters, civil suits, and foreclosures. These problems
persist and even originate long after a patient is admitted to a
mental health facility, yet no state provides these patients with
legal services.

In October, 1974, an experimental part-time ombudsman
program was implemented at Kalamazoo State Hospital, a state
institution for the mentally ill. The primary objective of the
program was to provide hospital residents with free legal services
in two areas: (1) everyday legal problems such as domestic relations, wills, estates, civil actions, and guardianships; and (2) problems related to chapter 4 (Admission and Discharge Procedures) and chapter 5 (Patients' Rights) of the *Michigan Mental Health Code* (Michigan Department of Mental Health, 1976).

The program emphasis was to be in the area of assistance with everyday legal problems. Additional program objectives included: (1) to function within the hospital's service delivery system as opposed to promoting radical systems changes; (2) to advocate hospital policies in patients' interests; (3) to remove legal obstacles which hinder placement of patients with families or the community; and (4) to produce savings to the Michigan Department of Mental Health by facilitating releases.

Services were to be provided by one part-time ombudsman attorney, who would be free to service the legal needs of residents within the institution without being subordinate to the institution administration, thereby avoiding potential conflicts of interest and prejudicial influence. This program was originally funded by a state formula Public Health Services 314(d) grant (Michigan Department of Mental Health, grant number 3-75; hereafter referred to as "314(d) grant") and remains the only ombudsman program in the nation which integrates legal services directly into the mental health service delivery system. Grant funding
expired June 30, 1976, and interim funding is being provided by the Michigan Department of Mental Health until an administrative decision is reached regarding the future status of the program.

The purpose of this study is to examine the Kalamazoo State Hospital Ombudsman Program, report the results, and make recommendations relative to its future status. The study is divided into six chapters.

The initial activity consists of a brief review of the historical status of mental patients and legal services, patients' rights as recipients of mental health services, the history and evolution of the ombudsman concept, a description of the classical ombudsman model, and a current overview of the mental health related applications of ombudsman functions. This review activity provides a viable perspective for the assessment of the Kalamazoo State Hospital ombudsman role and functions, made later in the study.

The Kalamazoo State Hospital Ombudsman Program is described in terms of the program rationale and objectives as delineated in the 314(d) grant, staffing, role characteristics and function of the ombudsman, client population served by the ombudsman, program budget, and development and utilization of program record keeping procedures. This information which is presented in Chapter III, facilitates the comparison of the
Kalamazoo State Hospital Ombudsman with the classical ombudsman model, which occurs later in the study. This description of program operation and structure also provides a basis for presenting and discussing program data, and assessing program deficiencies. The process for examining the assessment of program objectives, comparing costs for ombudsman and private attorney services, and comparing the Kalamazoo State Hospital Ombudsman with the classical model, is outlined prior to the actual presentation of program data. For purposes of presentation and discussion of ombudsman program data, this study focuses on the duration of program operation supported by 314(d) grant funding--October 1, 1974 to June 30, 1976. This 21 month period of time covers the program from its inception to its termination as a grant supported experimental project. In this chapter, the ombudsman caseload is described in terms of type and quantity of services rendered, outcomes, and relative costs of services. Ombudsman client characteristics (age, sex, hospital ward, etc.) are described and compared to hospital resident characteristics, for the purpose of establishing the representative nature of the ombudsman caseload and identifying segments of the hospital population which may be underutilizing ombudsman services.
The final section of the study contains conclusions relative to the ombudsman client caseload, legal services caseload, program impact, program deficiencies, and the role/function of the Kalamazoo State Hospital Ombudsman. Also included in this final section are recommendations regarding the future status of the program and topics for further study.
CHAPTER II

LEGAL SERVICES AND OMBUDSMANRY IN MENTAL HEALTH

The purpose of this chapter is to review the historical status of institutionalized mental patients and legal services afforded them, patients' rights as recipients of mental health services, and the development of the ombudsman concept. This chapter also includes a description of the classical ombudsman model and a current overview of mental health related applications of ombudsman functions.

The Mental Health Patient and Legal Services

According to Szasz (1974), sometime within the next year approximately one out of 10 Americans will be admitted to mental institutions, and nearly one and a half million of those will be involuntarily committed. Already, patients in mental hospitals outnumber patients in general hospitals, and there are "... three times as many mental patients as there are prisoners" (p. 9).

Historically, the mentally ill or recipients of mental health services, have been among the most discriminated against,
powerless, and voiceless segments of American society. In a White House Conference on the Handicapped Report, large mental institutions were characterized as having a dehumanizing, debilitating, stagnating effect on their patient populations; and as fostering deviancy, parasitism, and helplessness (Wilson, Beyer, & Yudowitz, 1976). Goffman (1961) stated that mental patients in total or closed institutions were forced to endure a mortification process with respect to representation of their interests in the society at large. Rosenhan (1973) also described the effects of institutionalization and emphasized the non-responsiveness of the system. He described the "... avoidance techniques of the staffs within such institutions ..." and remarked upon the "... curious perversion of values which causes those with the most prestige and training to have the least patient contact, and those lacking such credentials to have the most" (p. 393).

Of significant detriment to the institutionalized mental patient is the fact that he is uniquely deprived of legal services or access to such services. Many hospitalized patients require the services of an attorney for problems that often continue long after their hospitalization. For example, they may need help opposing eviction proceedings in order to have a placement following discharge. They may need assistance in opposing
civil proceedings such as foreclosures or repossession. They may also need help with criminal or domestic relations problems, such as child custody, guardianships, and divorce. Although many states provide temporary attorney services prior to and during initial commitment hearings, "... no state provides patients with free lawyers to handle their everyday legal problems" (Ennis, 1973, p. 41). Authors such as Szasz (1973) and Gottesfeld (1974) support the notion that stripping a patient of his civil liberties and denying access to representation, such as with everyday legal problems, "... facilitates the mental states that cause individuals to be labeled as mentally ill" (Gottesfeld, 1974, p. 308).

Ennis (1973) concurs and outlines two arguments involuntary patients could make in support of the right to free legal services in the hospital:

1. If the state does provide legal services to non-hospitalized persons, depriving patients of such services may constitute a denial of equal protection of the laws, and

2. Because the inability to obtain legal help often exacerbates the patient's depression or increases his paranoia, failure to provide such help may constitute a denial of the right to treatment (p. 43).

Patients' Rights

In an effort to recognize and protect the rights of patients, the American mental health service delivery system has recently
undergone dramatic change. This change has occurred within the framework of mental health statute reform. According to a survey conducted by McGarry and Kaplan (1973), the trends and changes in the new mental health statutes are generally in response to two problem areas:

1. The debilitative and dysfunctional effects of long-term custodial institutionalization, and

2. The neglect and abrogation of the rights and personal dignity of individuals committed to hospitals (p. 627).

Although McGarry and Kaplan observed that emerging, new mental health statutes included the constitutionally guaranteed right to legal counsel for individuals involved in commitment hearings, they found no mention of a guaranteed right to such counsel relative to everyday legal needs once an individual is committed to an institution.

The impetus for much of the change in mental health law is a series of federal court decisions beginning with Wyatt vs. Stickney (U. S. District Court, Alabama, 1970), which established rights due to recipients of mental health services. Subsequent court decisions have led to state legislation in the form of bills of rights and comprehensive mental health codes. Kopolow (1975) reviewed the most significant court decisions that have had impact on the field of mental health. He found that in the areas of
institutional psychiatry, civil rights of patients, patient-therapist-
public relationships, and the criminal justice system, rulings
guaranteed patients the right to be represented by legal counsel
in all areas concerning treatment and commitment. However,
in the area of civil rights, he found that legal representation did
not pertain to everyday legal problems faced by hospitalized
patients.

In an address to the Nineteenth Annual Conference of State
Mental Health Representatives, Llinas (1975) strongly urged mental
health professionals to recognize their responsibilities for pro-
tecting patients' rights. Although he was primarily concerned with
the right to treatment issue, he emphasized the need for legal
representation in all other areas. He felt patients should be able
to get married, drive, buy property, make wills, etc., and
implied that availability and access to legal counsel should
necessarily be considered an integral component in the mental
health service delivery system.

In response to court decisions, subsequent legislation,
and pressure from citizens and lobbyists, many states such as
Minnesota (Johnson & Aanes, 1974; Jansen & Krause, 1974),
Maine (Ettlinger, 1973) have developed patient advocacy programs,
and several states such as Ohio (Ishiyama & McCulley, 1969) and
New York (Wilson, 1976) have developed ombudsman programs.
designed to provide the mental health services recipient with a voice and to ensure the protection of his rights.

Origins of the Ombudsman Concept

According to Anderson (1969), Germanic tribes coined the word "ombudsman" to describe the messenger sent to collect the Wergild, or fine, which was levied against the family of an individual convicted of committing a crime. This ombudsman was a neutral person appointed by the community rulers and had no authority to administer any judicial action.

In 1809, the Basic Law of the Swedish Constitution provided for the establishment of the Riksdagens Justitieombudsman—Parliament's Agent of Justice. This legislation marked the formal beginnings of the ombudsman and created a mechanism for representing the interests of citizens involved in conflicts with their government bureaucracy. The function of the Justitieombudsman was to receive complaints from citizens and protect them against injustices. The ombudsman was neutral and had no judicial powers, but exerted considerable influence with both King and Parliament. Anderson (1969) described the post as:

A counterweight in the balance of power whereby King and Parliament both controlled the Administration, that is to say primarily the judges and police (p. 1).

Over 100 years later, in 1919, Finland established an
ombudsman office based directly on the Swedish model. This was the first attempt by any government to copy the Swedish Justitieombudsman. Further adoption of the ombudsman concept did not occur until post-World War II. A phenomenal world-wide increase in ombudsman offices occurred during the 1950's. These new offices were initially political in nature and were characterized as a function of government. As with earlier ombudsman programs, they provided citizens with a means of redress in matters of complaints against government. Linnane (1975) attributes the rapid increase in ombudsman programs to two key factors: (1) world governments were unable to deliver services proportionate to the rate of population growth, and (2) the growing gap between citizens and governments excluded most individuals from the decision-making process of government. According to Linnane, ombudsman offices provided many national leaders with a viable mechanism for alleviating the increasing and pervasive governmental influence over its citizenry.

Denmark developed an ombudsman plan in 1953, and in 1955 appointed Stephan Hurwitz as the first Danish ombudsman. Hurwitz was an able proselytizer and convincingly proclaimed the values of ombudsmanry to a worldwide audience. He served as the preeminent catalyst for the emergence and proliferation of present day ombudsman offices. Today, ombudsman offices are

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found in many municipal, state, and federal governments, as well as in such unique arenas as private corporations, labor unions, and educational institutions. Weeks (1973) demonstrated the apparent universality of the ombudsman, in his description of 18 ombudsman offices in 12 countries, with applications in six distinct areas (health care, law, education, government, business, and consumerism).

The Classical Ombudsman Model

The classical ombudsman model provides a basis for measuring conformity of a given ombudsman program to the general ombudsman concept. The model is characterized by a statement of purpose, definition of role, and a description of function.

Purpose

The purpose of the ombudsman is to resolve the grievances or problems encountered by individuals within a system and to correct malfunctions of the system.

Authorities in numerous fields have elaborated upon this statement of purpose and have applied it to their ombudsman programs. Forman (1974) describes the purpose of the classic legislatively based ombudsman as "... to resolve citizen grievances against government agencies or officials ... and to improve government administration" (p. 129).
Linnane (1975) reviewed the process and structure of the nursing home ombudsman programs sponsored by the U.S. Department of Health, Education, and Welfare. He described the primary purpose of the ombudsman in this setting as resolving complaints from the public (including nursing home patients), at no cost to the complainant. In a Public Affairs Report, Anderson (1974) discussed the purpose of ombudsmen in health care administrative settings. He felt the purpose was merely to elicit information regarding grievances of health care consumers directed against care providers.

Broderick (1973) stated that the purpose of an ombudsman in a mental hospital setting was to correct malfunctions of the system. The programs to which he referred did not provide legal services. Broderick viewed the ombudsman's constituency as the general public interest, rather than the specific concerns or grievances of an individual citizen.

In his book on corporate ombudsmen, Silver (1967) pronounced the purpose of the ombudsman as defense of the "little man" against the arbitrary "bureaucrat," and not reform of basic procedures within the system. Wyner (1973) studied the executive ombudsman in government and described two specific goals or purposes as being integral to the ombudsman concept.
First, the ombudsman strives to gain bureaucratic equity. That is, he "... gets bureaucrats to treat like cases alike, and on the basis of clear rules, known in advance ..." (p. 10). Second, the ombudsman strives to gain responsiveness in the administration of public policy by:

Inducement of bureaucrats to meet, with alacrity and compassion, those cases which can never be brought under a single national or state rule and which, by common human standards of justice or benevolence, seen to require that an exception be made or a rule be stretched (p. 11).

Role Characteristics

The role characteristics of the classical ombudsman involve seven components.

- **Neutrality and impartiality.** The ombudsman is politically neutral and impartial.
- **Independence.** The ombudsman is independent of any organization he might investigate.
- **Expertise.** The ombudsman is an expert in his speciality field and is familiar with administrative principles.
- **Status.** The ombudsman is appointed and highly placed (automously) within the organization, with access to individuals of power and influence.
- **Accessibility.** The ombudsman is universally accessible
to both individual citizens or clients, and the administration of the organization. Ombudsman services are free.

**Integrity.** The ombudsman commands respect and guarantees confidentiality.

**Functions**

The classical ombudsman engages in a specific set of tasks in fulfilling his purpose of resolving conflict and promoting adjustments within an organizational system.

**Investigation.** The primary ombudsman function is receiving and investigating complaints of citizens, regardless of their position within the organizational system. The ombudsman is capable of initiating complaints independently if the situation warrants such action.

**Mediation.** Mediation activities occupy a significant portion of the ombudsman's time, and problems are frequently resolved at the mediational level.

**Documentation.** Within the context of a specific case, the ombudsman has access to all organization or agency information. The ombudsman also writes general program reports which become part of public record.

**Powers.** The ombudsman cannot reverse administrative decisions and does not have the authority to change or create

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policies, procedures, or laws. The ombudsman makes recommendations to the executive or administrative branches of organizations.

The role and function of the classical ombudsman model has been applied to ombudsman programs in various fields such as government, industry, health care, and education. While the different ombudsman programs differ from each other with respect to discrete roles or functions, they are commonly based on the classical model.

Ombudsman programs in government settings most closely resemble the classical model. This is probably a result of the evolution of ombudsmanry from its initial political application. Several authors have offered descriptions of the role and function of an ombudsman in government. In discussing the legislative ombudsman, Forman (1974) stated that he (ombudsman) was 
"... an independent, highly placed official in national, state, or local government, appointed by and responsive to the legislature" (p. 130). Rowatt (1968) also reviewed legislative ombudsman programs. He found the role and function of the ombudsman to be that of:

An independent and politically neutral officer of the legislature, usually provided for in the constitution ... who has the power to criticize and publicize, but not to reverse such action (p. 36).
In an Institute for (U.S.) Governmental Studies report, Wyner (1973) voiced concern that bureaucracy itself complicates patterns of interactions between people and bureaucratic units. It was his opinion that the ombudsman could clarify procedures and ground rules, translate bureaucratic jargon, and recommend alternatives to reliance on precedent, which he felt "stifled creativity" (p. 310). Anderson (1969) defined the role and function of the classical ombudsman as applied to a legislative setting. He listed the essential characteristics (role and function) of the classical ombudsman as:

1. independence, 2. impartiality, 3. expertise in government, 4. universal accessibility, and 5. power only to make recommendations and publicize relevant information. Gelhorn (1967) identified essentially the same role and function described by Anderson, with the exception of explicitly stating that the ombudsman is impartial.

Silver (1967) discussed ombudsman programs in business and examined the application of the classical model to corporate settings. He described three limiting features as comprising the role of the classical ombudsman. First, the ombudsman can only investigate and recommend; he cannot reverse particular decisions. Second, he cannot attack an exercise of discretion (except in Norway, where he may find a decision to be "unjust," and in New Zealand, where he may think it is "wrong"). Third, he cannot
make policy decisions, although he is empowered to make recommendations for policy changes on the basis of his investigative findings. According to Silver, the weakest function of the ombudsman is policy recommendation.

Fitzharris (1973) supported the application of the classical ombudsman model to correctional facilities. Writing in a government publication, he described the role and function of the "ideal form of ombudsman" (classical model) in such a setting. He stated that the ombudsman should exhibit "... the essential characteristics of independence, impartiality, expertise in government, universal accessibility, and power only to recommend and publicize" (p. 9).

Several researchers have examined the role and function of classical model applications in the general field of health care. Anderson (1974) stated that the ombudsman in this setting must be an expert who independently and impartially investigates citizen complaints. While he felt it within the ombudsman's jurisdiction to recommend remedial action in specific grievance cases, Anderson noted that the ombudsman's role is limited to investigating, clarifying government action, and report writing. Broderick (1973) reviewed the classical ombudsman model as applied to general mental health settings. He described the classical ombudsman model as applied to general mental health
settings. He described the classical ombudsman in the role of administrative critic seeking ways to correct malfunctions of the system. According to Broderick, the chief mechanism afforded the ombudsman for this purpose, is the power of investigation and public disclosure of results.

The definitive treatment of the classical ombudsman in the field of health care was provided by Linnane (1975) in his Department of Health, Education, and Welfare report on nursing home ombudsman programs. He exhaustively described the role and function of the classical model in this setting. He stated that the most important role of the ombudsman is to remain politically neutral and independent from the legislature and administration. In order to maintain an objective posture, the ombudsman's tenure in office, promotions, and salary, must be independent of the administrative agency he will investigate. Impartiality, according to Linnane, must be "... for the citizen but not against the government" (p. 5). In further discussing the classical model role, Linnane noted that the ombudsman must demonstrate expertise in government and capability of commanding respect. In addition, he must be universally accessible, informal, unimposing, and confidential. The importance of these role characteristics is due to the inhibiting effect of citizens' timidity, ignorance of recourse, imagined extravagant costs, and the
imposing formality and impersonality of the bureaucratic system. Linnane viewed the primary functions of the classical ombudsman in the nursing home setting as investigating, criticizing, and reporting. In describing the investigation process, Linnane stated that the ombudsman may elect to dismiss a grievance subsequent to review of the complaint. Additional functions include preparation and dissemination of an annual report of ombudsman activities. In the nursing home setting, the report is delivered to the legislature and is a public document. Closely adhering to the classical ombudsman functions, the nursing home ombudsman possesses no authority to modify, reverse, or void administrative decisions or actions. This limitation serves to distinguish ombudsmen from judges. Linnane emphasizes that ombudsman powers are primarily related to processing citizen complaints. He has authority not only to accept complaints, but to initiate them as well. The investigatory powers of the ombudsman provide him with access to all information from government agencies. In the case of the nursing home ombudsman, this power includes authority to subpoena documents and testimony from public servants, and represents a deviation from the limited investigatory powers ascribed to the classical model.

Linnane described additional classical model functions which were relevant to the nursing home ombudsman. These
included facilitation, impartial evaluation, education, advocacy, and mediation. According to Linnane, the most frequent result of ombudsman intervention is that the complainant feels a sense of having been represented by government. Other results of nursing home ombudsmen interventions included modification or reversal of some administrative action, policy adjustment, clarification and promulgation of administrative policies, speedier governmental responses to citizen inquiries, and improved understanding of the options and implications of administrative policies on the part of citizens.

The classical ombudsman model has been adapted to diverse settings while retaining its basic purpose, role and function. Regardless of the arena, the classical model has provided an effective means to insure that individuals receive fair treatment from administrative authorities. Additionally, citizens have been provided with a point of entry into the system, and have been given a sense of participation in a system that is acting fairly (Linnane, 1975). Proclaiming the universability of programs based on the classical ombudsman model, Anderson (1974) stated that, "... a powerful case can be made for ombudsman-like institutions in all businesses and professions dealing with people ..., but that such programs "... must keep the role and function of the classical model in mind" (pp. 58-59).
Patient Advocacy or Patients' Rights Programs

Although they are technically not ombudsman programs, patient advocacy and patients' rights programs represent the initial effort of the mental health system to provide recipients with representation. These programs also provide a transition to ombudsman programs based on the classical model and reflect the degree of responsiveness of the service delivery system in meeting the legal services needs of its clients.

Johnson and Aanes (1974) described a full time advocate office at Fergus Falls (Minnesota) State Hospital. Their program was staffed by a social worker, a law intern, and several social work students. They found that the largest number (approximately 25 percent) of patients' complaints involved legal rights relative to the state's hospital and commitment law. Nevertheless, they stated that "... it would be helpful to have a lawyer available who could request injunctions or file actions for litigation immediately" (p. 445). They discovered that the majority of the civil matters involved the need for an attorney's services, and that their program was deficient in meeting this need.

Similar programs were established at Augusta (Maine) State Hospital (Ettinger, 1973), and Willmar (Minnesota) State
Hospital (Jansen & Krause, 1974). Both programs were referred to as Patient Advocate programs, and the majority of patient complaints received involved restrictions of patients by staff and dissatisfaction with individual treatment programs. These two programs differed from the Fergus Falls program in their use of a patients' rights committee as the mechanism for receiving complaints and effecting resolutions. Although each program identified patients' needs for assistance with everyday legal problems (divorce, civil suits, guardianship disputes, etc.), neither program was equipped to respond to such needs. The Willmar State Hospital program was staffed by nursing and social work personnel, and the Augusta State Hospital program by social workers and one law student who functioned as a patients' rights advisor.

Haggerty (1976) and Addison (1976) described advocacy programs for the retarded which employ a group approach as the representation modality. Addison evaluated these programs which were established in Pennsylvania, and reported common program services such as provision of legal assistance and/or advice regarding the rights, interests and service needs of disabled (retarded) individuals. This legal assistance, however, was limited to commitment and treatment issues.

Murray (1975) reviewed three patient advocacy programs
designed primarily to serve the needs of poor psychiatric inpatients. Murray emphasized the point that wealthier patients can hold psychiatric professionals accountable for services by cancelling and going elsewhere, but poor individuals are at the mercy of the institution and must take what is offered or go without treatment. Murray also identified the needs of poor patients for assistance with everyday legal problems and described a legal aid group which was developed at one institution to provide poor patients with assistance. This patient advocate group represented their clients regarding such everyday legal needs as creditor problems, divorce and child custody matters, tax problems, civil rights, criminal charges, landlord and tenant problems, personal injury and property loss, claims, traffic court problems, and real estate matters. The legal aid group lawyers were successful in helping poor patients, but did not offer their services to other hospital clients, and their services were not integrated into the service delivery system.

Ombudsman Programs

A number of ombudsman programs have been established in mental institutions for the purpose of representing the interests of patients. This representation has been limited, however, to issues such as commitment and discharge procedures, civil rights, and treatment. No ombudsman program has provided
patients with legal services in the area of everyday legal needs.

Ishiyama and McCulley (1969) reported on a Cleveland (Ohio) State Hospital ombudsman program which utilized a psychiatric aide as ombudsman. The intent of this program was to modify the balance of power within the hospital's organizational structure by handling complaints of grievances from both patients and staff. The program was declared, "not useful to patients, because the vast majority of patients did not avail themselves of the ombudsman's services" (p. 244). Poor accessibility to the ombudsman was the explanation for this finding. Another limiting feature of this program was the complete absence of legal assistance for those patients requesting such services. No data were presented relative to the numbers of patients participating and requesting legal assistance.

Forman (1974) reported on federally funded nursing home ombudsman programs in Idaho, Pennsylvania, South Carolina, and Wisconsin. These programs were designed to upgrade the quality of care and life in the nation's nursing homes. The targets for ombudsman involvement were cases involving subjection of patients to physical or mental abuse, poor or inadequate treatment, and loss of personal or property rights. The ombudsman programs were staffed by lawyers, social workers, and other health care professionals. The majority of cases handled during
the first year concerned quality of care, administrative policies, and payment for care. Forman did not consider use of attorneys as a necessity in effectuating ombudsman activities, primarily due to the low incidence of legal problems on the part of patients. However, the report stressed that further demonstrations and subsequent evaluations would be necessary in order to accurately assess the role and functioning of ombudsmen in this area.

The following year, Warner (1975) evaluated these same nursing home ombudsman demonstration projects and found that the programs were responding essentially to "patients' rights" issues. In situations involving issues other than quality of care or patients' rights, the ombudsman either referred the case to the local legal services agency or the state's attorney general. If neither action promoted resolution of the problem, the ombudsman relied on publicity to resolve it. At any rate, no emphasis was placed on everyday legal needs of patients.

Wilson (1976) reviewed four ombudsman programs sponsored by the New York (State) Mental Health Information Service (MHIS). Of the four MHIS programs, two were staffed by social workers and two by lawyers. These programs assumed responsibility for informing hospitalized mental patients of their legal rights in matters such as procedures for admission and various hearings. According to Wilson:
In those (programs) where MHIS is staffed by lawyers, there are hundreds of habeas corpus petitions submitted and tons of releases ordered, while in the (programs) staffed by social workers there are only a very few petitions and no releases (p. 32).

While Wilson was not indicting social workers, he cited the ability of lawyers to effectuate resolutions without resorting to litigation, thus adhering to the classical ombudsman model. Although the programs staffed by lawyers produced more releases, none of the programs provided patients with legal assistance on everyday legal affairs.

Proposed National Ombudsman Program

Even though there are only a handful of ombudsman-type programs operating within the nation's mental health service delivery systems, the validity and need for such programs is clearly evident in the literature. State legislatures and departments of mental health have not addressed the issue of "right to legal counsel" on matters other than admission and commitment procedures. Institutionalized persons may, however, receive such services from federally funded programs. United States Representative Florio (D-N.J.), in November, 1975, introduced a bill into the United States House of Representatives which
would provide for "mental health advocacy services." The bill, entitled "National Mental Health and Disability Advocacy Services Act of 1975 (H.R. 10827)", would require states receiving federal assistance under the Community Mental Health Centers Act, to establish and maintain advocacy services in all state psychiatric facilities. Specifically, ombudsman programs, with attorneys as ombudspersons, would provide legal counsel for all institutionalized persons requiring such service. The programs are primarily directed toward legal issues relating to admission, commitment, treatment, and discharge issues. However, Section II.C. of the bill states that it shall be the policy of Congress that any person who is a client of a state psychiatric facility and alleges that he has been deprived of ". . . any constitutional, civil, or statutory right, including but not limited to, right to treatment . . ." (Florio, 1976, p. 1), shall be provided with free legal counsel.

The Florio bill emphasizes the need for an ombudsman system to help solve patients' problems which require counseling advice or aid, but not necessarily litigation. Florio reports that ". . . such representation (legal counsel), ombudsperson and advocacy services are not now being adequately developed, and as a result substantial federal constitutional and other rights are being denied to clients of mental health systems" (p. 2). Florio proposed the establishment of a politically independent
federal ombudsman agency which could best serve the policy of the Act by working closely with the National Institute of Mental Health. This agency would be called the Office of Mental Health and Disability Advocacy Services and would function autonomously with respect to national program administration and funding. Florio estimated the cost of such a bill as approximately 70 million dollars. Currently, the bill is pending action in the United States House of Representatives.

Synopsis

Historically, institutionalized mental patients have not been afforded legal services within the framework of mental health service delivery systems. Numerous authorities have contended that mental patients particularly need assistance with everyday legal problems, and that lack of such assistance exacerbates patients' psychiatric conditions (Ennis, 1973; Szasz, 1973; Gottesfeld, 1974). Many states have developed patients' rights or patient advocacy programs, and most states provide patients with free attorney services during commitment procedures. No state, however, provides mental patients with routine legal services. The ombudsman model has been successfully adapted to several human services areas and is the basis for a federal program currently being considered in the
The proposed bill (Florio, 1975) would provide patients in all United States psychiatric facilities with access to free legal counsel within the context of an ombudsman program.
CHAPTER III

OPERATION AND STRUCTURE OF THE KALAMAZOO
STATE HOSPITAL OMBUDSMAN PROGRAM

The Kalamazoo State Hospital Ombudsman Program is the only program in the nation that provides institutionalized mental patients with routine (everyday) legal services within the context of the service delivery system. In this chapter, the program is described in terms of its rationale relative to Michigan mental health statutes, current mental health services, and patients' needs. The program objectives are stated as delineated in the original 314(d) grant. Also included in this chapter is a description of program staffing, the role and function of the Kalamazoo State Hospital Ombudsman, the client population served by the ombudsman, the program budget, and the development and utilization of program record keeping procedures.

Program Rationale

In October, 1974, an experimental ombudsman program was established at Kalamazoo State Hospital, a state institution for the mentally ill. The purpose of the program was to provide Kalamazoo State Hospital residents with free legal services in two areas: (1) everyday legal problems, which include divorce
actions being filed for or against patients, termination of parental
dependent rights under the Juvenile Court Code, property settlements under
civil judgments of divorce (which include the legal questions of custody,
visititation, support, etc.), pending civil or criminal actions, real
and personal property matters, inheritance problems, guardianship
issues, and others; and (2) legal problems associated with patients'
rights or civil admission and discharge procedures as established
in the Michigan Mental Health Code (Michigan Department of
Mental Health, 1976). These include discretionary hospital staff
actions relative to granting or withholding of privileges, removal
of legal obstacles relative to community placement, independent
medical examinations, explanations of hearings procedures, and
others. The emphasis of the Kalamazoo program was intended
to be in the area of assistance with everyday legal problems.
The project was based on the premise that residents of state
mental institutions did not receive needed services in the area of
everyday legal problems: (1) after they had been committed, or
(2) after they signed themselves into such hospitals as voluntary
admissions.

Humble (1974) stated that most everyday legal problems
faced by the mental patient are instituted after his admission to
a hospital, and listed five reasons for the current unavailability
of legal services to institutionalized persons in Michigan:

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1. Lack of financial resources of the mental patient to hire legal counsel (present in nearly every case in a state institution).

2. Lack of access to legal services due to confinement or hospitalization.

3. The mental condition of the patient which may prevent knowledge of pending legal problems.

4. The erroneous assumption that the Attorney General represents persons who are confined to state institutions, either voluntary or involuntary. The role of the Attorney General is to represent the Department of Revenue in seeking reimbursement from the patient, for his care and maintenance during hospitalization.

5. State statutes do not provide for legal services after commitment or admission to a state institution (regardless of voluntary or involuntary status). Exceptions may be in cases where a patient has been charged with a crime prior to his admission, and the pending criminal proceeding is dependent upon the outcome of his hospitalization (p. 3).

Ennis' (1973) statement that very few patients or prospective patients can afford lawyers, and that the real issue at present is whether or not states will provide them with free lawyers, supports the rationale for the Kalamazoo State Hospital program. While concerned with legal representation relative to commitment, Ennis acknowledges that mental patients often have everyday legal problems that persist long after they are hospitalized. Ennis states that the issue of free lawyers will eventually be resolved through litigation.
The Ombudsman Commission of the American Bar Association, in its Development Report (1974), spotlights the lack of post-admission legal counsel for hospitalized mental patients and notes that, "... there are no programs that offer legal services to mental patients" (p. 12). An extensive survey of state mental health service delivery systems revealed that several states (Maryland, Michigan, Minnesota, and West Virginia) have set up legal services within the mental hospitals to assist patients with respect to commitment and discharge procedures and patients' rights, but that "... no state has provided lawyers to handle the day-to-day legal problems of hospitalized patients" (Ennis, 1973, p. 42).

In Michigan, involuntary patients are provided with court appointed attorneys to represent them at Probate Court hearings. Section 454 of the Michigan Mental Health Code (Michigan Department of Mental Health, 1976) states that: "Every individual who is the subject of a petition is entitled to be represented by counsel," that the court will appoint such counsel within 24 or 48 hours; and that "If the subject of a petition is indigent, the court shall compensate appointed counsel from court funds in an amount which is reasonable and based upon time and expenses" (p. 22). The services of these court appointed attorneys are available only to involuntary patients and are limited to commitment or
discharge matters. No free legal services are provided to any
patient for everyday legal problems.

The Michigan Mental Health Code is a consolidation and
revision of all previous Michigan mental health statutes. The
Code is comprised of 11 chapters. Chapter 1 established policies
and procedures of the Department of Mental Health. Chapter 2
deals with community mental health programs. Chapter 3 is
conscened with state and county financial responsibility. Chapter
4 outlines civil admission and discharge procedures in institutions
for the mentally ill. Chapter 5 delineates civil admission and dis-
charge procedures in institutions for the mentally retarded.
Chapter 6 specifies policies regarding guardianship for the mentally
retarded. Chapter 7 defines the rights of recipients of mental
health services. Chapter 8 provides policies for determination of
financial liability for mental health services. Chapter 9 contains
miscellaneous provisions. Chapter 10 contains criminal provisions.
Chapter 11 consists of a Saving Clause, effective dates of sections
and chapters, redetermination of actions under repealed provi-
sions, and a list of repealed acts.

Pursuant to Chapter 7 (Rights of Recipients of Mental
Health Services), the Department of Mental Health has established
an Office of Recipients Rights (ORR) Department. Chapter 7
establishes what are commonly referred to as "patients' rights"
and includes such issues as confidentiality, freedom of movement, chemotherapy, physical restraint, privileged communication, quality of the institutional environment, treatment, and protection from abuses. The powers and duties of the ORR are stated as:

Section 754. The department, each county community mental health program, and any facility operated by a political subdivision of the state separate from a county community mental health program shall establish an office subordinate only to the chief official of the agency establishing it. The office shall receive reports of and may investigate apparent violations of the rights guaranteed by this chapter, may act to resolve disputes relating to apparent violations, may act on behalf of recipients of mental health services to obtain remedy for any apparent violations, and shall otherwise endeavor to safeguard the rights guaranteed by this chapter (p. 47).

The ORR Department staffs each institution with one non-attorney Rights Advisor, who is responsible for informing recipients of their rights, receiving reports of alleged rights violations, bringing the problems to the attention of the agency administration, suggesting possible resolutions, and referring problems to attorneys for legal action when necessary. The ORR director stated that attorneys should be used for commitment and release questions; for the resolutions of general legal problems which affect any indigent population, such as welfare benefits, consumer fraud, and domestic relations; and for the redress of the serious legal grievances of institutionalized persons when efforts short of litigation are unsuccessful (Coye, 1976). Coye
distinguishes between the ORR program which deals solely with "right to treatment" issues, and the need for legal counsel in such areas as domestic relations. It should be noted that ORR functions are those of an administrative nature, dealing with areas of concern regarding the impact of institutions on residents. The ORR Department does not afford residents with access to counsel relative to everyday legal problems.

Responding to the assumption that legal services programs for mental patients may not be necessary due to availability of legal aid bureaus, Humble (1974) reports that they do not meet patients' needs. He states that of the 11 counties served by Kalamazoo State Hospital, six have legal aid bureaus, "... none of which represent the mentally ill after admission ..." (p. 4). He further states that prior to the implementation of the new Michigan Mental Health Code, "... the role of the legal aid bureau ... was that of representing the petitioner, who was attempting to have a person committed to Kalamazoo State Hospital as a 'mentally ill person'" (p. 4). Humble also states that this duty has now been assumed by the Prosecutor's Office, and that, "... legal aid is no longer involved in mental health proceedings in this catchment area" (p. 4).
Program Objectives

The objectives of the Kalamazoo State Hospital Ombudsman Program were stated as:

1. To render free legal services to Kalamazoo State Hospital residents, with emphasis in the area of everyday legal problems as opposed to problems related to commitment and release.

2. To function as part of the Kalamazoo State Hospital service delivery system as opposed to promoting radical systems change.

3. To advocate Kalamazoo State Hospital policies which will make the hospital more responsive to the needs of patients.

4. To reconcile the patient with his community and family by removing those obstacles which are of a legal nature that prevent such reconciliation.

5. To produce a financial savings to the (Michigan) Department of Mental Health by facilitating timely releases (Humble, 1974, p. 3).

Program Operation

Staff: Role and Function

The Kalamazoo State Hospital Ombudsman Program staff, during the grant-funded period of program operation, consisted of one half-time ombudsman and one secretary who was shared by three other hospital staff members. The secretary was a typist-clerk who provided typing and phone-answering services.
for the ombudsman. The ombudsman was a licensed attorney with ten years of experience in representing mental patients as a probate court-appointed "Guardian Ad Litem." The ombudsman position was supported by grant funding on a four hour per day basis. To promote accessibility, the ombudsman's office was centrally located within the main section of the hospital's administration building. Although the ombudsman was physically located within the hospital, he was not subordinate to either the hospital administration or the Michigan Department of Mental Health. Similar to the classical model, this ombudsman was "appointed" by virtue of a Public Health Services 314(d) grant and owed no allegiance to political units. Inasmuch as the ombudsman was an attorney, client information was treated as privileged communication.

The Kalamazoo State Hospital Ombudsman functioned primarily as a provider of legal services for hospital patients. During the implementation phase of the program, the availability of these services was communicated by means of meetings with all ward staffs, such meetings being instigated and conducted by the ombudsman. The ombudsman explained the nature of the program, the types of services available, and the referral procedure to be used by the treatment team staff when they considered the ombudsman's services necessary. Ombudsman services were also described in a hospital pamphlet which was distributed to all
hospital patients at the time of the printing and to all subsequent new patients at the time of their admission. This information was also delivered verbally to new patients by a member of the admissions staff. Publicity by local media provided another facet of communication regarding the program and its services.

The ombudsman served as a "consultant" member of the executive administrative staff and occasionally attended weekly administrative staff meetings. In addition, the ombudsman maintained a close working relationship with local courts, judges, and legal aid societies within the hospital's 11 county catchment area (the counties of legal residence served by Kalamazoo State Hospital). In April, 1976, the ombudsman conducted a seminar for local probate judges, attorneys, and hospital staff psychiatrists, for the purpose of familiarizing these individuals with the ombudsman program.

The ombudsman received patients' requests for legal advice, complaints, and grievances by telephone, mail, and personal appointments. In some cases, clarification of policies sufficed to resolve problems over the telephone. Matters of substantive nature which were identified during telephone conversations were followed up by personal appointments. This was also true in the case of mailed requests and patients met personally with the ombudsman in his office. If a patient desired
an appointment with the ombudsman, but was confined to a locked ward, arrangements were made by the ward staff to escort the patient to the ombudsman's office, but not to participate in the interview.

The ombudsman resolved or attempted to resolve issues related to 'patients' rights,' by advising patients what they could expect from the hospital, describing their rights, ascertaining if violations of said rights occurred, notifying the hospital administration in instances involving alleged violations, and referring patients to appropriate hospital staff, or providing legal assistance relative to commitment or release. Matters involving everyday legal problems were resolved by mediation or direct legal action on the part of the ombudsman for the patient.

Program Budget

Funding for the ombudsman program was provided by a Public Health Services State Formula 314(d) grant (Michigan Department of Mental Health, grant #3-75, 1974), hereinafter referred to as "314(d) grant." The initial grant provided funding from October 1, 1974, through June 30, 1975, and was renewed for the fiscal year July 1, 1975, through June 30, 1976.

The ombudsman was treated as a contractual position and was funded in both instances on the basis of 50 percent of
time employed (20 hours per week, 52 weeks per year—prorated on initial grant). No allowances were made for fringe benefits or support (clerical) personnel, and the $26,090.00 total presented in Table 1, represents the total amount of money expended by the Department of Health, Education and Welfare in support of the program.

Kalamazoo State Hospital provided the ombudsman with office space, office equipment, utilities, and the quarter-time services of a clerk-typist.

Client Population

The ombudsman program was developed to serve Kalamazoo State Hospital patients. The period October 1, 1974, to June 30, 1976, represents the duration of the 314(d) grant and the period of program operation examined. The average hospital census during this time was approximately 760 patients, living on 13 distinct wards, within five treatments programs as identified by the Michigan Department of Mental Health. Those programs are described below.

Admissions and Intensive Treatment

The Admissions and Intensive Treatment program is designed to provide intensive psychiatric services for an
Table 1
Kalamazoo State Hospital Ombudsman Program Funding

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th>Initial 314(d) Grant Oct. 74 - June 75</th>
<th>Renewal 314(d) Grant July 75 - June 76</th>
<th>Total 314(d) Grant Oct. 74 - June 76</th>
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<td><strong>Budget Categories</strong></td>
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<td>Personnel Services</td>
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<td>0</td>
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<td>375.00</td>
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<td>$15,215.00</td>
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adult/geriatric population of short-term psychiatric, long-term psychiatric, and forensic patients. The primary objectives of this program are to diagnose and treat persons with psychiatric disorders, to restore them to an optimal level of functioning, and to return them to the community. The target population for this program is comprised of newly admitted or re-admitted patients, although individual patients from other hospital programs are occasionally transferred to the Admissions and Intensive Treatment program. Those patients who have not been released to the community or who have not received maximum therapeutic benefit within six weeks of having entered the Admissions and Intensive Treatment program are transferred to one of the continuing care programs, Extended Care or Extended Treatment.

The Admissions and Intensive Treatment program is divided into two male units (Admission Unit #3 and Admission Unit #4) and two female units (Admission Unit #1 and Admission Unit #2). Each unit accommodates a maximum of 30 patients, for a total maximum program capacity of 120 patients.

Extended Treatment

The Extended Treatment program is designed to provide continuing psychiatric services for an adult/geriatric population of short-term psychiatric and forensic patients. The primary
Objectives of this program are to treat persons with psychiatric disorders, restore them to an optimal level of functioning, and prepare them for release and discharge. These patients are candidates for discharge within 90 days of being transferred to the Extended Treatment program.

The Extended Treatment program is comprised of one female unit (E. W. Building, capacity 87) and one male unit (Noble Lodge, capacity 90).

Extended Care

The Extended Care program is designed to provide continuing psychiatric services for an adult/geriatric population of comfortable and regressed long-term psychiatric patients. The primary objectives of this program are to improve self-esteem and abilities necessary in making decisions for self-improvement.

The Extended Care program is comprised of four units: Holder Unit (Male, capacity 62), Morter Unit (Male, capacity 29), Palmer Unit (Female, capacity 50), and Northwest Unit 3rd and 4th floors (Male and Female, capacity 48 per floor = 96 total).

Medical-Surgical

The Medical-Surgical program is designed to provide medical treatment for chronic or acutely ill patients, or those with physical conditions requiring medical treatments.
The Medical-Surgical program is comprised of three units:

Men's Hospital (capacity 80), Women's Hospital (capacity 80), and
Acute Medical Building (capacity 44).

Children's Services

The Children's Services program is designed to provide
intensive psychiatric and educational services for children under
the age of 18.

The program is comprised of two male units (senior boys,
capacity 22; and junior boys, capacity 22), and one female unit
(capacity 22), all within the same building.

Program Records System

Patients established contact with the ombudsman in one of
three ways: (1) telephone inquiries, (2) mail inquiries, or (3)
personal inquiries (drop-ins). The ombudsman did not initiate
any patient contacts nor did hospital staff members initiate con-
tacts for a patient. In many cases, staff members on the units
referred patients to the ombudsman when requests were made for
assistance with legal problems. The patient could then either
telephone, write, or visit the ombudsman.

Many patients initially contacted the ombudsman with
problems that could be resolved by a simple explanation or direction.
In other instances, patients contacted the ombudsman in a behaviorally inappropriate fashion. These types of contacts were established predominantly by telephone. Due to time constraints on the part of the ombudsman and the lack of a full-time clerical assistant, these contacts were not recorded and were not reflected in the ombudsman's caseload. The ombudsman identified this practice as a screening procedure. If he decided the contact did not involve a legitimate request for legal advice or assistance, the patient was informed to discuss the situation with a member of the hospital staff.

Data were recorded on patients who survived the screening process and who were subsequently interviewed by the ombudsman. The following data were recorded:

a. name  
b. birthdate  
c. age  
d. sex  
e. ombudsman file #  
f. date (seen)  
g. KSH case #  
h. county of residence  
i. unit (current KSH)  
j. referral mode (by staff, self, or other)  
k. problem identification information
   1. domestic relations  
   2. real property  
   3. personal property  
   4. guardianship  
   5. creditors  
   6. criminal case  
   7. financial  
   8. juvenile court proceedings

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9. court proceedings (adult)  
10. placement  
11. in-hospital problems  
12. release  
1. problem synopsis  
m. problem resolutions

These data were recorded on a standardized five by eight card as illustrated in Figure 1. Data items (a) through (i) are indices used to describe the patient and are analogous to such statistics recorded in each patient's hospital clinical record. Item (j) indicates the method by which patients contacted the ombudsman. Data item (k) "problem identification information," is the coding system employed by the ombudsman to identify the types of legal services rendered. The problem categories are divided into two groups. The first group, items (k-1) through (k-9), pertains to everyday legal problems and is based on the standardized legal services categories established by the American and Michigan Bar Associations, and published in the Attorney's Desk Book (1970). In addition to describing the nature of legal services provided within specific categories, the Attorney's Desk Book lists suggested fees based on time and labor involved, novelty and difficulty of legal questions involved, legal skill required, and other factors such as the contingency or certainty of compensation. Descriptions of problem categories (k-1) through (k-9) are listed below.
### ADM/DIS INFORMATION

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<td>TYPE OF ADMISSION:</td>
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<td>(10) TRANSFER</td>
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<tr>
<td>(11) RE-ADM</td>
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<tr>
<td>(12) NEW ADM</td>
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<tr>
<td>(15) RET-CS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(17) RET-UL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROBLEM IDENTIFICATION INFORMATION

- (D) DOM REL
- (E) REAL PROP
- (F) PERS PROP
- (G) GRDNSHIP
- (H) CREDITORS
- (J) CRIM CASE
- (K) FINANCIAL
- (L) JUV COURT
- (M) CRT PROC
- (N) PLACEMENT
- (P) IN-HOSP

### PROBLEM SYNOPSIS:

### PROBLEM RESOLUTIONS:

- (S) NON-ACTION
- (T) REFERRED TO
- (U) NON-COURT
- (V) COURT PROCEEDING

### COMMENTS:

---

**FIGURE 1.** Data card used to record Ombudsman client information
Domestic Relations (k-1)

This category includes divorce, annulment, custody and support proceedings, matters involving visitation rights, and paternity actions. Attorney services in this category include preparation of complaints, negotiation of property settlements, visitations, drafting of documents, and representation in court proceedings.

Real Property (k-2)

This category includes real estate matters such as foreclosures, examination of abstracts, transfers of title, and drafting of real estate documents (deeds, land contracts, leases, mortgages, etc.). Attorney services in this category include conferences with realtors and bankers, examination and drafting of documents, and appearances at closings.

Personal Property (k-3)

This category includes loss of property through theft and deprivation of property by landlords. Attorney services in this category include negotiation and representation in court proceedings.
Guardianship Problems (k-4)

This category includes matters associated with excessive control (by guardians) over clients' property. Attorney services in this category include establishment of guardianship accounts, settlements of minors' and decedents' accident cases in probate court, and drafting of petitions and orders of settlement.

Creditor Problems (k-5)

This category includes bankruptcy, collections actions, and civil suits. Attorney services in this category include conferences with bankrupt, preparation of schedules, preparation and filing of petitions and objections, negotiations, and representation in court.

Criminal Matters (k-6)

This category includes felony, misdemeanor, and traffic violations. Attorney services in this category include conferences, investigations, drafting of documents, and representation in court.

Financial Matters (k-7)

This category includes inheritances and wills. Attorney services in this category include representation in probate court,
preparation and filing of estate income, federal estate and
Michigan inheritance tax returns, negotiations, and drafting of
documents.

**Juvenile Court Proceedings (k-8)**

This category includes felony, misdemeanor, and traffic violations, and termination of parental rights. Attorney services include representation in court, negotiations, and drafting of documents.

**Court Proceedings (Adult) (k-9)**

This category includes the special proceedings associated with the circuit court, such as jury trials, restorations of drivers licenses, habeas corpus, injunctions, mandamus, orders of superintending control, and quo warrants. Attorney services in this category include negotiations, representation in circuit court, and drafting of documents.

The second group of problem categories, items (k-10) through (k-12), pertains to legal problems associated with Chapter 4 (Civil Admission and Discharge Procedures: Mental Illness) and Chapter 7 (Rights of Recipients of Mental Health Services), of the Michigan Mental Health Code, and represents the secondary area of legal services provided by the ombudsman.
and identified in the program objectives. The three categories comprising this group, items (k-10) through (k-12), were developed by the ombudsman on the basis of his ten years experience in representing mental patients as a court appointed attorney in probate court, the pertinent statutes cited in the Michigan Mental Health Code, and standard legal services categories established in the Attorney's Desk Book (1970). Descriptions of problem categories (k-10) through (k-12) are listed below.

**Placement Matters (k-10)**

This category includes legal problems encountered in placement of hospitalized patients, such as competency issues, restoration of sanity, removal of guardianships when guardians inappropriately block placements, and removal of monetary claims by the state against the patient. Attorney services in this category include negotiations, drafting of documents, and representation in probate court. Legal services within this category are described in the Probate Court Proceedings category of the Attorney's Desk Book (Section 2.18, 1970), and are identified in Chapter 4 (Civil Admission and Discharge Procedures: Mental Illness) of the Michigan Mental Health Code (1974).
In-hospital Matters (k-11)

This category includes matters associated with alleged violations of "patients' rights," such as discretionary actions of hospital staff relative to granting or withholding of privileges, freedom of movement, privileged communications, physical or mental abuse, and others. Attorney services in this category include counseling, negotiations, and referrals to the hospital's Recipients' Rights Advisor. This category is based on Chapter 7 of the Michigan Mental Health Code, "Rights of Recipients of Mental Health Services."

Release from Kalamazoo State Hospital (k-12)

This category includes matters associated with release, such as questions regarding the quality of a patient's prior legal representation, compliance of probate court relative to development of alternative treatment orders, and various procedures related to probate court hearings. Attorney services in this category include negotiations, preparations of objections, drafting of documents, and representation in probate court. Legal services within this category are described in the Commitment Proceedings and Probate Court Proceedings sections of the Attorney's Desk Book (Section 2.17 and Section 2.18, 1970), and

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are identified in Chapter 4 (Civil Admission and Discharge Procedures: Mental Illness) of the Michigan Mental Health Code.

The legal services problem categories, items (k-1) through (k-12) are mutually exclusive. That is, each discrete legal problem and subsequent legal service rendered will be identified in only one problem category. Individual patient-clients, however, may request ombudsman assistance with more than one legal problem. In this situation, each discrete legal problem and subsequent legal service is identified and recorded in the appropriate problem category. The distinction is thus made between the ombudsman's client caseload and the legal services caseload. The client caseload is the total number of Kalamazoo State Hospital patients for whom legal services were rendered during the period October 1, 1974, to June 30, 1976. The legal services caseload is the total number of discrete legal services rendered by the ombudsman during the period October 1, 1974, to June 30, 1976. Legal services are those services identified in problem categories (k-1) through (k-12). This distinction between clients and actual number and type of services rendered, is consistent with law practice procedures and the fee structure utilized by attorneys (Michigan Bar Association, 1970). For attorneys who have only their time to sell, each discrete legal service is considered a single business transaction and is so charged.
Discrete legal problems are identified and described by the ombudsman in the problem synopsis (data item '1') section of the program data card. This synopsis facilitates summarization of data relative to specific legal services rendered.

Legal services outcomes are recorded in the problem resolutions (data item 'm') section of the program data card and are divided into four areas: (1) non-actions (case terminated by patient), (2) referrals, (3) non-court actions (negotiated settlements, etc.,) and (4) court proceedings.

With respect to legal services data, the overall procedure utilized by the ombudsman is to: (1) place a checkmark next to the appropriate legal problem category(s), (2) write a synopsis for each problem in each category checked, and (3) indicate the legal services outcome by checking the appropriate problem resolution and briefly describe the nature of the outcome in the space provided (see Figure 1, page 50). An additional space is provided on the data card for comments.

Synopsis

In accordance with the state Mental Health Code, Michigan provides prospective patients with free legal counsel during commitment proceedings, and provides institutionalized patients...
with access to "Rights Advisors" who investigate any alleged patients' rights violations within state mental institutions.

The Kalamazoo State Hospital Ombudsman program was designed to provide institutionalized mental patients with free legal counsel relative to routine legal problems. No other program in the nation provides mental health recipients with such services within the service delivery system.

The Kalamazoo State Hospital Ombudsman program was staffed by one part-time attorney and one quarter-time secretary; and served the routine legal needs of patients within the five program areas of Kalamazoo State Hospital. The $26,090.00 in program funds were provided by a 314(d) grant over a period of 21 months, from October, 1974, through June, 1976. During this period, the ombudsman recorded various program data relative to the client caseload and the legal services caseload.
CHAPTER IV

EXAMINATION PROCESS OF THE KALAMAZOO
STATE HOSPITAL OMBUDSMAN PROGRAM

Examination of various aspects of the Kalamazoo State
Hospital Ombudsman program focuses on the duration of program
operation supported by Public Health Services 314(d) grant, State
of Michigan, funding—October 1, 1974, through June 30, 1976.
This period of time covers the program from its inception to its
termination as a grant supported experimental legal services
project. Program examination processes described in this
chapter include: (1) assessment of the degree of program effec-
tiveness relative to stated program objectives, (2) assessment of
comparative costs of ombudsman and private attorney services
and relative financial status of patients, and (3) comparison of
the Kalamazoo State Hospital Ombudsman program with the
classical ombudsman model.

Kalamazoo State Hospital Program Objectives

Objectives of the Kalamazoo State Hospital Ombudsman
program, as stated in the original 314(c) grant, are examined
in Chapter V. The examination process for each objective is
described below.
Program Objective #1

To render free legal services to Kalamazoo State Hospital residents, with emphasis in the area of everyday legal problems, as opposed to problems related to commitment and release (Humble, 1974, p. 3).

The definitions of "everyday legal problems" and "problems related to commitment and release" (Associated with Michigan Mental Health Code), are provided in Chapter III. This objective represents the primary thrust of the ombudsman program. The effectiveness of the program in achieving this objective is assessed in Chapter V by summarizing and describing ombudsman client and hospital population data, and legal services data.

Ombudsman client and hospital population data. The clinical records of all patients at Kalamazoo State Hospital contain information relative to date of birth (age), sex, date of admission, date of discharge, county of legal residence, and treatment program unit assignment within the hospital. These data are commonly used by hospital clinical administrators to characterize an individual patient or cumulatively, to characterize the entire patient population. External groups and organizations such as the Michigan Department of Mental Health, the Joint Commission
on Accreditation of Hospitals, and Medicaid, also rely on these standard descriptors in reference to the patient composition of a given facility. These data provide a basis for comparing the ombudsman's client caseload with the hospital population and assessing the representative nature of the ombudsman's caseload. These data also serve to identify groups within the hospital population which utilize ombudsman services and the extent to which these groups are represented in the caseload. These client data may describe trends relative to the type of patient most likely to utilize such services.

During the period October 1, 1974, to June 30, 1976, the ombudsman's Kalamazoo State Hospital client caseload was 261 individual patients. The ombudsman program-related data presented in Chapter V (Results and Discussion) are based on frequency measures of age, sex, county of legal residence, and treatment program unit assignment data which were recorded by the ombudsman on individual program data cards, an example of which is illustrated in Figure 1, page 50. Admission and discharge data were not recorded by the ombudsman for any of the 261 clients served during the October, 1974, to June, 1976, period. Length of stay (duration of hospitalization) data were instead obtained by referring to the admission and discharge lists maintained in the hospital's central records area and subtracting the admission
date from the discharge date of each patient. If the patient was still hospitalized, the admission date is subtracted from June 30, 1976. Frequency totals for the five variables comprising the ombudsman client caseload characteristics are presented as percentages and are compared to similar variables comprising the hospital population.

Kalamazoo State Hospital population data are generated by referring to the central records card files which contain age, sex, county of legal residence, treatment program unit, and length of stay data on each patient. Length of stay data are calculated for the hospital population in the same manner as for the ombudsman client caseload. All of the hospital population data are based on the inpatient census of the institution on May 30, 1976. On that date there were 760 patients in the hospital. The average hospital census for the six month period ending June 30, 1976, was 762.

Ombudsman legal services data. These data refer to the 12 legal problem categories described in Chapter III and represent legal services rendered with respect to problem categories. Ombudsman legal problem (services) data are assessed for the purpose of determining the quantity and types of legal problems encountered and served by the ombudsman, and identifying trends.
relative to legal problems most frequently incurred by hospitalized patients. This latter information is useful in projecting legal services "needs" of patients as discussed in Chapter VI.

Legal problems data are generated by summarizing the number of legal problems recorded on the "problem identification information" section of each client's program data card by problem category.

Problem resolutions, or outcome data, are divided into non-action, referrals, non-court, and court proceedings categories. Non-action refers to resolutions effected by legal advice. Referrals involve ombudsman-initiated referrals of patients to other legal sources or to non-legal sources such as the hospital's Rights Advisor. Non-court refers to resolutions effected by negotiations or preparation of documents. Court proceedings refer to resolutions effected by the ombudsman by representation of a patient in court (probate, circuit, etc.).

Outcomes data are generated by summarizing by problem category, the total number of non-action, referrals, non-court, and court proceedings resolutions as recorded on the program data cards by the ombudsman.

The legal problems and outcomes data comprise the ombudsman's legal services caseload. The legal services caseload is distinguished from the client caseload in that the legal

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services caseload represents the total number and type of legal problems (and outcomes) recorded by the ombudsman. The client caseload, on the other hand, represents the total number and type of clients served by the ombudsman. Each legal problem is treated as a discrete component of the legal services caseload and an individual client may utilize the ombudsman for more than one problem requiring legal assistance. Legal problem categories as described in Chapter III, are mutually exclusive; therefore, each problem is assigned to a single problem category for data analysis purposes. The total number of legal problems identified and recorded by the ombudsman for the duration of the 314(d) grant (October 1, 1974, through June 30, 1976) is 477.

Program Objective #2

To function as a part of the Kalamazoo State Hospital service delivery system, as opposed to promoting radical systems change (Humble, 1974, p.3).

This objective refers to the ombudsman's personal philosophy of enhancing the mental health system by extending the range and scope of services provided without becoming a detriment to the system by initiating individual or class actions suits whenever the system falters (Humble, 1974, p. 6-7). The stated intent of this objective is to philosophically distinguish between the Kalamazoo State Hospital Ombudsman program and other

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ombudsman or "patients' rights" programs based on the principle of advocacy. Humble (1974) describes programs which continually bring lawsuits against mental health systems as, "... hit and run programs" and states that such programs bring little benefit to patients on a day-to-day basis. Program objective number two represents an intent on the part of the ombudsman to establish legal services as a complementary component in the delivery system.

The measurability of this objective is subjective at best and treatment of this topic is deferred to Chapter VI, Conclusions and Recommendations.

**Program Objective #3**

To advocate Kalamazoo State Hospital policies which will make the hospital more responsible to the needs of patients (Humble, 1974, p 3).

This objective is assessed by identification and description of all patient-related policies which were adopted by the Kalamazoo State Hospital administration and in which the ombudsman provided input to the administration during the development of the policy. This also includes existing policies which were revised. This examination activity also includes a description of the specific input or influence on the part of the ombudsman.
Program Objective #4

To reconcile the patient with his community and family by removing those obstacles which are of a legal nature, that prevent such reconciliation (Humble, 1974, p. 3).

This objective refers to problem category (k-10), "Placement Matters," as described in Chapter III. Specifically, the relative effectiveness of the Kalamazoo State Hospital Ombudsman program in achieving this objective is measured by presentation and discussion of category (k-10) data. These data are generated by the ombudsman on individual program data cards. These data are assessed as a function of total placement problems and by number and type of placement problem resolutions (outcomes).

Program Objective #5

To produce a financial savings to the Department of Mental Health by facilitating timely releases (Humble, 1974, p. 3).

It is difficult to define and measure "timely releases." Ombudsman legal problem category (k-12) involves matters associated with release of patients from Kalamazoo State Hospital. The total number of patients whose releases were effected by the ombudsman are summarized from the program data cards.
Rather than expressing release data in terms of money thus saved, such data are projected in terms of savings that could be realized. This inference is derived by multiplying the number of ombudsman-effected releases by the per diem hospital rates (daily costs) and projecting these "prevented costs" on a daily, weekly, and monthly basis. There is no accurate method for assessing true savings to the Michigan Department of Mental Health based on ombudsman-effected releases. The primary reason being that it is impossible to state with certainty that these released patients would not have been released by the hospital, or at what later date such release would have occurred.

Comparative Costs of Legal Services and Relative Financial Status of Patients

In Chapter V, relative costs for the services provided by the ombudsman are compared to projected costs for the same services if provided by a private attorney. Cost comparisons are made on the basis of legal problems identified in the ombudsman problem category data, items k-1 through k-12 (see Chapter III for definitions). Ombudsman costs are determined by dividing the total personnel salary funds received from 314(d) sources as recorded in Table 1, page 44, by the total number of legal problems for which the ombudsman provided service. This results
in an average cost per legal problem. All cost data are computed for the period of ombudsman program operation which was supported by 314(d) funding. The average cost for private attorneys is determined by first dividing the total number of hours worked by the ombudsman during the grant supported period of program operation by the total number of legal problems serviced. The average time per problem figure is then multiplied by the standard minimum hourly rate established for private attorneys in the Attorney's Desk Book (Michigan Bar Association, 1970). This product is the average cost per problem for private attorneys which would be assessed against the patient-client. This figure is presented both for comparison with ombudsman costs and for the purpose of discussing the relative financial status of hospitalized patients; that is, their ability to pay for such services. It should be noted that the minimum hourly rates described in the Attorney's Desk Book are no longer legally in effect, as attorneys are allowed, as of 1976, to set their own fee schedules. At any rate, minimum fees were in effect during the 21 month grant period.

The assessment of the relative financial status of Kalamazoo State Hospital patients is based on a report prepared by the hospital's Patient Affairs Department. This report identifies segments of the hospital population as a function of
financial assets. Based on this information, inferences are made concerning the probable utilization of private attorney services based on the individual patient's ability to pay. These inferences provide the only means of assessing utilization by patients of private attorneys, as no records are kept at Kalamazoo State Hospital relative to such usage. It would be an extremely difficult task to canvass the private attorney population in the southwestern Michigan area regarding such information.

Comparison of Kalamazoo State Hospital Ombudsman and the Classical Model

One of the common issues discussed in the ombudsman literature is the role/function of the ombudsman in a given setting compared to that of the classical ombudsman. This examination includes a comparison of the Kalamazoo State Hospital Ombudsman with the classical model. The purpose, role, and function of the Kalamazoo State Hospital Ombudsman is described and compared to the purpose, role, and function of the classical ombudsman as presented in Chapter III. Similarities and differences between the Kalamazoo State Hospital Ombudsman and the classical model are described and discussed in Chapter V.
Synopsis

Examination of the Kalamazoo State Hospital Ombudsman program which occurs in Chapter V, involves assessment of data relevant to four of the five ombudsman program objectives, a comparison of ombudsman costs with projected costs for private attorneys, an assessment of the relative financial status of the Kalamazoo State Hospital patients, and a comparison of the Kalamazoo State Hospital Ombudsman with the classical ombudsman model. Data for this examination are obtained from ombudsman program data cards, hospital clinical records, the 314(d) budget, a hospital patient financial report, the Attorney's Desk Book, and classical ombudsman material described in Chapter II.
Chapter V
Results and Discussion

The format for presentation and discussion of Kalamazoo State Hospital Ombudsman Program data which occurs in this chapter is based on the examination process described in Chapter IV. Four of the five program objectives described in Chapter IV will be assessed by examining data relevant to the ombudsman client caseload, ombudsman legal services caseload, hospital population, and hospital policies. In addition, costs of ombudsman and private attorneys services are compared on the basis of 314(d) funding, projected minimum private legal fees, and information relative to the financial status of Kalamazoo State Hospital patients. The purpose, role characteristics, and function of the Kalamazoo State Hospital Ombudsman is examined by comparison with the purpose, role characteristics, and function of the classical ombudsman model as described in Chapter II.

Kalamazoo State Hospital Ombudsman Program Objective #1

To render free legal services to Kalamazoo State Hospital residents, with emphasis in the area of everyday legal problems, as opposed to problems related to commitment and release (Humble, 1974, p. 3).
Ombudsman Client Caseload and Hospital Population Data

*Age group data.* Four age group categories (10-25, 26-45, 46-65, and 66 years and over) were established for the ombudsman client caseload and the hospital population. The male, female and total percentage distributions for each age group are presented in Table 2. The hospital population distribution across the four age groups averaged 25 percent per category, as illustrated in Figure 2, page 74. The ombudsman client caseload, however, was concentrated primarily in the 26-46 age group (53.3 percent of total clients), with poor representation in the 66-over group (4.6 percent of total clients). Of the total number of ombudsman clients, 78.2 percent were concentrated in the two age groups between 10 and 45 years of age. In contrast to this high degree of representation, ombudsman clients from the 46-65 and 66-over group accounted for only 21.8 percent of the total client caseload. The ombudsman client caseload and hospital population distributions were relatively similar only for the 10-25 age group; the ombudsman client caseload distribution was 24.9 percent and the hospital population distribution was 20 percent. Chi-square tests indicated significant differences between the ombudsman client caseload and the hospital population distributions for males, \( \chi^2 (3) = 28.66, p = .000 \); females, \( \chi^2 (3) = 88.1, p = .000 \); total, \( \chi^2 (3) = 89.33, p = .000 \).
Table 2

Distribution of Kalamazoo State Hospital Population and Ombudsman Client Case-Load as a Function of Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ombudsman</td>
<td>Kalamazoo State</td>
<td>Ombudsman</td>
</tr>
<tr>
<td></td>
<td>Client</td>
<td>Hospital Population</td>
<td>Client</td>
</tr>
<tr>
<td>n = 144</td>
<td>n = 424</td>
<td>n = 117</td>
<td>n = 336</td>
</tr>
<tr>
<td>10 - 25</td>
<td>36.1</td>
<td>24.8</td>
<td>11.1</td>
</tr>
<tr>
<td>26 - 45</td>
<td>44.4</td>
<td>33.3</td>
<td>64.1</td>
</tr>
<tr>
<td>46 - 65</td>
<td>13.9</td>
<td>24.5</td>
<td>21.4</td>
</tr>
<tr>
<td>66 - over</td>
<td>5.6</td>
<td>17.5</td>
<td>3.4</td>
</tr>
</tbody>
</table>
Figure 2. Comparison by age groups of ombudsman client caseload with Kalamazoo State Hospital population.
The age group data reflect a disproportionate utilization of ombudsman services by hospital patients in the 26-45 age group and very little utilization of services by patients in the 66 years-over group. These data may reflect the relative mobility and ability to communicate associated with certain age groups within a state mental institution. Ages have been correlated with hospital discharge rates (Linn, 1970) which indicate that patients 56 years of age or older, are more likely to be "institutionalized." Institutionalized patients are individuals who have adapted to the institutional environment so well, that they have "lost" many of the social skills necessary to adequately verbalize personal needs, requests, etc. (Bentinck, Pokorny, & Miller, 1970). As the ombudsman program is essentially an "open door" program with the added dimension of staff referrals, it may be that patients in the 66-over age group are not benefiting to the fullest extent from legal services.

Length of stay data. Eight length of stay categories ranging from zero to three months to 16 years-over, were established for the ombudsman client caseload and hospital population distributions. The distribution of the hospital population was symmetrically bi-modal, with approximately 23 percent of the population distributed in the first category (0-3 months) and 22 percent in the last (16 years-over). The remainder of the population distribution

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across the middle categories averaged nine percent per category as illustrated in Figure 3, page 77.

The bulk of the ombudsman client caseload (61 percent) was distributed in the seven-twelve months and one-two years categories. The remaining clients (39 percent of the total caseload) were distributed among the other categories at the rate of 6.5 percent per category. Chi-square tests indicated significant differences between the ombudsman client caseload and the hospital population distributions for males, \( \chi^2 (7) = 143.82, p = .000 \); females, \( \chi^2 (7) = 245.19, p = .000 \); and total, \( \chi^2 (7) = 342.2, p = .000 \).

The ombudsman client caseload and hospital population distributions differed with respect to four length of stay categories. In the zero-three month category, the ombudsman distribution was 7.3 percent and the hospital distribution was 23.6 percent as presented in Table 3, page 78. The zero-three months category data would appear to present a paradoxical situation. Most patients falling into the zero-three months category receive treatment in one of the Admission and Intensive Treatment Program units, which are designed to be short-term (see the discussion in this chapter on program unit data). While 58 percent of the ombudsman client caseload came from one of these four short term (two-three months) units, only seven percent of the
Figure 3. Distribution comparison by length of stay of ombudsman client caseload with KSH population.
<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ombudsman</td>
<td>Kalamazoo State</td>
<td>Ombudsman</td>
</tr>
<tr>
<td></td>
<td>Client</td>
<td>Population</td>
<td>Client</td>
</tr>
<tr>
<td>n = 144</td>
<td>n = 424</td>
<td>n = 117</td>
<td>n = 336</td>
</tr>
<tr>
<td>0 - 3 months</td>
<td>8.3</td>
<td>24.5</td>
<td>5.9</td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>6.3</td>
<td>4.7</td>
<td>2.6</td>
</tr>
<tr>
<td>7 - 12 months</td>
<td>25.0</td>
<td>11.8</td>
<td>27.4</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>34.0</td>
<td>10.4</td>
<td>36.8</td>
</tr>
<tr>
<td>3 - 5 years</td>
<td>13.2</td>
<td>12.0</td>
<td>9.4</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>7.6</td>
<td>6.6</td>
<td>5.9</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>2.1</td>
<td>8.7</td>
<td>6.8</td>
</tr>
<tr>
<td>16+ years</td>
<td>3.5</td>
<td>21.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>
client caseload was represented in the zero-three months length of stay category, as compared to 23 percent of the hospital population being represented in that same category. This situation is probably due to the fact that the Admission and Intensive Treatment Programs produce the highest turnover in the hospital patient population, and many such patients may simply not be hospitalized long enough to avail themselves of ombudsman services, and/or patients in this category do not experience as many legal problems as do patients hospitalized for longer periods of time.

In the combined seven-twelve months and one-two years categories, the ombudsman distribution was 62 percent, compared to the hospital distribution of 23 percent. The reason for the disproportionately higher percent of ombudsman clients in these two length of stay categories, may be that patients in these categories are hospitalized long enough to experience legal problems and utilize ombudsman services, but not long enough to become "institutionalized." Hassall, Spencer, and Cross (1965) reported that patients hospitalized for two years or less were generally more capable of appropriate social interaction and more mobile than patients hospitalized for longer durations. As patients were essentially responsible for initiating contacts with the ombudsman or requesting assistance with such contacts, it may be that patients in the seven-twelve months and one-two
years categories represent the more "socially appropriate and mobile" segment of the hospital population.

In the 16-over years category, the ombudsman client caseload distribution was 4.2 percent and the hospital population was 22.1 percent. As Bentinck et al. (1970) observed, institutionalized persons have lost many of the social skills required to recognize their own needs and verbalize requests for assistance. Without doubt, patients hospitalized 16 years or more are, in fact, institutionalized and not capable of recognizing legal needs and initiating ombudsman contacts or requests for assistance. As the ombudsman program is not one of "patient solicitation," low representation in the 16-over years category appears to be due to the institutionalized composition of the patients within the category.

**County of legal residence data.** The 13 counties of the Kalamazoo State Hospital catchment area (region served) comprise the county of legal residence categories. The ombudsman client caseload and hospital population distribution were closely matched, as illustrated in Figure 4, page 81, and presented in Table 4, page 82.

No chi-square test was performed on this data as several of the categories (counties) had too small ns and there was no logical method for grouping categories (counties).
Figure 4. Comparison by catchment area county of legal residence, of ombudsman client caseload and KSH population distribution.
Table 4

Comparison by Catchment Area County of Legal Residence of Kalamazoo State Hospital Population and Ombudsman Client Caseload

<table>
<thead>
<tr>
<th>County</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegan</td>
<td>4.1</td>
<td>4.7</td>
<td>4.6</td>
</tr>
<tr>
<td>Barry</td>
<td>0</td>
<td>1.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Berrien</td>
<td>10.3</td>
<td>10.2</td>
<td>9.9</td>
</tr>
<tr>
<td>Branch</td>
<td>1.4</td>
<td>3.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Calhoun</td>
<td>6.2</td>
<td>9.2</td>
<td>9.5</td>
</tr>
<tr>
<td>Cass</td>
<td>0</td>
<td>1.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Eaton</td>
<td>0</td>
<td>.5</td>
<td>.8</td>
</tr>
<tr>
<td>Ingham</td>
<td>1.4</td>
<td>.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Kalamazoo</td>
<td>34.5</td>
<td>24.6</td>
<td>24.6</td>
</tr>
<tr>
<td>Kent</td>
<td>21.4</td>
<td>24.4</td>
<td>25.0</td>
</tr>
<tr>
<td>Ottawa</td>
<td>4.8</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>4.8</td>
<td>2.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Van Buren</td>
<td>7.6</td>
<td>5.2</td>
<td>4.9</td>
</tr>
<tr>
<td>Other</td>
<td>3.5</td>
<td>4.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>
Sex data. The ombudsman client caseload distribution by sex was 55 percent male and 45 percent female, as compared with the hospital population distribution of 56 percent male and 44 percent female (see Table 5, page 84). A chi-square test indicated no significant difference between the ombudsman client caseload and hospital population distributions, $\chi^2 (1) = .06, p = .806$.

Patient unit data. The Kalamazoo State Hospital patient wards are divided into five treatment programs (see Chapter III). The bulk of the ombudsman client caseload distribution (57.9 percent) was represented in the Admissions and Intensive Treatment Program category, and the lowest percentage of clients from the Medical/Surgical and Children's Services Programs, as illustrated in Figure 5, page 85. The hospital population distribution averaged 25 percent across the four adult program categories, whereas the Children's Services Program comprised only 6.7 percent of the total distribution. A chi-square test indicated a significant difference between the ombudsman client caseload and hospital population distributions, $\chi^2 (4) = 456.05, p = .000$.

The ombudsman client caseload distribution was similar to the hospital population distribution in Extended Treatment (ombudsman 16.2 percent; hospital 23.6 percent) and Children's Services (ombudsman 5.4 percent; hospital 6.7 percent) program categories (see Table 6, page 84). In the Admissions and
### Table 5

Comparison by Sex of Kalamazoo State Hospital Population and Ombudsman Client Caseload

<table>
<thead>
<tr>
<th>Sex</th>
<th>Kalamazoo State Hospital Population - n = 760</th>
<th>Ombudsman Client Caseload - n = 261</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>55.8</td>
<td>55.1</td>
</tr>
<tr>
<td>Female</td>
<td>44.2</td>
<td>44.8</td>
</tr>
</tbody>
</table>

### Table 6

Distribution of Kalamazoo State Hospital Population and Ombudsman Client Caseload as a Function of Program Unit

<table>
<thead>
<tr>
<th>Program</th>
<th>Unit</th>
<th>Kalamazoo State Hospital Population n = 760</th>
<th>Ombudsman Client n = 261</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>AU1</td>
<td>3.7</td>
<td>13.4</td>
</tr>
<tr>
<td>&amp; Intensive</td>
<td>AU2</td>
<td>3.6</td>
<td>14.6</td>
</tr>
<tr>
<td>Treatment</td>
<td>AU3</td>
<td>3.7</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td>AU4</td>
<td>3.7</td>
<td>21.1</td>
</tr>
<tr>
<td>Extended</td>
<td>NL</td>
<td>12.3</td>
<td>8.1</td>
</tr>
<tr>
<td>Treatment</td>
<td>EWB</td>
<td>11.3</td>
<td>8.1</td>
</tr>
<tr>
<td>Extended</td>
<td>HOL</td>
<td>8.6</td>
<td>3.8</td>
</tr>
<tr>
<td>Care</td>
<td>MOR</td>
<td>4.2</td>
<td>5.4</td>
</tr>
<tr>
<td></td>
<td>PAL</td>
<td>6.7</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>NWU</td>
<td>13.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Medical/</td>
<td>MH</td>
<td>12.5</td>
<td>2.3</td>
</tr>
<tr>
<td>Surgical</td>
<td>WH</td>
<td>11.5</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td>AMB</td>
<td>4.3</td>
<td>4.4</td>
</tr>
<tr>
<td>Children's</td>
<td>CU</td>
<td>6.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 5. Comparison by program type of ombudsman client caseload and KSH population distributions.
Intensive Treatment program category, the ombudsman distribution was 67.9 percent, compared to the hospital distribution of 14.7 percent. There are two possible reasons for this difference.

First, the Admissions and Intensive Treatment units are physically located in closer proximity to the ombudsman's office than any other hospital units, thus providing somewhat easier accessibility. Second, patients from these units are less likely to be characterized as "institutionalized" as are patients from continued treatment areas (Extended Care, Extended Treatment). This is primarily due to the fact that patients in these admission units have not been in the hospital long, as the units are designed as entry units. All newly admitted patients are assigned to one of the Admissions and Intensive Treatment units. Hassall et al. (1965) described the debilitating effects of institutionalization relative to social skills and ability to request assistance with problems. This is relevant to the ombudsman caseload analysis, in that ombudsman clients must necessarily be capable of recognizing their legal services needs, requesting such services, or requesting assistance in procuring assistance (staff referral); residents on Admission and Intensive Treatment units are more likely to have such skills and abilities in their repertoires than are patients in long term treatment units.
In the Extended Care program category the ombudsman client caseload distribution was 17.6 percent, compared to the hospital distribution of 33.4 percent. This difference is probably due to the nature of the resident composition of units in this program category. These units comprise what are traditionally referred to as the Continuing Treatment wards. That is, individuals on these wards are regressed long-term psychiatric residents (see Chapter II). The "institutionalization" effect mentioned in the preceding paragraph applies most appropriately to patients in the Extended Care program, and may explain the proportionately lower participation of such patients in the ombudsman program.

The last distribution difference is found in the Medical/Surgical program category. The ombudsman client caseload distribution was 3.1 percent, compared to the hospital population distribution of 35 percent. These disparate percentages most likely reflect physical condition as the primary reason for low-rate participation by residents in the ombudsman program.

Ombudsman Legal Services Caseload Data

Legal problem categories data. Of the 12 categories, legal problems associated with Domestic Relations (14.9 percent) and Release (14.9 percent) accounted for approximately 30 percent.
of the ombudsman's legal service caseload, as presented in Table 7, page 89. An additional 35 percent of the legal service caseload was distributed across the Placement, Financial, and Court Proceedings (Adult) categories. The remainder of the legal services caseload was generally divided among the other seven categories (Guardianship, Criminal Cases, Personal Property, In-Hospital, Real Property, Creditors, and Juvenile Court).

An interesting feature of this data is the comparison between the problem categories which comprise the two areas of legal services identified in Chapter III. Everyday legal problems are represented by the Domestic Relations, Real Property, Personal Property, Guardianship, Creditors, Criminal Cases, Financial, Juvenile Court, and Court Proceedings (Adult) categories, and comprise 68.2 percent of the ombudsman's legal services caseload. The remaining 31.8 percent represent the legal problems associated with commitment and release (the Placement, In-Hospital, and Release legal problem categories).

In addition to accounting for almost one-third of the ombudsman's legal services caseload, two of the three problem categories (Release and Placement) making up the group of legal problems associated with commitment and release, ranked second and third respectively in the total distribution order (see Table 7).
Table 7

Ombudsman Client Caseload Distribution By Legal Problem Category

<table>
<thead>
<tr>
<th>Problem Category</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Relations</td>
<td>71</td>
<td>14.9</td>
</tr>
<tr>
<td>Release</td>
<td>71</td>
<td>14.9</td>
</tr>
<tr>
<td>Placement</td>
<td>57</td>
<td>11.9</td>
</tr>
<tr>
<td>Financial</td>
<td>56</td>
<td>11.8</td>
</tr>
<tr>
<td>Court (Adult)</td>
<td>51</td>
<td>10.6</td>
</tr>
<tr>
<td>Guardianship</td>
<td>44</td>
<td>9.3</td>
</tr>
<tr>
<td>Criminal Cases</td>
<td>37</td>
<td>7.7</td>
</tr>
<tr>
<td>Personal Property</td>
<td>28</td>
<td>5.9</td>
</tr>
<tr>
<td>In-Hospital</td>
<td>24</td>
<td>5.0</td>
</tr>
<tr>
<td>Real Property</td>
<td>16</td>
<td>3.3</td>
</tr>
<tr>
<td>Creditors</td>
<td>14</td>
<td>3.0</td>
</tr>
<tr>
<td>Juvenile Court</td>
<td>8</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Outcomes data. Almost half (48.9 percent) of the ombudsman's legal problem outcomes occurred in the Non-Court category (see Table 8, page 91). Court Proceedings and Referrals accounted for 23.2 percent and 20.5 percent respectively, of the outcomes distribution. The fewest outcomes, 7.3 percent of the total distribution, were in the form of Non-Action resolutions. These data indicate that the ombudsman actively intervened or provided direct legal services, in approximately 80 percent of the cases. However, even though Referrals (20.5 percent) may not be considered direct legal service, the ombudsman's time must still be expended in listening to the problem situation and making the decision to refer.

There were no problem categories for which more than one-quarter of the outcomes were Non-Action type (see Table 9, page 91). With the exception of the Domestic Relations problem category (23 percent), most of the problem categories produced fewer than 13 percent of Non-Action outcomes.

Criminal Cases and In-Hospital legal problem categories resulted in 100 percent Referral outcomes. In the case of In-Hospital problems, all referrals were made to the hospital's Rights Advisor. Referrals accounted for 32 percent of Domestic Relations legal problems resolutions but for the remaining problem categories, Referrals were eight percent or less.
Table 8

Distribution of Ombudsman's Legal Services Caseload as a Function of Outcomes

<table>
<thead>
<tr>
<th>Outcome Category</th>
<th># of Outcomes</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Action</td>
<td>35</td>
<td>7.3</td>
</tr>
<tr>
<td>Referral</td>
<td>98</td>
<td>20.5</td>
</tr>
<tr>
<td>Non-Court</td>
<td>234</td>
<td>48.9</td>
</tr>
<tr>
<td>Court Proceedings</td>
<td>111</td>
<td>23.2</td>
</tr>
</tbody>
</table>

Table 9

Distribution of Ombudsman Legal Problem Outcomes by Problem Category

<table>
<thead>
<tr>
<th>Problem Category</th>
<th>Distribution by Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Action</td>
</tr>
<tr>
<td>Domestic Relations</td>
<td>71</td>
</tr>
<tr>
<td>Real Property</td>
<td>16</td>
</tr>
<tr>
<td>Personal Property</td>
<td>28</td>
</tr>
<tr>
<td>Guardianship</td>
<td>44</td>
</tr>
<tr>
<td>Creditors</td>
<td>14</td>
</tr>
<tr>
<td>Criminal Cases</td>
<td>37</td>
</tr>
<tr>
<td>Financial</td>
<td>56</td>
</tr>
<tr>
<td>Court Proceedings</td>
<td>51</td>
</tr>
<tr>
<td>Placement</td>
<td>59</td>
</tr>
<tr>
<td>In-Hospital</td>
<td>24</td>
</tr>
<tr>
<td>Release</td>
<td>71</td>
</tr>
</tbody>
</table>

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Non-Court outcomes clearly comprised the bulk of the outcomes distribution. Real Property, Personal Property, Guardianship, Creditors, Financial, Placement, and Release problems were resolved by Non-Court actions on the average of 81 percent of the time. The remaining four problem categories reflected a total of zero (0) Non-Court outcomes.

Court proceedings outcomes occurred 100 percent of the time for the Court Proceedings (Adult) category of legal problems. The only other problem categories which were resolved by court proceedings more than two percent of the time were Domestic Relations (45 percent) and Guardianship (38 percent).

As reflected in the data in Tables 8 and 9, page 91, the ombudsman resolved most cases by either Non-Court or Court Proceedings actions. Very little of the ombudsman's time was taken up by simply giving out legal advice.

Kalamazoo State Hospital Objective
Program Objective #3

To advocate Kalamazoo State Hospital policies which will make the hospital more responsive to the needs of patients (Humble, 1974, p. 3).

Advocacy of Hospital Policies

During the period of grant supported program operations, the ombudsman frequently (one of two times per month) attended
the weekly administrative staff conferences for the purpose of providing the hospital administration with input relative to the ombudsman program. During these sessions the ombudsman advocated adoption or revision of patient-related hospital policies based on problems being experienced by patients which were communicated to the ombudsman. Although In-Hospital problems (patients' complaints) were referred to the hospital's Patients' Rights Advisor, the ombudsman advocated policy changes that would prevent or eliminate such problems. Ombudsman "advocacy" actions consisted of familiarizing the administrative staff with the nature of the patients' problems and advising the staff of flaws or deficiencies in hospital policies as they related to the patients' problems.

In two instances, existing policies were revised incorporating ombudsman suggestions. In the first situation, the ombudsman suggested that the hospital's placement policy be revised to indicate individual responsibilities of various staff members relative to the placement process, as patients' complained about getting the "run around" when questioning staff concerning placement.

Kalamazoo State Hospital policy number seven, "Adult Placement Plan Under S. S. I" was revised December 7, 1976, and designated individual staff responsibilities in the placement process.

In the second situation, patients complained to the ombudsman
that they were not adequately informed concerning their individualized plan of treatment. The ombudsman verbally communicated this information to the administrative staff and suggested that the hospital policy regarding individualized treatment plans be revised to include involvement of the patient in the formulation of the plan, or notification of the nature of the plan. Kalamazoo State Hospital policy number 37, "Individualized Treatment Plan," was revised January 8, 1976, to include provisions for patient involvement in the treatment plan formulation process.

Kalamazoo State Hospital Ombudsman Program Objective #4

To reconcile the patient with the community and family by removing those obstacles which are of a legal nature, that prevent such reconciliation (Humble, 1974, p. 3).

Placement Outcomes

There were 59 cases involving legal problems associated with Placement, or 12.4 percent of the total legal services case-load. Of the 59 placement problems, 96 percent were resolved by Non-Court activities, and the remaining four percent were resolved by means of Court Proceedings. These data imply that the ombudsman was almost totally successful in effectuating Placement resolutions by means of negotiations, rather than litigation in court.

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Kalamazoo State Hospital Ombudsman
Program Objective #5

To produce a financial savings to the (Michigan) Department of Mental Health by facilitating timely releases (Humble, 1974, p. 3).

Release Data

During the period of grant funded program operation, the ombudsman directly effected the release of 71 patients. These services were the result of patients' requests for assistance with legal problems associated with commitment or release, and were recorded in the Release category of the ombudsman's legal services caseload.

Cost-benefit. Although it was not possible to determine the amount of financial savings to the Michigan Department of Mental Health which may have accrued as a result of these releases, "projected" savings were computed on the basis of daily hospital costs. The per diem rate for all hospitalized patients during the October, 1974, to June, 1976, period, was $62.80 per day. At this rate, the 71 patients who were discharged would have cost the hospital $31,211.60 for each week, or $124,846.40 for each month they remained hospitalized. On an

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individual basis, the costs for each additional week are $439.60, and month, $1,758.40. The assumption that discharged patients will be replaced by new patients does not invalidate the real savings incurred by the state when patients are discharged. First of all, there is no guarantee that patients will continue to be admitted at a constant rate. The hospital census has decreased from an average of 1,100 in fiscal year 70-71, to the average of 760 during the grant funded period. Second, there is an increased probability that patients who are discharged may resume some degree of work productivity, thus eliminating some of the drain on the state's human services funds and putting some monies back into the system by way of income taxes and spending.

Comparative Costs of Legal Services and Relative Financial Status of Patients

The ombudsman's average cost per legal problem served was $53.12, compared to an average cost per legal problem of $133.98 for a private attorney.

The ombudsman's cost per problem ($53.12) was determined by dividing the total ombudsman salary from the 314(d) grant ($25,340) by the total number of legal problems serviced (477). The private attorney's average cost per problem ($133.98) was determined by: (a) calculating the number of days between
October 1, 1974 and June 30, 1976 (639 days); (b) dividing total days by seven to determine the number of weeks (91.3 weeks); (c) multiplying weeks by 20 hours per week to determine total hours worked (1,826 hours); (d) computing the average time per legal problem by dividing total hours by the 477 total legal problems (3.83 hours per problem); and (e) establishing the average cost per legal problem by multiplying the 3.83 average hours per problem by the $35.00 per hour average minimum rate for private attorneys, as suggested in the Attorney's Desk Book fee schedule (Michigan Bar Association, 1970).

The projected average cost for a private attorney is two and one-half times that of the ombudsman. Based on the ombudsman's client caseload of 261 patients, total costs for services provided by the ombudsman averages $97.00 per client. If services had been provided by a private attorney, the average cost per client would have been $245.00. The latter figure is based on the total ombudsman hours (1,826) multiplied by the average minimum (private attorney) rate of $35.00 per hour, and this total ($63,910.00) divided by the 261 ombudsman clients. Ombudsman costs were not charged to client patients. However, private attorney charges of the average magnitude described previously would prove too expensive for most patients at Kalamazoo State Hospital.
The Kalamazoo State Hospital Patient Affairs Department prepared a report which described the financial condition of patients hospitalized during fiscal year 1974-75 (Dunleavy, 1975). Based on an average census of 800 patients, only two percent (16 patients) were identified as having adequate financial resources to pay the full $62.80 per diem charge for their treatment at Kalamazoo State Hospital (see Table 10, page 99). Actual per diem charges ranged from zero to $62.80 and were based on a sliding ability-to-pay scale. Ability to pay was determined by calculating the individual patient's net worth on DMH form 2451, and his financial liability for resident care (daily costs = $62.80) on DMH form 2452. Net worth was determined by subtracting the patient's total liabilities from total assets. The hospital then could charge the patient up to 50 percent of this net worth figure for resident care, based on a maximum yearly charge of $22,922. Daily (per diem) charges were then established by prorating the percent of $22,922 which could be charged that would not exceed 50 percent of the individual's net worth.

The report indicated that 58 percent of the total hospital patient population were financially capable of paying only 25 percent of their care. The majority of patients in this group received only Social Security as income.

These patient financial data strongly suggest that the
Table 10

Distribution of KSH Per Diem Costs as a Function of Percentage Paid by Patients, Based on 800 Patients and $62.80 Per Diem Costs

<table>
<thead>
<tr>
<th>Number of Patients</th>
<th>Percent of Total Population</th>
<th>Percent of KSH Costs Paid by Patients</th>
<th>Prorated KSH Cost per Day</th>
<th>Total Costs Incurred by KSH per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>25</td>
<td>0</td>
<td>$0</td>
<td>$12,560.00</td>
</tr>
<tr>
<td>264</td>
<td>33</td>
<td>25</td>
<td>15.70</td>
<td>12,434.40</td>
</tr>
<tr>
<td>320</td>
<td>40</td>
<td>50</td>
<td>31.40</td>
<td>10,048.00</td>
</tr>
<tr>
<td>16</td>
<td>02</td>
<td>100</td>
<td>62.80</td>
<td>0</td>
</tr>
</tbody>
</table>
majority of hospitalized patients are functionally indigent and are therefore unable to pay the costs of private attorneys.

Comparison of Kalamazoo State Hospital Ombudsman and the Classical Model

The Kalamazoo State Hospital (KSH) ombudsman was compared to the classical model as described in Chapter I, relative to purpose, role characteristics, and functions.

Purpose

The purpose of the classical ombudsman is to resolve grievances or problems encountered by individuals within a system and to correct malfunctions of the system.

The purpose of the Kalamazoo State Hospital Ombudsman is primarily to render free legal services to Kalamazoo State Hospital residents, and also to advocate hospital policies based on patients' needs and reconcile patients with community and family.

The purpose statement of the Kalamazoo State Hospital Ombudsman is compatible with that of the classical model. Rendering legal services may be considered the same as resolving problems encountered by individuals within a system, as Kalamazoo State Hospital patients certainly encounter legal problems while in the Kalamazoo State Hospital system. Advocacy

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of hospital policy, while not the primary purpose of the Kalamazoo State Hospital Ombudsman, is similar to correction of system malfunctions. In summary, although the purpose statement of the Kalamazoo State Hospital Ombudsman (program) is consistent with that of the classical ombudsman model, all individuals within the Kalamazoo State Hospital system are not served; that is, ombudsman clients are limited to patients.

Role Characteristics

The role characteristics of the Kalamazoo State Hospital Ombudsman are compared with the seven role characteristics of the classical ombudsman model.

Neutrality and impartiality. The classical ombudsman is politically neutral and impartial. The Kalamazoo State Hospital ombudsman is politically neutral but is not completely impartial regarding services rendered to patient-clients. As the nature of the Kalamazoo State Hospital program involves legal services, the KSH Ombudsman is necessarily an attorney for the individual client. At the same time, however, in matters involving patients' complaints about the hospital or treatment programs, the Ombudsman becomes "impartial" to the degree that he refers the patient to the hospital's Patients' Rights Advisor, and in

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some instances may follow-up the patient's complaint by bringing it to the attention of the hospital superintendent. This follow-up behavior occurs in the form of conversation with the superintendent or as a memo to the superintendent, and is not to be construed as an official feedback mechanism for identification of patients' complaints. The Patients' Rights Advisor fulfills this responsibility during the course of his duties.

**Independence.** The classical ombudsman is independent of any organization he might investigate. The KSH Ombudsman is independent of Kalamazoo State Hospital and the Michigan Department of Mental Health by virtue of a Public Health Services 314(d) grant.

**Expertise.** The classical ombudsman is an expert in his speciality field and is familiar with administrative principles. The KSH ombudsman is an expert in mental health law and is a (Michigan) licensed attorney.

**Status.** The classical ombudsman is appointed and highly placed (autonomously) within the organization, with access to individuals of power and influence. The KSH Ombudsman is not actually placed within the hierarchy of the Michigan Department of Mental Health or that of Kalamazoo State Hospital. Rather,
he is physically located in the hospital and enjoys accessibility to all KSH staff, but is not a member of the staff. This situation is both advantageous and disadvantageous. The advantage being that the KSH Ombudsman is not constrained in any way by any subtle effects of the organization, such as pressure to avoid bad publicity or protect the hospital against harmful criticism. On the other hand, the KSH Ombudsman must depend on his ability to elicit cooperation from hospital staff, as he has no official organizational support or endorsement for his program. The KSH Ombudsman does, however, have immediate access to hospital or Michigan Department of Mental Health officials.

**Accessibility.** The classical ombudsman is universally accessible to both individual citizens or clients and the administration of the organization. Ombudsman services are free. The Kalamazoo State Hospital Ombudsman is universally accessible to hospitalized patients and his services are free.

**Integrity.** The classical ombudsman commands a respect and guarantees confidentiality. The Kalamazoo State Hospital Ombudsman enjoys the respect of the hospital and department administrators and guarantees client confidentiality.
Functions

The functions of the Kalamazoo State Hospital Ombudsman are compared to those of the classical ombudsman model.

Investigation. The primary classical ombudsman function is receiving and investigating complaints of citizens, regardless of their position within the organizational system. The ombudsman is capable of initiating complaints independently if the situation warrants such action. The primary function of the KSH Ombudsman is provision of legal services for patients and not investigation of patients' complaints. In the case of patients' complaints, the KSH Ombudsman refers the patient to the Patients' Rights Advisor and is subsequently not directly involved in the complaint process.

Mediation. Mediation activities occupy a significant portion of the classical ombudsman's time and problems are frequently resolved at the mediation level. Many of the KSH Ombudsman's activities (nearly 50 percent) consist of mediation or negotiation. This negotiation activity, however, is related to the patients' legal problems, and in fact is a form of legal service. When providing legal service, the KSH Ombudsman is not acting as a neutral agent; rather, he is serving the patient-clients' interests.
This is in direct conflict with the implied neutrality of the classical ombudsman when involved in mediation.

**Documentation.** Within the context of a specific case, the classical ombudsman has access to all organization or agency information. The ombudsman also writes general program reports which become part of public record. By virtue of official appointment by an organization to a position of prominence within the organization, the classical ombudsman is allowed access to any or all organizational information relevant to his case. The KSH Ombudsman does not mediate patients' complaints, is not a "member of the organization" (Kalamazoo State Hospital or the Department of Mental Health), and is, therefore, not officially provided with access to hospital information. Information relevant to a specific legal problem, however, is usually made available to the ombudsman (by the hospital) on the basis of best serving the patients' interests. This information could include Placement Review Committee reports, Reimbursement Department judgments concerning a patient's costs for treatment and other material relevant to the case. Patients' hospital clinical records can be made available to the KSH Ombudsman if the individual patient signs a release of information form. There is no KSH
or Department of Mental Health policy which establishes access to organizational information for the KSH Ombudsman.

**Powers.** The classical ombudsman cannot reverse administrative decisions and does not have the authority to change or create policies, procedures, or laws. The classical ombudsman makes recommendations to the executive or administrative branches of organizations.

Relative to power, the functions of the KSH Ombudsman differ from those of the classical model. The classical ombudsman's powers are described in the context of a grievance handling mechanism which is not relevant to the service-based function of the KSH Ombudsman. The KSH Ombudsman, in the rendering of legal services, necessarily has the authority to initiate legal action on the behalf of a client which again is in sharp contrast to the neutral mediation of the classical ombudsman. It would appear that the KSH Ombudsman is not bound by the limitation of power ascribed by the classical ombudsman model; rather, the KSH Ombudsman may invoke the power of the legal system to effect resolution of a client's problem.

**Synopsis**

Examination of the KSH ombudsman program involved the assessment of four program objectives, a cost comparison of
ombudsman and private attorney services, and a comparison of purpose, role characteristics, and functions of the Kalamazoo State Hospital Ombudsman and the classical ombudsman model. It was found that the ombudsman client caseload differed significantly from that of the hospital population with respect to age group, length of stay, and program unit assignment. Ombudsman legal services caseload data indicated that Domestic Relations and Release problems accounted for approximately one-third of the caseload. Outcomes data reflected nearly half of all legal problems handled by the ombudsman as being resolved by Non-Court actions. Hospital financial data demonstrated the inability of most patients to pay for private legal counsel and ombudsman legal services were shown to be considerably less expensive than those of private attorneys. The KSH Ombudsman compared favorably with most elements of the purpose, role characteristics, and functions statements of the classical ombudsman model; but differed with respect to primary function, audience served, powers, absolute neutrality, and mediation.
CHAPTER VI
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Ombudsman Client Caseload

The obvious implication stated in program objective #1 (Chapter IV), is that the Kalamazoo State Hospital ombudsman program is being directed toward the entire hospital patient population. However, client caseload data discussed in Chapter IV indicate that the program is predominately delivering services to adults 26-45 years of age (53.3 percent of client caseload) who are hospitalized between seven months and two years (62 percent of client caseload) and who initiate requests for legal assistance when residing in one of the Admission and Intensive Program units (57.9 percent of client caseload).

Certain segments of the hospital's patient population receive little or no ombudsman services. These segments are characterized by patients who are over 66 years of age (4.6 percent of client caseload) who have been hospitalized for more than 16 years (4.2 percent of client caseload), and who reside in an Extended Care (17.6 percent of client caseload compared to

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33.4 percent of hospital population) or Medical/Surgical (3.1 percent of client caseload compared to 35 percent of hospital population) unit.

The reasons for the disparities between the composition of the hospital population and that of the ombudsman client caseload involve several factors. First of all, the ombudsman program is an "open door" program. That is, utilization of ombudsman services are available to any hospital patient but are contingent upon individual patients initiating requests for services (by mail, telephone, or personal visit) or being referred to the ombudsman by hospital staff. Even in the case of referral, it is the incumbent responsibility of the individual patient to initiate contact with the ombudsman after being referred there by staff. At no time does the ombudsman solicit cases from either individual patients or hospital staff (regarding potential patient-clients). Based on the client caseload data described in Chapter V and highlighted in the preceding chapters, it is clear that disparities in utilization of ombudsman services are probably due to inconsistency of staff referrals and the lack of a formal staff referral system (and education regarding ombudsman services). The rationale for this conclusion is that the segment of the hospital population receiving the fewest ombudsman services is characterized as old, physically ill or incapacitated, and institutionalized. These factors play an
inhibiting role with respect to the patient's capability to recognize his legal needs and procure assistance. At this point, staff intervention (identifying the patient's legal predicament and referring him to the ombudsman) is crucial, as no intervention means no service and, therefore, no resolution.

The ombudsman recorded staff referral data on each individual program data card (see Figure 1). Of the total ombudsman client caseload, 47 percent utilized ombudsman services as a result of staff referrals. Of the total number of staff referrals (123), 52 percent were made by Admissions and Intensive Treatment unit staff, 29 percent by Extended Care unit staff, 17 percent by Children's Services unit staff, two percent by Extended Care unit staff, and zero percent by Medical/Surgical unit staff. The areas which are low in numbers of staff referrals (Extended Care and Medical/Surgical) are also low in utilization of ombudsman services and comprise the older, less mobile, more institutionalized segments of the hospital patient population. This is in contrast to areas which are high in relative number of staff referrals (Admissions and Intensive Treatment) which are utilizing the majority of ombudsman services; these areas are comprised of patients more likely to recognize their legal needs, initiate requests for assistance, and follow-up on staff referrals (to the ombudsman)
because they are younger, more mobile, and not institutionalized (Hassall et al., 1965).

Legal Services Caseload

Program objective #1 in addition to implying hospital wide patient services, describes the primary objective of the ombudsman program as the provision of free legal services with emphasis on everyday legal problems, as opposed to problems related to commitment or release.

The ombudsman handled 477 legal problems which were distributed across 12 mutually exclusive problem categories. Over the 21 month period of grant funded program operation, the ombudsman provided service for an average of 22.7 legal problems per month or an average of one problem per working day. The nature of the legal profession dictates a certain amount of lag time, negotiation time, and preparatory work, in order to effect resolution of a given problem. In other words, legal problems are not generally resolved during the initial contact with one's attorney. A conclusion that may be drawn regarding the legal services caseload is that there were too many legal problems for one-half time attorney to handle. In a published article, the ombudsman reported that he "... usually puts in about seven hours a day at the (Kalamazoo State) hospital ...." (Humble, 1976b, p. 33).
Legal services were to be emphasized in the area of everyday legal problems as opposed to legal matters associated with commitment and discharge. The data described in Chapter V indicate that the majority (68.2 percent) of the ombudsman's legal services consisted of everyday legal problems. The two categories (Release and Placement) comprising legal problems associated with commitment and discharge were rank-ordered second and third respectively in terms of caseload distribution. However, they accounted for only 26.8 percent (see Table 7, page 89) of the total legal services caseload—a statistic consistent with program objective #1.

The In-Hospital problem category concerned matters associated with alleged patients' rights violations. A specific mental health department, the Office of Recipients' Rights, is established exclusively to deal with such matters. Ombudsman In-Hospital data (see Table 7) reflect the functional distinction between the ombudsman program and the Recipients' Rights program. Only five percent of the ombudsman's cases involved In-Hospital category problems and 100 percent of these cases were referred by the ombudsman to the hospital's Recipients' Rights Advisor. The In-Hospital problem category is superfluous and does not accurately reflect a potential ombudsman legal service.
Program Impact

Prior to the implementation of the ombudsman program, KSH patients had essentially one option with respect to assistance with legal problems. That option, private attorneys, is demonstrably beyond the financial capabilities of most hospitalized patients (see related discussion, Chapter V). Another alternative, legal aid bureaus, is available only to residents of the county in which the legal aid bureau is located. Of the 11 counties served by KSH, only six have legal aid bureaus. In a report submitted to the Michigan Department of Mental Health, these six legal aid bureaus (in Kalamazoo, Berrien, Kent, Calhoun, Ottawa, and Ingham counties) were described as totally non-responsive to hospitalized mental patients (Humble, 1976a). According to Humble, the role of legal aid bureaus (relative to mental patients) prior to implementation of the new Michigan Mental Health Code, was that of representing the petitioner who was attempting to have a person committed to a state mental institution. Humble stated that these legal aid bureaus did not provide Kalamazoo State Hospital patients with assistance in resolving their legal problems.

In July, 1976, the investigator contacted each of the six legal aid bureaus by telephone and the bureau director or designated representative was interviewed regarding utilization of their
services by KSH patients. Each director or designated repre-
sentative was asked: (a) how many KSH patients were served
since 1971 (frequency by year), and (b) what type of legal problems
were most frequently encountered. The definition for a "Kalamazoo
State Hospital patient served" was: (1) the individual was either a
voluntary or involuntary in-patient at KSH at the time, (2) the
service provided by the legal aid bureau was not that of acting as
a court-appointed attorney for probate hearings, and (3) the
individual was a resident of the county in which the legal aid bureau
was located. Each legal aid director or designated representative
contacted stated that no bureau information was recorded which
would identify a client as a state hospital patient. Berrien,
Calhoun, Ottawa, and Ingham County legal aid directors or repre-
sentatives stated that to the best of their knowledge no KSH patients
had been provided legal aid services between 1971 and July, 1976.
The Kent County Legal Aid contact stated that services had been
provided infrequently for KSH patients since 1971. "Infrequently"
was clarified as representing less than 10 patients; the exact
number and types of legal problems not being available as the
Kent County Legal Aid client files do not indicate whether or not
an individual is a KSH patient. A Kalamazoo County Legal Aid
spokesman stated that one KSH patient had utilized their services
since 1971, but did not disclose the nature of the legal problem.
The absolute accuracy of the information obtained relative to legal aid utilization by KSH patients is subject to argument. As the six legal aid bureaus do not record whether or not a client is a patient at KSH, it is possible that some of their client caseload may be KSH patients. However, during the course of the telephone interviews, each spokesman expressed the opinion that hospital patients were not being served by their respective bureaus and that if some patients had utilized legal aid services, they must have done so as any other county resident. That is, utilize the service in the community. With the exception of occasional weekend leaves-of-absences, KSH patients reside at Kalamazoo State Hospital and it is improbable that patients could seek out and utilize legal aid services in the communities (Holland, Battle Creek, Grand Rapids, Kalamazoo, Lansing, and St. Joseph). It is, therefore, concluded that legal aid bureaus in the six counties of Ottawa, Kent, Kalamazoo, Berrien, Ingham, and Calhoun, do not represent viable alternatives for KSH patients, relative to assistance with their legal problems.

The KSH Ombudsman Program was the only viable source of legal services for KSH patients during the October, 1974, to June, 1976, period. The legal services caseload of 477 problems for which services were provided at no cost to the patients, may be interpreted as a measure of patients' legal services needs.
The program did not serve certain segments of the hospital population, however, and the resultant program data (Chapter V) cannot be construed as representing the legal needs of all hospital patients.

One of the ombudsman program objectives (#2, Chapter V) was for the ombudsman program to function as part of the hospital's service delivery system as opposed to promoting radical system change. Conclusions concerning the program's relative success in achieving this objective are completely subjective. The hospital's superintendent was reported as being supportive of the program (Humble, 1976b). The 100 percent referral rate of clients with In-Hospital problems to the Patients' Rights Advisor is indicative of intent on the part of the ombudsman to promote in-house resolutions to such matters. This approach is consistent with program objective #2. Additional support for the conclusion that the ombudsman program functioned as an integral component of the service delivery system is the fact that the ombudsman influenced revision of two hospital policies which involved system sensitivity to patients' concerns (see discussion, Chapter V).

Program Deficiencies

The primary deficiency of the KSH Ombudsman Program was its failure to serve certain segments of the hospital population.
An additional program deficiency is the lack of a client and staff feedback mechanism for measuring client satisfaction with services and attitudes toward the program. The importance of these data are stressed in a Center for Health Studies proposal to study ombudsman programs (Muldavin, 1977). The proposal draft emphasizes patient (client) satisfaction, quality of service, and staff morale as issues gaining significant importance in the field of mental health.

Another program deficiency is related to utilization of hospital staff. There are no in-service education programs for hospital staff relative to the ombudsman services available to patients and there is no systematic patient referral system.

Finally, the ombudsman record keeping system did not provide for the collection of admissions or discharge information. This pertains to the patients' status (voluntary or involuntary), the admission date, discharge date, type of admission, and type of discharge (Figure 1, page 50, represents an individual program information card with these categories included). This information is relevant to client caseload data analysis, as it could indicate ombudsman utilization trends and the relationship of ombudsman services to discharges or changes in the status of patients.
Kalamazoo State Hospital Ombudsman

The KSH Ombudsman is, in fact, not an ombudsman in the classical sense. He is a patients' attorney or a provider of legal services for mental patients. The comparison of the hospital ombudsman with the classical model (Chapter V) describes similarities between the two with respect to purpose (resolution of problems). Major differences are described relative to role characteristics and functions, however, that distinguish the KSH Ombudsman from the classical model. The hospital ombudsman is not impartial; rather, he advocates the interests of his patient-clients. The hospital ombudsman is not an investigator or mediator in the classical sense; rather, he is a provider of direct legal services. He does not neutrally "investigate" or "mediate" all aspects of a bankruptcy case, for example; rather, he represents his client for the purpose of protecting that client's interests.

Recommendations

It is recommended that the KSH Ombudsman Program be funded as a permanent Michigan Department of Mental Health program incorporating the following changes.
Program Designation and Purpose

The suggested program designation is the Kalamazoo State Hospital Legal Services Program. The purpose, or sole objective of the program, is the provision of legal services to patients at Kalamazoo State Hospital.

Program Budget/Staff

Salary for a full time patients' attorney should be at least comparable to the amount funded for the ombudsman by the 314(d) grant. That amount, prorated on a full time, yearly basis, is $28,960.00. The civil service Attorney 18 classification provides for an average annual salary of $29,069.00, and is the suggested classification level for the patients' attorney position.

A full time civil service steno-clerk 04 (secretary-receptionist) with an average annual salary of $8,122.00, would bring the total projected program budget to $37,191.00. As the Michigan Department of Mental Health is considering the possibility of implementing an individualized billing system for treatment services rendered to patients (usually billed to insurance agents or Medicaid, Medicare) the relative costs for patients' attorney legal services could also be charged as "treatment service." This would be appropriate, as the patients' attorney would be a
Michigan Department of Mental Health employee, rendering services to Kalamazoo State Hospital patients.

The patients' attorney would be a member of the hospital's administrative staff and would be responsible for developing a comprehensive program for familiarizing hospital clinical staff with the legal services program. This program, which could be produced on video tape by the hospital's Department of Education and Training (Audio-Visual Section), should include an explanation of the kinds of legal services provided by the program, instructions relative to procedures for identifying the needs of legal patients in certain target areas of the hospital, and procedures for making referrals to the patients' attorney. The need for staff intervention in the legal needs assessment process is discussed for several hospital areas in Chapter V. The legal needs assessment would and could be accomplished within the context of individual patients' treatment planning or review conferences, which are mandated no less than monthly by hospital policy #37--"Individualized Treatment Plan."

Program Procedures

Legal services program data should include all information indicated on the individual program card as illustrated in Figure 1, page 50. The patients' attorney should regularly

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assess certain program variables to: (1) determine which segments of the hospital population are not receiving representative services, (2) identify staff which are not utilizing the referral system, and (3) obtain other pertinent program data. All of the major departments within the hospital submit quarterly program reports to the hospital administration. This would be an appropriate vehicle for the legal services program assessment. To facilitate data storage and subsequent analysis, it is recommended that the patients' attorney utilize the computer codes represented in parentheses on the data card (see Figure 1, page 50), and request the hospital's data processing section to develop codes for the additional data categories. Data from individual cards could be key punched into the hospital's computer and the various program analyses would be greatly expedited.

An additional program format recommendation is for the utilization of a patient-client and staff feedback mechanism for establishing data relative to client satisfaction, quality of service, and staff morale--issues gaining significant importance in the field of mental health (Muldavin, 1977). A possible model for this type of feedback system is the one employed by the Western Michigan University Ombudsman (Graff, 1976). This system involves a seven-item questionnaire which is concerned with such issues as ombudsman accessibility, promptness, manner
of treatment, fairness, and mode of referral. A self-addressed postcard that simply asks for the client's opinion of the problem resolution effected by the ombudsman (excellent, good, average, fair, or poor) and provides a space for comments, is also used. Both the questionnaire and the postcard are coded and are a part of the Western Michigan University Ombudsman's computerized code system (Graff, 1976).

Areas for Further Study

Writing in Innovations Now, Humble (1976) stated that he, Often finds (his) services are therapeutic—if certain legal problems that are confronting the patient can be resolved, he or she can then better respond to the treatment program (p. 33).

Others such as Szasz (1974), Ennis (1973), and Gottesfeld (1974) support this contention. A thorough examination of the program's (legal services) therapeutic impact, however, is clearly beyond the scope of this study. It is, in the investigator's opinion, a valid topic for future research.

Although the use of ombudsman in the area of human services has increased in the past 15 years, the clarity of the ombudsman's role has deteriorated. An important topic for future research, in the opinion of the investigator, would be the development of a clear, precise ombudsman model that could be
applied to a variety of mental health settings such as day care centers, community mental health programs, and outpatient clinics, as well as institutions. It would appear that based on the data derived from the Kalamazoo State Hospital Ombudsman study, ombudsmen and/or patients' attorneys may eventually become a basic component in the mental health delivery system. Further research in the area of model development could enhance the viability of not only future ombudsman programs, but the entire mental health system as well.

As Victor Hugo remarked, "Greater than the tread of mighty armies is an idea whose time has come." Hopefully, further research will prevent the panacea from becoming another bureaucratic Edsel.
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