

State of Minnesota

**Office of the Ombudsman for  
Mental Health and Mental Retardation**

121 7<sup>th</sup> Place E. Suite 420 Metro Square Building, St. Paul, Minnesota 55101-2117  
651-296-3848 or Toll Free 1-800-657-3506 TTY/Voice – Minnesota Relay Service 711

June 9, 2005

Mr. Michael Tessneer  
Director of State Operated Services  
Department of Human Services  
444 Lafayette Road  
St. Paul, MN 55155

**Re: Minnesota Sex Offender Program**

Dear Mr. Tessneer:

Thank you for the opportunity to meet with you and the administration of the Minnesota Sex Offender Program, (MSOP), on April 11, 2005, to address recent developments within the program. The meeting was a good opportunity for our agency to express concerns about issues that impact the resident population and for you to share with us the challenges the MSOP faces in providing an effective treatment program that also ensures the safety of the public.

As you are aware, the Office of the Ombudsman for Mental Health and Mental Retardation is charged, under Minnesota Statute 245.92, with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental illness, developmental disabilities and related conditions, chemical dependency and emotional disturbance from an agency, facility or program. Accordingly, individuals who are committed to the MSOP are included in the populations that are served by the Ombudsman's Office. In accordance with Minnesota Statute 245.94, our agency may investigate the quality of services provided to clients and review matters that influence the delivery of those services.

As we discussed at our meeting, the purpose of the meeting and this letter is to set forth growing concerns we have with the operation of the MSOP. Over the past twelve years, issues have arisen that are of concern to the Ombudsman's Office because of the unique nature of the sex offender program. Some of these concerns pre-date the building of the Moose Lake facility and the development of Rule 26. As the program has evolved and changed over the most recent 10 years, we have seen the balance that must be struck between safety and treatment. However, there has been little or no clinical progress that would lead the residents to believe that there is hope for their ultimate completion of the program and release from treatment. This has led to a sense of frustration and hopelessness on the part of the residents making them more prone to problems associated with the day-to-day operations of the facility. While some of the residents have repeatedly refused treatment, others have been sincere in their efforts to progress in treatment - but the outcome appears to them to be the same. This sense of hopelessness can lead to conditions that present challenges to the safe

operation of the facility for both the residents and the staff who must work there. Great effort must be placed on the day-to-day operation to prevent dangerous conditions from developing. Because of the escalating number of issues being brought to our attention, the rapid growth and the recent programmatic changes, the Ombudsman feels it is important to address those issues in an effort to prevent negative and unintended outcomes.

Over the past two years you and I have discussed a number of proposed changes to the MSOP program. In general, this agency has been supportive of your vision and understood the unique difficulties associated with running such a program. When we discussed changes to the application of the Health Care Resident and Patient Bill of Rights, we were assured that there would not be a wholesale application of rights restrictions without justification on a case by case basis. However, as we have discussed, our concern arises from our observation that the day-to-day operation of the program does not seem consistent with the long term vision, as our agency understood it, and it seems appropriate to revisit those discussions. I want to emphasize that we are not focusing on any one of the individual actions of the facility or the staff but rather on a pattern of practice or trend that all of these actions, when considered together, can lead to conclusions or assumptions by the residents, the courts or the public. When factored with other external factors, which are outside of the facility's control, these can contribute to residents' feeling of hopelessness that contributes to our concern for safety.

In raising these issues, the Ombudsman's goals are as follows:

1. to protect the safety of the residents and staff of the facility;
2. to minimize Minnesota's risk of financial loss due to court action or harm that may come to residents or staff of the program;
3. assure fair living conditions for the residents and safe working conditions for staff; and
4. to promote the development of an institutional culture where therapy is effective for those who desire to change.

In approaching the problem, I sincerely considered information from past interactions with the program and issues raised by program staff. Often we have heard that "if we (MSOP staff) did not have to worry about the Health Care Resident and Patient Bill of Rights, we could do the things we need to do to address the problems." With that in mind, I decided to look at this from the view of any forensic facility, including correctional facilities. I also decided to consider basic rights (legal, civil and human) that are not unique to a health care setting but to all human interaction. When the population being served is particularly unpopular, it becomes too easy to move down a path that risks violating rights or engaging in problem practices because the public does not seem to care, especially in a closed institutional setting.

As part of our review, I considered information gathered in cases brought to our agency, interviewed members of the Hospital Review Board (HRB), met with citizen participants in the Resident Advisory Council, spoke with individuals in the Department of Corrections (DOC), met with a former Commissioner of Corrections and read The Big House, Life in a Supermax Security Prison by Jim Bruton, former Warden of Oak Park Heights Correctional Facility and former Assistant Commissioner of Corrections. I looked at how DOC can safely

house these same individuals for years and with fewer incidents or problems than are currently experienced by the MSOP. In the end, I have concluded that to run a safe facility, a fundamental component for control is dignity and respect<sup>1</sup> with an emphasis on fair rules, well trained staff, and policies that are firm, fair and applied consistently regardless of the unit or the staff person that implements them. It must be a facility where everyone is held accountable to follow the rules; staff as well as residents.

During a recent visit at the Moose Lake facility, Michael Woods, our Regional Ombudsman in Moose Lake, interviewed a number of residents in an attempt to gauge the frustration level of the residents.<sup>2</sup> The following are some of the statements made by residents:

? "This isn't a treatment facility. The clinical team hasn't accomplished anything in ten years so why should we put our faith in them that the next ten years is going to be any different. They are only interested in warehousing us. We can't distinguish between treatment and punishment. There are guys in here that know they'll never get out and they don't want to grow old and die in here, they want to die now."

? "Staff are going to keep pushing us and pushing us into a corner until one day someone's going to snap and a staff person is going to get killed. And it's going to happen soon. I predict it's going to happen within the next year."<sup>3</sup>

? "When we question staff on how we are being treated and how the program is run, they tell us, 'Take us to court if you don't like how things are run around here.'"

? "Even Lassie will eventually turn and attack Timmy if he's poked with a sharp stick long enough."

? "It is difficult to find hope in a hopeless situation. At least in prison you know when you're going to be released, whereas here there doesn't seem to be any end in sight."

With this in mind, we present some of the issues in a sincere effort to effect positive changes within the treatment program that will help ensure its continued viability and legitimacy as well as reduce the tension level among the residents and staff.

### **1. Lack of Diversity Training/Insensitivity Towards Cultural Diversity.**

Our agency, along with the Hospital Review Board and the Resident Advisory Council, has expressed concern over the apparent lack of diversity training and cultural diversity within the MSOP. Members of the African-American community within the MSOP have expressed

---

<sup>1</sup> Pages 136-146, The Big House, Life in a Supermax Security Prison Warden James H. Bruton, Voyageur Press 2004.

<sup>2</sup> The Ombudsman does not represent these statements as validated or investigated complaints but as examples of the emotional climate in the facilities.

<sup>3</sup> It is important to note that the individual was not conveying a specific threat on their part, nor was it directed at any individual but merely an observation of the frustration levels building in the program.

their frustration, anger and resentment over what they perceive as staff insensitivity and lack of awareness for their cultural differences. Despite repeated attempts to get this issue addressed by the MSOP, this issue has been largely ignored.

For example, the Hospital Review Board recommended in its 2002 report that the MSOP permit an organization unaffiliated with the Department of Human Services, such as The People's Institute, to evaluate the program and assist the MSOP "in developing processes for dismantling racism and educate facility staff." The report goes on to recommend that "All Staff should participate to insure success. Since the program's approach is highly cognitive, perhaps different strategies could be used for those patients who have intellectual and/or language difficulties."

A good example of the lack of cultural diversity is the program's use of very complex concepts. The program has a list of "thinking errors" and "distorted styles of thinking" that it expects the resident to know, understand and incorporate into his everyday life. Staff is insensitive to the fact that a young minority male, growing up in poverty on the streets of Minneapolis with a very limited level of education, may be confused and frightened when placed in this foreign world within the MSOP. When staff accuse and confront this resident for "compartmentalizing" his behavior, or engaging in "polarized thinking," or "catastrophizing," or acting "superoptimistic," staff fail to appreciate how this person's life experiences, background and culture would cause him to feel alienated from the treatment process. The program is cognitively based with some assumptions about the ability of the participants and does not appear to adequately take into account how an under-educated minority, who speaks limited English, may have difficulty in understanding the program.

Another example of the cultural insensitivity within the MSOP is the case of a Mexican-American resident. Prior to the new changes in the program, the resident was permitted to order his Mexican spices and ingredients from a St. Paul specialty store, at his own expense, since they are not available in Moose Lake. Under the new program, staff refuses to grant the resident's request to purchase these items.

An additional example of the day-to-day interaction with staff that causes African-Americans to be suspect of the cultural sensitivity of staff is what happened recently between staff and residents. Aspects of black culture are grounded in early history of slaves in this country, including the practice of being disciplined if they looked their slave master in the eye without permission. They were taught to always look down. Two African-American residents were instructed by a staff person to look him in the eye when they ask to leave the unit "because it is part of socializing." Socializing is one of the categories residents are evaluated on by security staff and they need to score high enough on this topic before they progress in treatment. This scenario has a three fold negative impact on the African-Americans involved: 1) it invokes aspects of their cultural history, 2) it defines socialization in the staff's cultural norms and 3) the resident receives a low evaluation in the socializing category.

Despite requests over the last three years by our agency, the Resident Advisory Council and the Hospital Review Board to implement a strong diversity training program, MSOP has failed to address the problem. The program manual states that racial discrimination is not

tolerated, yet it is not evident that steps are taken to ensure that what is written on paper is actually implemented in the course of staff's daily interaction with people of color.

## **2. Broken and Inadequate Means To Address Concerns.**

The residents don't believe that there are adequate means for them to address their concerns. While on paper, there appear to be a number of venues the residents may use to bring their concerns to the attention of the Administration, in practice these avenues are ineffectual.

For example, there is a formal grievance process but, for a host of reasons, the system is completely broken and the residents have absolutely no faith in the process. Residents believe that the unit directors do not adequately investigate their issues prior to responding and, when it reaches the final stage, senior administration simply rubber stamps the conclusion reached by the unit director (i.e. "I agree with the above response" or "As stated by the AGS").

The patient advocate is sometimes kept out of the loop until it is too late to advocate. He spends a disproportionate amount of time in the grievance process, rather than on the units with the residents and staff facilitating outcomes. The residents feel that when the advocate raises issues with administration, the issues are ignored.

The Hospital Review Board's recommendations and requests have gone unheeded. The MSOP administration has not responded to the Hospital Review Board's recommendations since September of 2004. At a recent meeting, the chair requested that the administration arrange a meeting with the residents of color to be held one hour before the next HRB meeting. This was intended to attempt to address the cultural issues being raised. The date of the next meeting was set at least a month in advance. Despite repeated written requests to set up the meeting, when the members of the HRB arrived for the meeting, no arrangements had been made for the meeting and the HRB was not advised in advance that the meeting was not arranged. The facility director was out of town and the assistant went home ill that morning. The administrator-in-charge refused to make any adjustments to accommodate the HRB's request without direction from facility leadership. Neither the director nor the assistant were available by pager or telephone. The creation of the Hospital Review Board was ordered by the Minnesota Supreme Court and the members are appointed by the Commissioner. While I can appreciate how busy administrative staff have been, this apparent lack of respect for the HRB and their role sets a tone throughout the facility and sends a clear message to the residents and the staff.

While residents may express some of their complaints to the Department of Health's Office of Health Facility Complaints, that department has not done a review inside the MSOP and refers all matters to the Ombudsman's Office for review.

All of the recommendations of the Resident Advisory Council appear to be ignored, regardless of the merit of the recommendations. For example, the Council made a recommendation requesting the expansion of the facility's visitation hours, including their rationale: two hours a day for visitation seemed too restrictive given the limited capacity of the visiting area. Visiting hours are only from 6:00 p.m. until 8:00 p.m. Monday through Friday and only seven

hours on Saturday and Sunday. Twenty-four (24) hours a week for 150 men seemed unreasonable. Capacity needed to be increased. Family and friends drive for hours to get to Moose Lake, only to then have to sit and wait for a spot in the visitation room to become available. If residents voice frustration over this issue, they are accused of having "treatment issues" in their documentation, i.e., "visitation issues are high external risk factors" for this resident. Yet this issue went unaddressed by the MSOP. On January 5, 2004, the Council wrote a letter to the clinical director addressing this issue and it received no response.

The Ombudsman is sensitive to the issue of the volume of complaints, that some of the residents abuse the process, and that some individuals "shotgun" their complaint to multiple outlets or "shop" for a different answer. A process to sort the legitimate issues from the frivolous must be found. To simply not respond or to overlook growing concerns can only lead to more problems in the future.

### **3. Property Issues.**

The authority of MSOP to limit the property rights of residents is contained in M.S. 253B.185, sec. 18, subd. 7, which states that the property rights may be restricted only as "necessary to maintain a therapeutic environment or the security of the facility or to protect the safety and well-being of patients, staff, and the public." Recent changes to the program have led to property restrictions that appear to be more coercive or punitive, rather than related to either progress in treatment or safety. Having unit levels that encourage residents to participate and progress in treatment makes sense. But in our opinion, defining the number of handkerchiefs, socks, etc., seems overly detailed and not related to the therapeutic environment. We realize that the amount of property that was being accumulated led to problems, but we would suggest that each resident be allowed a defined volume of personal property with a specific documented list of banned or contraband property, and have your treatment incentives be related to something beyond the basics. Different residents have different views on what property is important to them and they are unlikely to respond to what administration might define as "incentives." In addition, when asking staff members what is allowable, residents get different answers from different staff members as to what is and what is not contraband. This only increases the anger and frustration felt by the residents who attempt to follow the rules.

Another example of what appears to be an arbitrary practice is the restriction on computer software. Windows XP is allowed on one unit but not on another, yet public safety and access to the internet is given as a reason. Use of their personal computers, purchased at their own expense, is useful for writing letters, for learning and development and sometimes for diversion from the reality of life. To get access to the internet hardware is needed, such as wires or a wireless base unit, modems and an internet service provider (ISP). To the best of our knowledge, residents can not gain access to the internet without an ISP, and the facility controls that access. If there is a legitimate problem, it has not been adequately presented in a way the residents or the Ombudsman can understand. These types of inconsistencies are inadequately explained in terms of either safety or therapeutic programming and leave the appearance that these issues are decided on the whim of the unit or individual staff. It would appear that the MSOP believes that every possible action can and will in fact happen and so they take arguments to the extreme. If the staff can imagine something might be able to

happen, they act as if not only is it possible, but also inevitable. If that is the case, it is imperative that these decisions are based on correct information and not speculation, with consistent written explanations provided to residents and their representatives alike.

#### **4. MSOP's Possible Violation of Law and Statutes:**

The Security Director allegedly said "We're going to do things around here the way we want until a court makes us do otherwise." Also as previously noted, the staff has responded to residents by saying, "Take us to court if you don't like how things are run around here." If this is the attitude of staff, then the MSOP is at risk of ignoring laws and rules that could lead to a violation of rights challenge. Indeed, this seems to be an invitation to the residents to file a law suit as the only way to effect change. This sets up an adversarial atmosphere and leads to expensive litigation that unnecessarily expends public money that could be more effectively used in the treatment program or elsewhere in the state.

An Ombudsman staff member reported to me that while out at a local establishment in a community that was experiencing the closure of an RTC, they overheard two DHS employee's discussing their options. One had taken a security counselor position at Moose Lake and another was considering their options. The security counselor was heard to say to the HST, "You should transfer up. It is so much better, you can do what you want to the clients and nobody cares or gives you S---! If you are tired of those advocates, come up to Moose Lake."

When staff is not held accountable for following the laws and rules, but residents are, it does not send a clear and consistent message. It is not clear that staff is adequately trained on the laws and rules that apply to the operations of the MSOP. In addition, residents are being given different answers by different staff members. This can lead to institutional chaos and the perception that either no one is in charge or the rules do not matter.

#### **5. Use of Restraints**

The MSOP indiscriminately uses restraints, both handcuffs and shackles, without regard to the individual resident's security risk. At least under the prior treatment program, residents were assessed a security rating and restraints were used based on their individual security rating. This isn't to say, however, that the MSOP's former practice of issuing security ratings was not without its faults. For example, a resident was assigned a low security rating, not because he was a security risk, but because he wasn't in treatment and, therefore, the resident never graduated beyond the rating level that would allow him to become restraint-free. Under the former program, there was some individualization in determining the use of restraints. Currently, only those residents that are on the Advanced Treatment Unit are transported free from restraints. All other residents—residents on the Non-Participation Unit, Behavioral Unit, Initial Treatment Unit and Mid-Level Treatment Unit—are transported in, at the very least, handcuffs and in some instances shackles, without any consideration of whether the person is an actual security risk.

In St. Peter, residents that pose no security risk whatsoever, due to their physical limitations, are placed in restraints. Staff recently shackled a geriatric resident even though, with his advanced age and limited mobility, he posed little security risk. One resident was shackled even though he is permanently confined to a wheelchair due to the lost use of his legs as a result of complications stemming from diabetes and cerebral palsy. Staff appears to be insensitive to the resentment and anger the resident population experiences from hearing about the shackling of a physically disabled man and a medically fragile senior citizen.

## **6. Security Measures**

As a result of the recent security breach in St. Peter, the security situation has gone from inadequate security to excessive security measures. An over-reaction on the part of the program causes the residents to feel that they are being punished for the actions of two men. The new security measures are seen as a knee-jerk reaction which leads to frustrated and angry residents which, in turn, leads to an unsafe working environment for staff and unsafe living conditions for the residents.

One potential negative consequence of the new security measures being taken is the sleep deprivation suffered by the residents. Staff members enter residents' rooms at midnight and at six o'clock in the morning, for security checks, without any consideration that the resident is sleeping. It is well known that sleep deprivation can be a cause of problematic behavior. Staff's practice of waking people up during the night, startling the residents out of their sleep, whether intentional or accidental, can lead to sudden, inappropriate behavior on the part of the residents. Not only does sleep deprivation negatively impact the mental health of the residents, but it creates an unsafe, volatile working environment.

## **7. Issues At St. Peter Campus**

One of the primary causes creating the tension, frustration and resentment on the part of the residents on the St. Peter campus was the lack of a smooth and orderly transition of their transfer from Moose Lake to St. Peter. In December of 2003, leadership staff provided our agency with a presentation forecasting the expansion and changes the MSOP would undergo in the coming year. If these developments were anticipated long before our meeting, the MSOP knew at least 15 months before the opening of Shantz Hall that the census was going to increase and that there would be a need to transfer men to Shantz Hall. Despite this knowledge, steps were not taken to ensure that acceptable conditions were in place prior to the transfer of the residents.

We understand that Pexton Hall is in the process of being renovated so that the residents can be transferred there from Shantz Hall. We want assurances, however, that the lack of planning that occurred when the men were transferred from Moose Lake to St. Peter is not repeated when the residents are moved a second time. Below are deficiencies within the St. Peter program that we hope will be addressed as soon as possible and, at the very least, before the opening of Pexton Hall.

? Unlike the acceptable mattresses provided at Moose Lake, the residents in St. Peter are forced to sleep on county jail style mattresses. The residents would be satisfied with the bedding that is provided at Moose Lake, but instead they have to sleep on steel framed beds that require a wooden board for support.<sup>4</sup>

? The mail system is inadequate in that, unlike Moose Lake, there are no locked mailboxes on the units, mail is not delivered on Saturday, and the postage system is haphazard. In Moose Lake, a resident places a postage request on the item to be mailed out, whether it be a package or a heavy envelope, and the staff in the mail room weighs the item and the resident's account is billed and a receipt given. The Moose Lake residents know when the item is mailed and are able to track it. In St. Peter, the residents have to speculate as to the amount of postage needed and they are not given a receipt.

? Unlike at Moose Lake, the residents are not given access to a library.

? In Moose Lake, there is an adequate banking system in place whereas in St. Peter the patients are not given receipts for the transfer of money from one person to the next and they are not provided a record for the transaction. They are only provided a monthly bank statement.

? Under Minnesota Rule 4665.2200, the Minnesota Health Department requires there be at least one bathtub or shower for every eight residents. When the men first arrived at Shantz Hall, there was an inadequate shower facility. There were 34 men and only one working shower and one bathtub. In St. Peter, staff locks the shower at 9:30 p.m., apparently because that's "quiet time." The staff shift change is at 10:00 p.m. and the night staff, who don't work for the MSOP, refuses to accommodate residents' requests. When the men initially were transferred to Shantz Hall, there was only one washing machine and one dryer for two units-- the 30 men plus those on the transition unit. The laundry room is locked at 9:30 at night.

? Residents in St. Peter are denied recreation. Residents have been told that they will never be able to use the tunnel to access the gym. The men are only given two, fifteen minute fresh air breaks a day, whereas in Moose Lake the guys have unlimited access to the outdoors during the daylight hours. For the residents in St. Peter, gone are the days when they could go outside and plant a garden or throw a Frisbee or walk around for exercise. We have been told that inmates in segregation at Oak Park Heights prison get more fresh air than the residents in the St. Peter treatment program.

? Shantz Hall has inadequate air ventilation and lighting in the rooms and in the shower rooms.

? Staff are not adequately trained before being assigned to the units. They are non-responsive to resident issues and some staff members have hostile attitudes. Unless staff is doing rounds, they separate themselves in the office and do not interact with residents. Staff

---

<sup>4</sup> Changes such as these, while small, lead to frustration. Page 54-55 The Big House Life Inside a Supermax Security Prison, 2004 Voyager Press.

does not understand the chain of command, the unit policies, or the unit procedures. When residents attempt to compare rules to those in Moose Lake, and point out inconsistencies, staff informs them that the security hospital administration is running the MSOP, not the administration in Moose Lake. There is a lack of consistency among staff in implementing policy and procedures. It is not uncommon for one staff member to overrule another staff member, leaving the residents confused as to how to proceed.

? In Moose Lake, the residents are able to secure their rooms and food lockers with locks, whereas the residents in St. Peter are without a means to secure their rooms in order to protect their property.

? The implementation of the new cable service is being viewed as unjust. The St. Peter campus has apparently negotiated a deal with the local cable company so that it receives a bulk rate of \$14.00 per room. The program charges each resident \$39.00 for the upgrade package deal. Even though there is only one jack in the room, both roommates must each pay the \$39.00 or they will not connect the cable for either resident and they are made to place their television in storage. So for each double-bunked room, the cable cost the campus \$14.00 and they, in turn, charge the two residents \$78.00, a \$64.00 profit a month, for each room. The Administration states that the profits are spent on "media" items for the men. However, what those media items consist of has not been clearly identified nor has information been solicited from the residents as to what media would be used by them (within limits of allowable material).

## **8. Telephone Restrictions**

The Ombudsman is aware that MSOP intends to implement the installation of a phone system that is similar to those in prison and county jails that will inform those receiving calls that the call is from a sex offender treatment program. The system will also automatically time and record all calls. It is our understanding that this has been necessitated by the actions of some of the residents in attempting to inappropriately call potential victims. This agency is sympathetic to the dilemma faced by the MSOP. However we want to raise certain concerns with the new telephone system. One is the ever expanding appearance that the balance is shifting to one of a correctional facility more than a treatment facility. It is not clear to the Ombudsman whether or not the system being considered is similar to jail and prison systems which requires the call to be placed 'collect' which charges the call's recipient, most of whom are family or friends. Our experience with those systems is that the calls are very expensive to the recipient averaging between \$ 10 and \$ 20 per call. With the restriction on receipt of incoming calls, family and friends are forced to receive calls well outside regular rates. We also raise concerns about the confidential access of the residents to the Ombudsman's Office without fear of retaliation, which is outlined in MN. Stat. § 245.91-.97.

Because of the escape of two residents, the facility has instituted interim procedures for recording calls, having staff sit in on calls and the elimination of all incoming calls. Procedures for staff were not clearly conveyed so that some residents report that some staff would not grant privacy of communication with attorneys or the Ombudsman, even after

being informed that this privacy was guaranteed to them. Again this type of reactive policy development, done in haste and without clear direction to all staff on what is and is not allowed, leads to further chaos and frustration in the program, unnecessary complaints to multiple outlets and administrative time spent on calls from these outside parties. Residents then report that staff retaliates against them either by charting that residents are creating problems or are oppositional in their treatment program and/or with unit rules. Examples of this type of charting are evident throughout the program.

## Summary

In summary, while not exhaustive of all issues, these are examples of issues both small and large. The Ombudsman believes these issues have brought the program to a point where both resident and staff safety is a serious concern, and that a major negative event could happen. It truly is our goal to assist DHS in preventing this from occurring and to help achieve a program where therapeutic treatment can occur for those who choose to participate.

After our last meeting we all agreed to meet again to continue these discussions. In preparation for such a meeting, the Ombudsman would like to advance the following recommendations for your consideration and further discussion:

1. Take steps to ensure that the resident takes ownership of his treatment plan. To help bring this about, the MSOP must ensure that each resident has an **individualized** treatment plan. Many residents have indicated to our agency and the Review Board that the only difference between each treatment plan "is the name on the plan." In its annual report for 2002, the Hospital Review Board recommended that the MSOP clinical staff engage in a process to "ensure the patient's . . . participation in [his] treatment planning and review. A patient invested in his treatment program tends to be more motivated, hence [a] more cooperative treatment participant." DHS has chosen not to accept the Review Board's recommendation. We recommend that they reconsider their stance on this issue.

2. Increase cultural diversity in the program. The Review Board recommended in its 2002 report, and one the Ombudsman supports, that the MSOP permit a neutral, non-DHS, agency such as The People's Institute, to evaluate the program and assist MSOP.

The People's Institute is recognized as one of the foremost anti-racism training and organizing institutions in the nation. The People's Institute's website states that the organization "believes that effective community and institutional change happens when those who would make change understand how race and racism function as a barrier to community self determination and self sufficiency."

3. Separate the clinical and security functions and assure that clinical staff is in charge of the program level and programmatic progression decisions for the team. Dr. Donald Meichenbaum, from the University of Waterloo, stated that the degree to which a patient internalizes and practices the theories and techniques his therapist has presented to him is

directly proportional to the level of trust and acceptance the patient has for his therapist.<sup>5</sup> If there is, what Dr. Meichenbaum titled, a strong “therapeutic alliance” between clinical staff and residents, there is a higher likelihood that the patient will practice what the therapist has preached.

As a result of the MSOP clinical staff’s participation in Op Team meetings<sup>6</sup> and their contribution to meting out punishment, residents are distrusting and resentful toward the very individuals entrusted with their treatment. The Department of Health, Office of Mental Health Practice, investigated this very issue and had serious concerns as well, and were articulated to the MSOP in a letter from that office.

Currently, security staff is listed as team leaders and have disproportionate authority over the progress of residents. While security staff is vital to providing input into what is going on, it is the clinical staff that is professionally trained to interpret the meaning of behaviors and the future directions needed. Security personnel should report activities to the clinical professionals and allow the clinical professional to interpret the meaning of those behaviors. The MSOP should have security staff focus more on long range security planning and crisis/situational safety and security situations, rather than treatment. While both security and clinical staff should be on the team and invested in the treatment concepts, the blurring of these two functions has added to the sense of chaos that led many to question who is in charge of the facility.

4. Improve the training of new and existing security staff. Currently the training at MSOP is similar in time as training for new correctional officers at the DOC. But somehow the content of training that leads to how security staff deal with residents is a different approach than what is taught at the DOC academy. Correctional Officers at DOC appear to have clearer boundaries as to what actions they can take against an inmate than what appears to happen at the MSOP. While this may seem contrary to the Ombudsman’s overall concern that the MSOP not appear to be a correctional facility, this is one area where this agency believes that DOC could provide guidance on protocols that appear to have a consistent approach. We suggest consideration be given to hiring an associate program director who has served as a Warden or Asst. Warden of a DOC correctional facility or a former Administrator of a county jail. In these facilities security is a necessity but adherence to strict policies by staff is an important factor in keeping the facility safe.

5. Develop clearly articulated policies that are fairly and consistently implemented and plan for changes that must occur. Assure that these policies are adequately communicated to, and understood by, both staff and residents before the change is implemented.

6. Seek voluntary professional accreditation or certification. - Minnesota passed a law in 1999 that required sex offender treatment programs to be certified by the Department of Corrections. DHS sought, and was granted, exclusion from this legal requirement. However,

---

<sup>5</sup> 2001 Minnesota ATSA Conference

<sup>6</sup> Discipline meetings

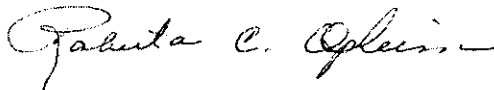
the rules simply state minimum standards required for such programs and were a beginning step at best practices when public funds are being spent. While not required to be certified, the MSOP should seek outside certification from DOC, JCOHA, or ATSA to demonstrate quality assurance and development of reasonable (if not best) practices in the rapidly changing practice of sex offender treatment. This certification helps to assure that public funds are being spent effectively given that civil commitment is the most expensive of the methods of dealing with sex offenders.

7. Improve the quality of documentation in the program. There has been a long-term concern about the quality and consistency of documentation in the program. These problems, the staff's unwillingness to address residents' concerns and the broken grievance process, can lead to frustration and unnecessary formal administrative challenges to accuracy and completeness of records. While some residents will chronically pursue this avenue no matter what improvements are made, others would not, if they felt the charting was fair and inaccuracies would be addressed within the program.

It is my hope that we can focus on the overall trend in this message and not proceed to debate the validity of any one item. Our goal is to share the tone and direction rather than individual detail. Often perception is as important in reality and these examples are provided to demonstrate the perceptions that exist. In addition these examples are consistent with a number of complaints expressed so as to create a pattern. Despite the length of this communication, I do not want to minimize how difficult a task that DHS and the MSOP leadership have in the development and ongoing management for this program. The Ombudsman agrees with the vision the State Operated Services has for this program. However, we remain concerned that the vision SOS has is not playing out in the day-to-day operations of the facility. I look forward to our continuing discussions about how the Ombudsman can be of assistance in the development and operation of a safe and effective treatment program.

Please do not hesitate to contact me with questions or concerns regarding the issues raised. We see this as a process with continuing dialog rather than a critical report. Finally, please contact me to set up a follow up meeting.

Sincerely,



Roberta C. Opheim  
Ombudsman

C: Wes Kooistra, Asst. Commissioner, DHS  
Josefina Colond, Ph.D., Chair, Hospital Review Board