Minnesota Sex Offender Program Hospital Review Board
Annual Report
July 2004-December 2005

This is the third comprehensive report prepared by the Hospital Review Board (HRB) of the Minnesota Sex Offender Program (MSOP) based in Moose Lake and St. Peter, and covers activities of the Board during the period July 2004 through December 2005. Two similar reports had been submitted previously; the first one covering the period January 2002 through June 2003; the second one covering the period July 2003 through June 2004. A separate report submitted on July 15, 2005 presented findings and recommendations of the HRB regarding the status and treatment of individuals in the MSOP patient population who are members of various minority groups.

A number of events have taken place at MSOP during the period covered by the present report, including a significant increase in patient population (from roughly 150 in 2003 to around 267 in January 2005), a major shift in the focus and delivery of treatment within the program, and notable changes in both the administrative and clinical staff rosters. These events are mentioned here for their potential impact on the nature and tenor of concerns brought by patients before the Board.

During the past 18 months, the Board held 29 regular meetings (16 in Moose Lake and 13 in St. Peter) to listen to the concerns brought forward by 160 patients of the MSOP. It became necessary to schedule separate meetings for patients in St. Peter since the population on that campus grew dramatically. Two special meetings (April 15, 2005 in St. Peter and May 6, 2005 in Moose Lake) were conducted to hear the concerns of minority groups within MSOP. In addition, the Board held four reviews relating to the use of protective isolation. The HRB also met with MSOP staff 14 times, and with senior management staff of the Department of Human Services on three occasions.

I. Findings of the Hospital Review Board: The following is a listing of concerns presented to the Board by MSOP patients during this period. The list does not present the concerns in order of importance nor does it indicate the number of times the concern was heard by the HRB.

A. Concerns and issues related to treatment:

The system used to assign patients to different levels of care seemed highly questionable and experimental at best.
The program seemed to be punitive and the focus placed on consequences for misbehavior rather than the development of skills to solve problems
Behavior programs seemed long and punitive in nature and reviews of such are inadequate.
Progress in treatment was slow to non-existent and criteria were not well defined.
The rating system used to make decisions on treatment advancement appeared questionable and subjective.
There appeared to be no transitional program for those presumably making progress.
Treatment did not appear to be individualized.
Wrong diagnoses had been made at times. (Some patients who felt that they were misdiagnosed, and therefore given civil commitment in error, presented this concern.)
Requests for medical treatment had been reported to be either slow or totally ignored.
There were several objections made to their placement (in various levels of care groups).
There were complaints about the higher controlled/restricted environment at both the St. Peter and Moose Lake campuses following the March 2005 escape of two patients.
Treatment plans were not updated; there were no end of trimester reports.
Requests for individual therapy were said to be denied.
Requests for community pass were claimed to be either ignored or denied.
Needs of special patients were said to be ignored.
Trauma experienced in group sessions was said to be either ignored, or not followed up.

There were complaints about the use of the lie detector test in treatment.
There were complaints about the lack of coordination and/or poor communication between clinical teams in St. Peter and Moose Lake.

B. Concerns and issues related to staff:

There were complaints about the Patient Advocate.
There were complaints about the Ombudsman.
There were complaints about the Clinical Director (unresponsive, unavailable).
There were complaints about the Security Director.
There were complaints about the COO (unresponsive, unavailable, unreasonable, unfair).
There were complaints of staff harassment and favoritism.
Staff were said to be disrespectful, unprofessional in manner and dress, rude, threatening, and abusive.
There were complaints about the questionable skills of MIS staff and MSOP security staff.
There were complaints of staff discrimination and insensitivity to the needs of minority patients.
There were complaints about supervisors being inaccessible or being not responsive at all to patients' requests for services and/or information.
There were complaints that staff behavior during lockdowns was deplorable.
There were complaints that staff were unfamiliar with, or arbitrarily enforced, MSOP policies and rules.
There were complaints that patients' families were treated disrespectfully.

C. Concerns and issues related to MSOP services:

Requests for medical services were reported to be either slow or totally ignored.
There were complaints of limited access to fresh air/exercise/recreation equipment.
There were complaints of inadequate health care for patients with ailments.
There were complaints of inadequate dental care, lack of access to dental records.
There were complaints that access to law books/law library was either denied or blocked.
There were complaints about the inadequate or poor mail system (mail/money had been misplaced; staff read mail in patients' absence).
The cable system was described as expensive.
There were complaints about the new phone system (too restrictive, too expensive, violates patients' bill of rights, objectionable introduction message).
There were no nurses available at night.
Access to therapeutic activities/materials were said to have been denied.
Requests for special diets were said to have been denied.
Access to full supply of pain medication was reported to have been denied.

D. Concerns and issues related to MSOP program/policies/practices:

There were complaints about the lack due process: Op teams were seen as a joke, access to lawyers was reported to have been either denied or blocked.
Access to the Patient Advocate and/or the Ombudsman was either denied or blocked.
There were complaints about little or slow to no response to requests for information/things.
There was a complaint about the Security Director's violation of a computer consent decree.
There were complaints about MSOP's lack of respect for HRB evidenced by MSOP's non-response to HRB recommendations and comments made by staff regarding the HRB.
There were complaints about the need to increase consistency in implementing policies.
There were complaints about the need to revise the visitation policy/practice (currently seen as not affording enough privacy and allows disrespect of visitors).
The grievance process was said to be broken (slow, ineffective, non-responsive).
The new media policy was seen as violating rights and inconsistently applied by reviewers not qualified to do so.
There were reports of inconsistent enforcement of rules.

The were complaints about the way room searches were conducted (staff were disrespectful to patients and patients' properties).
There were complaints about the cancellation of ECRC hearings
There concerns raised about the need to improve charting on patients' records and the need to be more accurate, objective and more professional and timely in the documentation of events.
Food ordering procedures were seen as needing examination and change.
There were complaints about MSOP's shift into levels of care (uncoordinated, information not shared, property lost or broken, group assignment questionable, poor living conditions in St., Peter, the Chief Operating Officer and the Clinical Director were unresponsive to requests for information and did not heed objections).
Patients were said to be treated poorly while in isolation (Protective or Administrative Isolation).
The use of Administrative Isolation in March 2005 was seen as questionable.
The food delivery procedures were seen as inflexible and in need of change.
There were concerns about the need to increase the diversity in the program (increase the diversity of staff composition, program needs to be more sensitive to the needs of minorities).
There were complaints over how many were punished because of the two who escaped in March 2005.
There were complaints about the policy governing attendance at funerals of family members.
There were concerns about the need to have more involvement of families in treatment.

E. Miscellaneous concerns and issues:

There were several requests for copies of the HRB annual report.
Pleas were made for the rights of patients on judicial holds.
There were complaints about patients' loss of federal checks and/or loss of mail.
There were patients who expressed concern for personal safety.
There were patients who felt concern for their mental health and well-being.
There were patients who expressed that DHS had abused the commitment act.
Patients expressed loss of hope and feelings of desperation about their plight; there were patients who expressed a desire to go back to the Correctional system rather than staying at MSOP.
There was a request to be allowed to wear female clothes/make up.
There was a request for HRB recognition of patients' efforts at evangelization
There were requests for assistance in appealing their civil commitment
There was a request for assistance in obtaining a community pass that DHS reportedly continues to deny.
There were requests for help in printing legal material.
Work area rules and contract were seen as coercive.
There were objections to the use of quotas in the work area
There were complaints about the lack of work and/or activities for patients.
There was a complaint about being denied a wood project.
There was a complaint that a desk previously approved to be ordered was subsequently denied after it was delivered.
There was a complaint that legal papers taken during a room search were later lost.
There were complaints about absence of handicap-accessible doors.
There were complaints about the general deterioration of MSOP.
There were complaints about security ratings given/taken.
The borrowing/buying practices among patients were seen as in need of review/change.
There were complaints of violations of Minnesota Supreme and District Court judges' policy regarding the duties of court-appointed attorneys.

II. Recommendations of the Hospital Review Board: To begin with, the Hospital Review Board acknowledges that both the MSOP administrative and clinical staff, as well as senior management staff at DHS, had been responsive to requests by the Board to discuss certain critical issues and concerns. The Board also acknowledges that some of these critical issues and

concerns had been looked at and addressed at some level, and that there appears to be a serious intent to improve the program and conditions at MSOP, as suggested by the following:

1. The living-conditions-concern for patients in the St. Peter campus had been looked into; and some of the major issues appear to have been resolved.
2. Staff from medical services eventually addressed the HRB. A night nurse had been hired and the Board was told that psychiatric services would be increased.
3. The plight of transition patients at the St. Peter campus appears to have improved.
4. The clinical teams' decision to reconsider the future of some would-be transition patients was noted by the HRB.
5. There has been no recent request for increase in access to fresh air.
6. A new grievance procedure has been put in place.
7. An independent team of professionals in the field of sex offender treatment had recently audited the MSOP.

Items 1 through 7 above notwithstanding, the MSOP Hospital Review Board is concerned that the good intention to improve the program and its parameters does not consistently get translated into the ways MSOP patients are dealt with on a daily basis, and consequently makes the following recommendations:

1. The HRB urgently recommends that MSOP respond to HRB recommendations. While as noted above, MSOP administrative and clinical staff and DHS senior management staff have been cooperative with the HRB in the verbal discussion of certain critical issues and concerns, the lack of written response by MSOP to HRB recommendations in the past has been read as yet another example of MSOP's blatant disregard for a legally designated means by which patients' concerns are heard and addressed. This lack of response, despite letters expressing concern from both the Chairperson of the Board and the Ombudsman's Office, as well as reported comments made by staff about the HRB's role, sends several messages, neither positive nor flattering; to wit, it calls into question the seriousness with which MSOP takes the Board's offer of assistance in improving the program; it implies a level of disrespect and perhaps even an arrogant stance that the facility can, and does, ignore expressions of concern by patients, and renders the input of the HRB meaningless and pointless. Even as one grants that certain pathologies might sometimes manifest themselves in the nature of issues presented, the prudent and responsible position to take appears to be to actively listen as the concern is presented. It had been intimated that the Board considers only the patients' sides when it makes its recommendations. Albeit, that one of the reasons the HRB was created was indeed to review patients' concerns and programs, such an intimation is totally unfounded and greatly suffers credibility when even the HRB's requests for the facility's side on issues remain ignored. It had also been suggested that only the disgruntled patients, and not those well into treatment, come to the Board with concerns. Again, this position is unsupported by the data: about half of the patients who have come to see the HRB during this period were participants in treatment. Further, when the HRB spoke to patients in the Transition Program and the Advanced Treatment Unit, echoes of unhappiness and dissatisfaction with the program were also heard from these patients who have consistently participated in the program with apparent serious intent. Finally, the excuse that only unhappy patients present their concerns to the HRB is a poor one to use for not responding to HRB recommendations, as MSOP should be endeavoring to hear the concerns voiced by ALL its patients.

2. There is a serious need to improve the environment at both the Moose Lake and St. Peter campuses to reflect MSOP's stated intent of providing treatment to patients. While acknowledging the need for ensuring security and safety, the barbed wires, yellow uniforms, the highly intrusive way of doing window checks, reported indiscriminate use of cuffs and shackles, the seemingly punitive emphasis of the program, all take away from a therapeutic atmosphere. The HRB recommends that MSOP take another look at, and separate, and address accordingly, treatment from security concerns. It is disturbing that patients who had been civilly committed because they display symptoms of certain pathologies may not be receiving therapies to address

the very same pathologies. Also, conceivably, it is difficult to accept invitations to participate in treatment when the program offered does not resemble one's idea of treatment. The Courts have made it clear that these patients are committed for treatment NOT punishment. MSOP faces potential civil rights suits due to the punitive nature of the program.

3. Related to the second recommendation is the Board's observation of the pervasive feeling of hopelessness among patients that was reported in the first HRB annual report in 2003, and continues to be persistent at this time. This, the Board has heard from patients who have just been civilly committed as well as patients who have almost completed the treatment program; there seems to be no "real graduation from this program", and that in effect, a patient's civil commitment is equivalent or parallel to a life sentence in prison. While the Board acknowledges that at the moment, there is no conclusive and incontrovertible proof that sex offender treatment really works, and that it is more than prudent to have safeguards in place to ensure the public's safety, the HRB recommends that MSOP seriously consider end of treatment options, if one there be, for patients who have assiduously and consistently participated in treatment. The aid of currently available monitoring technology, as well as strategies used by similar treatment programs in other States, might be useful to consider. There is currently a critical need to convince patients at MSOP that progress is possible and that an achievable goal is indeed part of the program.

4. The Board reiterates the recommendation to make treatment and treatment plans really individualized. For example, it seems pointless to have someone attend a module on how to deal with substance abuse when the patient neither has a history of, nor an identified need, in the area. Further, the need to involve the patient in his own treatment planning is reiterated; it not only helps the patient understand better the need to pursue certain treatment strategies, it also helps the patient become more invested in his own treatment plan.

5. The Board reiterates the recommendation for a regular and timely review of treatment progress and treatment plans.

6. The Board reiterates the recommendation for MSOP to improve documentation and charting. The heavy reliance on records to make decisions affecting patients' lives makes this concern critical. The need to improve accuracy and objectivity has been previously noted. There is also a need for more timely documentation of reviews and events.

7. The need to change the entire culture of the program has been discussed by the HRB with MSOP administrative and clinical staff and also with senior management at DHS. Assurances had been given that this area would be a focus of the facility's efforts. However, the HRB continues to hear that patients are treated with disrespect and with such blatant disregard for their dignity and rights as human beings. There remains to be an apparent need for staff to deliver treatment to, and interact with patients, with more respect and at a certain level of professionalism. Patients who already feel they have little to no dignity do not need to be treated with further indignity. The Board recommends a more serious tracking of staff in this regard, and that consequences be spelled out for staff who violate the rules of decent and respectful interaction with patients.

8. The Board reiterates the recommendation that MSOP reviews and addresses the needs of patients whose particular deficits (mental health issues, cognitive deficits, or physical needs) prevent them from benefiting from what MSOP offers.

9. The Board recommends that MSOP review its visitation policy. Additionally, the HRB recommends that MSOP explore the roles of family members and friends can play in the treatment process and how those who are willing can aid in treatment, instead of discounting them.

10. The Board recommends that MSOP look into, and address immediately, reports of possible due process violations. The fact that this patient population does not seem to have any real constituency backing them makes this a real serious concern; that is, to ensure that their rights are protected becomes of paramount importance.

11. The Board reiterates the recommendation that MSOP review its current behavior programs and terminate or revise the ones that have produced neither increase in desirable behavior nor decrease in undesirable behavior.

12. The Board reiterates the recommendation that MSOP increase diversity in the program. A more serious look at how to increase staff diversity needs to be done. A more serious look at how staff skills might be improved so that the needs of minority members of the patient population are considered and addressed should also be taken.

13. The Board is concerned about the use of administrative isolation by MSOP without an actual policy defining clearly how, when, and the why of its use; and what parameters guide staff's use of this isolation practice. The HRB recommends that the use of administrative isolation be stopped immediately until a policy defining its use is in place. If the need for isolating a patient is urgent, the protective isolation policy currently in existence might be used, allowing independent review of each use of isolation.

14. The HRB is concerned about the seemingly big chunks of time (on a daily basis, and in between trimesters) patients appear to have and recommends that the MSOP clinical teams pursue more work options, other strategies for skill development, or other pursuits by which these patients can engage their time in more meaningful ways.

15. Finally, it is the Board's overall recommendation that MSOP put just as much time and money into developing a functionally viable treatment environment, as they have into facility security and the creation and enforcement of new and existing policy. There does not appear to be a balanced effort toward these two pursuits as evidenced by the many inequities patients had reported, and continue to bring, to the HRB. Added to this is the increasingly scary prospect that MSOP is beginning to look like a black hole that feeds primarily on dollars; that is, taxpayers' dollars. There has to be a way to assuage the public's fear while providing a genuine therapeutic intervention.

In conclusion, the Hospital Review Board reiterates its desire to work with MSOP administrative and clinical staff in their efforts to improve their program, one that in the foreseeable future appears destined to grow at a vastly rapid pace.

Submitted by:

John N. Akwuba, Esq.
Wilbur E. Johnson
Thomas L. Powell
Thomas B. Wilson III, Esq.
Josefina S. Colond, Ph.D., L.P., Chairperson of the MSOP HRB