DEPARTMENT OF HUMAN SERVICES

Legislative Report

Minnesota Sex Offender Program: Annual Performance Report (2020)

Direct Care & Treatment Division

January 20, 2021

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $6,000.

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I. Executive Summary

The Minnesota Sex Offender Program (MSOP) provides comprehensive programming to individuals who have been court-ordered to participate in sex offender specific treatment. Clients are civilly committed by the courts and placed in treatment for an indeterminate period, usually following completion of their prison sentence. As of December 31, 2020, there were 737 MSOP clients in St. Peter and Moose Lake facilities, 15 clients at the Department of Corrections who were returned due to revocation or new criminal sentencing, and 30 clients on provisional discharge currently living in the community.

MSOP continues to provide sex offender treatment in a safe and therapeutic environment with a voluntary 85.4% client participation rate. Clients are demonstrating progress, making changes, and advancing through treatment as evidenced by the increasing numbers of clients in the later phases of treatment, court-ordered transfers to Community Preparation Services (CPS), court-ordered provisional discharges into the community, and full discharges.

With the global COVID-19 pandemic affecting so many aspects of life for people personally and professionally, MSOP was no different. Our program needed to immediately and effectively respond to the contagious virus potential within our residential facilities across two campuses. Command Posts were established, protocols and practices were developed and implemented, and our staff worked diligently to keep themselves and our clients safe and healthy. For almost nine months, MSOP was fortunate to not have had one positive COVID case within our client population. However, by late November, clients began testing positive and by the close of 2020, a total of 88 clients contracted COVID. Also, to date we sadly have had 3 client deaths, which occurred while they were hospitalized. Programming and treatment opportunities have been greatly impacted due to the need to separate clients by unit and maintain isolation and quarantine units within our facilities. Our health services staff have done a remarkable job taking the lead as we navigated our way through this pandemic.

MSOP's interdisciplinary teams continue to maintain a strong therapeutic environment supportive of client change. Improvements continue to occur within our clinical department for enhanced delivery of services. This past year we explored and implemented numerous cost savings ideas, time and program efficiencies, and instituted streamlining processes across MSOP departments.

Due to budget deficits within Direct Care and Treatment this past year, DHS made the decision to close the MSOP-DOC site which was located within the Moose Lake prison. Established in 2002, the program successfully provided MSOP treatment to sex offenders who were at high risk to be civilly committed. In addition to this closure, several employees of MSOP were laid off, which was a difficult and disheartening process.

Quality and safety being of highest priority for our program, MSOP was again recognized and received safety awards from the Minnesota Safety Council for excellence in workplace safety at both our Moose Lake site (6th consecutive year) and our St. Peter site (8th consecutive year).

Strengthening our therapeutic living environments, ensuring program quality and integrity, growing as a learning organization, encouraging ongoing employee engagement, all while maintaining our responsibility to safety and security, are the values we are invested in and continue to promote. MSOP highlights for 2020 contained in this

report reflect continued focus on our mission to promote public safety by providing comprehensive treatment and reintegration opportunities for civilly committed sexual abusers.

II. Background

M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for MSOP by January 15 of each year. During the 2016 legislative session, a proposal for extending the report's due date to February 15 of each year was approved. This assures a complete and accurate report that reflects all data and statistics of the entire reporting year.

The statute specifies that this report include:

- Program descriptions, including strategic mission, goals, objectives and outcomes
- Calculation of program-wide per diem
- Annual statistics
- Program Evaluation Report occurred in September 2020 (attached)

MSOP is one program, operating across two campuses with three sites. Admissions and most of the primary treatment occur in Moose Lake. After clients demonstrate meaningful change and progress through the first two phases of treatment, they are considered for transfer to the St. Peter campus.

The St. Peter campus has two primary missions which are programming for clients in the Alternative Program and preparation for reintegration through deinstitutionalization. St. Peter provides the Alternative Program for clients with compromised executive functioning due to learning disabilities, developmental disabilities, head injury or trauma, and other issues that prevent them from being successful in conventional programming. These clients participate in all three phases of programming on the St. Peter campus. Clients in Phases II and III of conventional programming participate in opportunities that demonstrate their abilities to use new coping skills and risk management techniques in settings with less structure.

III. Program Overview

MSOP provides comprehensive sex-offender-specific treatment to individuals (clients) who have been civilly committed to the program by the courts.

MSOP operates treatment facilities in Moose Lake and Saint Peter. Clients are civilly committed as Sexual Psychopathic Personalities (SPP), as Sexually Dangerous Persons (SDP), or as both SPP and SDP. The courts are responsible for determining if an individual meets the legal criteria for commitment. The courts are also responsible for determining when a client meets criteria to be provisionally discharged and/or completely discharged from MSOP.

All clients enter MSOP through the admissions unit at the Moose Lake facility. Conventional program clients begin their treatment at Moose Lake; those assessed as being appropriate for the Alternative Program are transferred to St. Peter for all phases of treatment. After successfully progressing through most of their treatment in Moose Lake, conventional clients are transferred to the St. Peter facility to complete treatment and begin working toward reintegration.

All clients participating in treatment develop skills through active participation in group therapy and individual sessions. Clients are provided opportunities to demonstrate meaningful change through their participation in rehabilitative services programming such as education classes, therapeutic recreation activities, and vocational opportunities. MSOP staff observe and monitor clients in treatment groups as well as in all aspects of daily living to determine and provide feedback on how clients are applying new knowledge and prosocial skills.

Strategic Mission

MSOP's mission is to promote public safety by providing comprehensive treatment and reintegration opportunities for civilly committed sexual abusers.

Priorities

MSOP is committed to maintaining a safe and therapeutic living environment for clients and staff. Respect is defined as transparent and proactive communication, accountability, and recognition of the individualized needs of clients. Inherent in respect is the belief that all people can make meaningful change if they possess the motivation and tools to do so. MSOP Principles that guide our staff and clients include personal accountability, respect for others, and community responsibility. MSOP executive leadership has established five strategic goals. These strategic goals are organized under the following five core values: Program Integrity, Therapeutic Environment, Responsibility to the Public, Learning Organization, and Employee Engagement.

MSOP Strategic Goals and Outcomes

Program Integrity

Description:

Program integrity defines the extent to which all program services have been delivered as intended. Integrity ensures that MSOP is carrying out common goals that maintain consistency and quality across departments and sites, encourages compliance and accountability, and protects public funds.

Goal:

1. Increased use of best practices across targeted areas and departments at MSOP by using quality assurance system.
2. Enhance and maintain continuity and consistency of programming.

Strategies:

- Develop and implement a process that evaluates our system relative to current best practices and research in the field.
- Revise ongoing audit system to enhance quality of programming and services.
- Research department establishes and prioritizes hypotheses for research projects.

Therapeutic Environment

Description:

The therapeutic environment refers to the physical, social, and psychological spaces that are specifically designed to support change for each individual and the community. It involves keeping "the client in the center of the room," speaking the same language, having a unified approach while upholding ethical morals and values, understanding theory, and balancing treatment, safety, and security. It is individualized, flexible, and designed to support differing functional levels and approaches to care.

Goal:

1. An established treatment culture is fully integrated into all departments and across all shifts.
2. A strong and comprehensive therapeutic environment exists for all staff and clients.

Strategies:

- Increase training for staff that will weave a "treatment culture" across the program and will enhance understanding of roles within a secure setting.
- Role model how treatment threads throughout the program across all departments and encourage all staff to take responsibility in this process.
- Enhance culture and environment through therapeutic language and messaging during staff supervision and across meeting settings.

Responsibility to the Public

Description:

The extent to which MSOP maintains safety within the facilities and to the public, demonstrates transparency consistently, fulfills obligations to stakeholders, is responsive and timely to concerns and questions, and is fiscally responsible.

Goal:

1. Increased awareness and education regarding MSOP's commitment to public safety.
2. MSOP clients are well prepared to enter the community with safe and healthy engagement.

Strategies:

- Increase community awareness by teaching, presenting, and networking about sexual offending behavior, civil commitment in MN, sex offender treatment, and risk at a wide variety of public forums.
- By soliciting feedback from clients on PD, outpatient providers, and reintegration agents, increase and refine client reintegration preparation strategies inside the perimeter and at CPS to enhance public safety and client success.

Learning Organization

Description:

MSOP promotes and maintains a strong learning environment with valuable learning opportunities to meet the diverse professional development needs of staff within an organic and evolving program. MSOP strives to create, transfer, and modify philosophy and policies to reflect new knowledge and insights.

Goal:

1. Staff are confident and competent in their roles and recognize how they contribute to client change.
2. Reputation as being a state-of-the-art sex offender treatment program is enhanced.

Strategies:

- Learning and supervision gaps are addressed on all watches.
- To build on competencies, support and engage staff in self-assessment as part of their professional development.
- Build comprehensive framework and promote "One MSOP Team" concept fostered by multi-discipline and multi-location exchanges for learning and solution finding.

- Increase professional networking opportunities “bringing the outside in.”

Employee Engagement

Description:

MSOP promotes a culture where all staff are essential to maintaining a safe and therapeutic treatment environment. Employee engagement encompasses the relationship between the employee and the work. MSOP provides opportunities for staff to contribute meaningfully to the program, to be supportive of one another, to recognize and acknowledge employee commitment, and to encourage new ideas and alternative ways of thinking.

Goal:

1. MSOP has an engaged work culture.
2. Staff build and maintain healthy person-centered supervisory relationships to enhance overall employee satisfaction.

Strategies:

- Staff are supported and encouraged to invest in self-care activities.
- Staff have opportunities to learn about and understand the expected benefits of change as well as participate in creative ways to promote positive client change.
- Collaboration with other departments becomes the norm through joint efforts and inclusiveness of ideas across departments and disciplines.

IV. Treatment and Model Progression

Program Philosophy and Approach

MSOP draws on several contemporary treatment approaches in its programming. These include cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by the professional psychological literature in the areas of risk/needs/responsivity and stages of change, with additional philosophical influence from the “Good Lives” model.

Each client participating in treatment is guided by an Individualized Treatment Plan that defines measurable goals. These goals are updated as the client progresses through treatment.

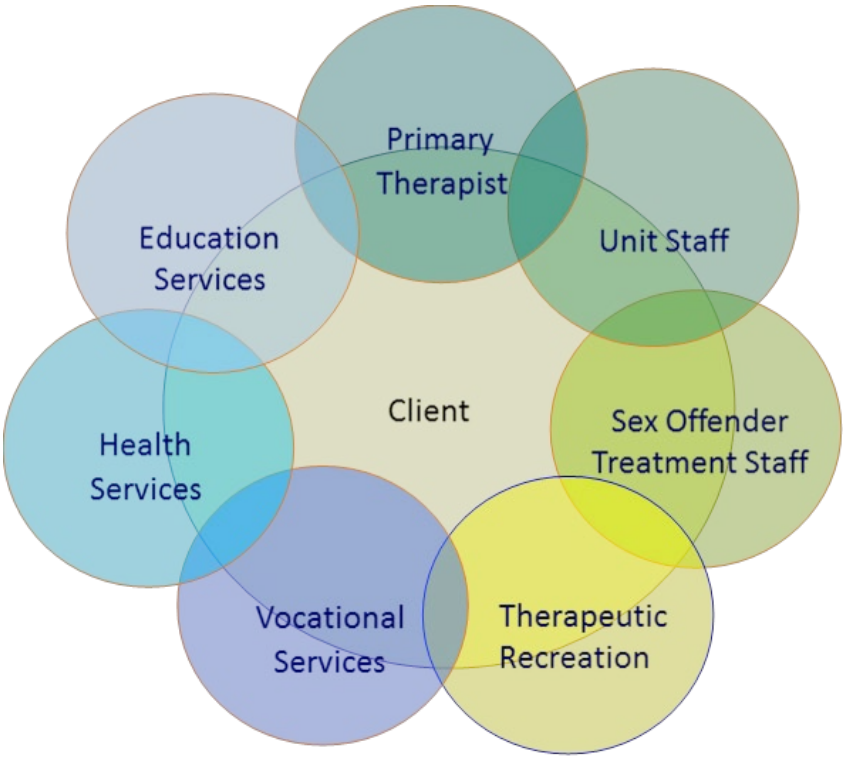
Clients progress through three phases of treatment. In the initial treatment phase, clients acclimate to treatment and address treatment-interfering behaviors and attitudes. The next phase is the intermediate treatment phase with a focus on a client’s patterns of abuse and on identifying and resolving the underlying issues in their offenses. Clients in the final treatment phase focus on maintaining the changes they have made and demonstrating their ability to consistently implement those changes and manage their risk while they work on deinstitutionalization and community reintegration.

Comprehensive and Individualized Treatment

MSOP provides comprehensive treatment. Clients acquire skills through active participation in psychoeducational modules and group therapy and are provided opportunities to demonstrate meaningful

change through participation in rehabilitative services including education classes, therapeutic recreational and vocational work programs. Clients are observed and monitored not only in treatment groups, but in all aspects of daily living. Observation and monitoring are crucial for assessing clients' progress in making and maintaining meaningful personal change and in consistently applying treatment concepts, thereby decreasing their risk for re-offense.

Clients who participate in treatment have an Individualized Treatment Plan. Each plan is developed with the client and the client's primary therapist. The plan's goals are written to address the client's individual risk factors for recidivism and specific treatment need areas. Treatment progress is reviewed on a quarterly basis, and plans are modified annually or as needed.



MSOP clients who choose to engage in treatment participate in a sex offender assessment that sets the foundation for their Individualized Treatment Plan. Clients are then placed in programming based on their clinical profiles. MSOP provides sex-offender-specific treatment to meet the needs of all clients.

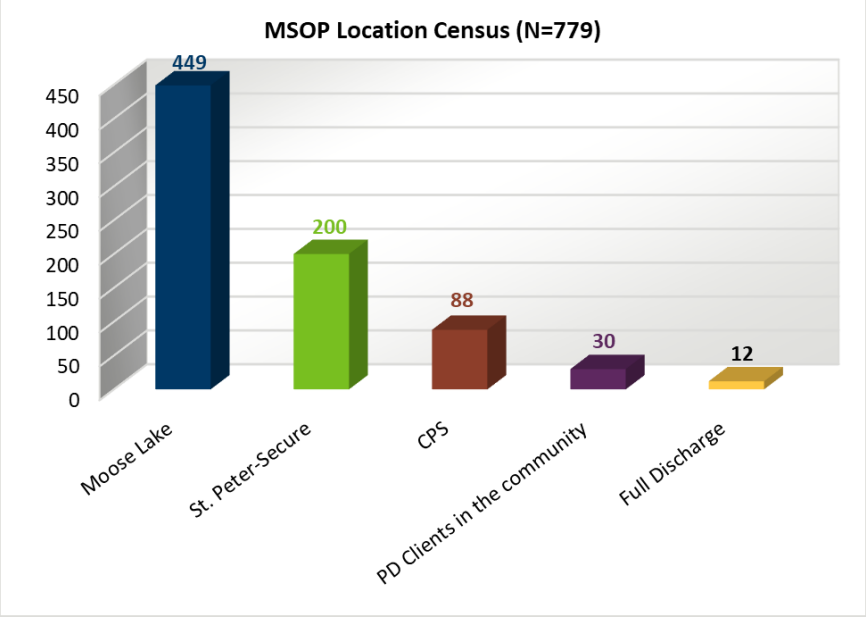
Treatment Progression

Clients address their own individual risk and treatment needs by adhering to their Individualized Treatment Plans. They attend psychoeducational modules based on their treatment needs and core groups. On a quarterly basis, all clients are reviewed on MSOP matrix factors, which are based on the criminogenic needs in current research.

The matrix factors are:

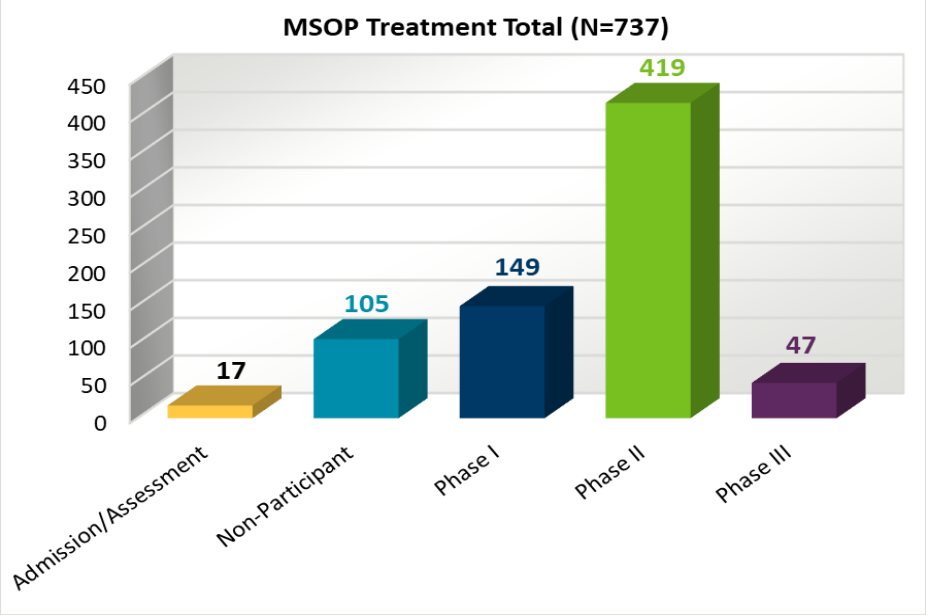
- Group behaviors
- Attitude to change
- Self-monitoring
- Interpersonal skills
- Sexuality
- Cooperation with rules and supervision
- Healthy lifestyle
- Life enrichment
- Thinking errors
- Prosocial problem solving
- Emotional regulation

On a quarterly basis, each client participating in treatment conducts a self-assessment and the results are compared with the observations and assessments of the client's primary therapist and treatment team. Individualized Treatment Plans and treatment targets are modified accordingly.



Note: *Chart Data as of 12/31/2020*

In the history of the MSOP, 45 clients have been given provisional discharge orders. Thirty are currently living in the community on provisional discharge, 6 have been revoked, 12 have been fully discharged, and 2 have provisional discharge orders issued and are waiting placement/appeal.



Note: *Chart Data as of 12/31/2020*

V. Community Preparation Services

As part of the treatment program at MSOP, Community Preparation Services (CPS) was developed and operates as a free-standing, unlocked, "step-down" residential facility located on St. Peter's lower campus. CPS prepares clients for their transition and reintegration back into the community. When a client petitions for a reduction in custody, the Commitment Appeals Panel (CAP) grants orders for clients who meet the statutory criteria for transfer from the secure perimeter to CPS to continue their treatment in a less restrictive setting.

Treatment at CPS utilizes the same treatment progression phase system as used in the secured MSOP facilities. Additionally, a stage system is used to indicate progress at CPS. Client treatment focuses on increasing internal motivation for change, learning and managing individual risks, and applying treatment skills across settings. When clinically indicated, clients may have supervised opportunities to practice treatment skills in community settings in preparation for successful reintegration into the community.

Established in 2008, the program has experienced tremendous growth in the past few years. A total of 187 clients have received transfer orders since the inception of CPS. At capacity since 2016, 88 clients reside at CPS. Due to bed capacity limitations, a waitlist of 49 clients existed as of December 31, 2020.

Phase I of the approved 2015 bonding request was completed in 2016 and MSOP opened a 30-bed wing for clients being transferred by the courts. Due to that expansion, we have 89 total beds at CPS, which has been at capacity since the addition opened in 2016. Bonding for Phase II was in the Governor's budget for the 2016, 2017, 2018, and 2019 legislative sessions; however, the bonding requests were not approved. Bonding for Phase II would expand CPS to accommodate the additional clients granted transfer orders by CAP. Without additional bed space and infrastructure added outside the secure perimeter, the state is forced to defer a growing number of court-ordered transfers. The Governor supported $18 million in funding during the 2020 legislative session to resolve this issue. MSOP was approved $1.8 million to expand CPS by 20 beds. We are currently attempting to work with that funding to build additional beds. However, the remaining $16.2 million is still necessary to build a total of 50 beds and basic infrastructure.

VI. Reintegration

MSOP operates a robust Reintegration Department that provides management and supervision of MSOP clients granted a provisional discharge (PD) and placed into the community. MSOP clients on PD are closely monitored and supervised by trained Reintegration Agents who are responsible for overseeing compliance with the client's court-ordered Provisional Discharge Plan. In addition, Reintegration Agents assist clients in establishing housing, securing out-patient sex offender treatment, finding employment, as well as providing other case-management services. MSOP has a Tier 1-5 supervision continuum that is aligned with best practices and matches each individual client's risk and needs with supervision dosage and intensity.

Twelve clients were granted a provisional discharge and placed into the community in 2020, while 4 clients were granted a full discharge from civil commitment. As of December 31, 2020, MSOP is supervising a total of 30 clients who are residing throughout Minnesota communities on a provisional discharge. In the history of MSOP, 45 clients have received a provisional discharge from the courts and 12 clients have received a full discharge.

The priority of the MSOP Reintegration Department is to promote public safety by closely managing and supervising clients on provisional discharge to reduce recidivism and promote successful client outcomes.

VII. Program Per Diem and Fiscal Summary

Description		FY 2021 Approp. $$	Per Diem
Direct Costs			
Clinical	$	19,050,756	69.49
Healthcare and Medical Services	$	6,599,805	24.08
Security	$	38,101,579	138.99
Community Preparation Svcs	$	6,526,464	23.81
Dietary	$	2,460,951	8.98
Physical Plant & Warehouse	$	8,083,445	29.49
Program Support	$	12,394,300	45.21
Total Direct Costs	$	93,217,300	340.04
Operating Per Diem			*$ 340*
Indirect Costs			
Statewide Indirect	$	94,124	0.34
DHS Indirect	$	2,781,722	10.15
DCT Operations Support	$	1,790,189	6.53
Building Depreciation	$	4,216,563	15.38
Bond Interest	$	5,670,200	20.68
Capital Asset Depreciation	$	90,840	0.33
Total Indirect Costs	$	14,643,639	53.42
Total Costs	$	107,860,939	393.46
Average Daily Census (ADC)		749	
Published Per Diem Rate			$ 393

MSOP Per Diem

MSOP uses a comprehensive per diem calculation that includes all direct and indirect costs, including costs incurred by the state for bonding and construction of physical facilities. This all-inclusive per diem for fiscal year 2021 is $393.

Direct Costs – Costs attributed to providing care and treatment to clients, maintaining facilities and providing general support services to operate the program.

Indirect Costs – Costs not directly attributable to the program but are allocated/assigned as a cost of the overall operations of the program.

NOTE: *The program support costs mainly consist of legal (including litigation), client evaluations, and Workers Compensation expenses.*

VIII. Annual Statistics

Current program statistics through December 31, 2020 are listed below.

- Total MSOP Clients: 737

Clients by Location	Count	Percentage
Moose Lake	449	60.9%
St. Peter-Secure	200	27.1%
CPS	88	11.9%
Total	737	100.0%

Clients by Age	Count	Percentage
21 - 25	3	0.4%
26 - 35	72	9.8%
36 - 45	184	25.0%
46 - 55	182	24.7%
56 - 65	199	27.0%
Over 65	97	13.2%

Age Ranges

- **Youngest:** 24 years
- **Oldest:** 87 years
- **Average Age:** 51 years

Clients by Race	Count	Percentage
American Indian/Alaskan Native	53	7.2%
Black/African American	105	14.2%
Other/Unknown	39	5.3%
White/Caucasian	536	72.7%
Asian/Pacific Islander/Multi Racial	4	0.5%
Total	737	100.0%

Clients by Education	Count	Percentage
Elementary School	17	2.3%
Some High School	52	7.1%
GED	221	30.0%
High School Degree	326	44.2%
High School Degree and GED	8	1.1%
Some College	51	6.9%
College Degree	20	2.7%
Unknown	42	5.7%
Total	737	100.0%

Commitment Type	Count	Percentage
PP Final	38	5.2%
SDP Final	431	58.5%
SPP Final	9	1.2%
SPP/SDP Final	252	34.2%
Judicial Hold	7	0.9%
Total	737	100.0%

Commitment County	Count	Percentage
Metro	287	40.8%
Non-Metro	450	59.2%
Total	737	100.0%

* Metro counties include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Population Statistics

Admissions	Count
New Admissions	18
Transfers In	25
Total Admissions	43
Departures/Transfers	
Transfer – Provisional Discharge	14
Transfer – DOC Revocation	5
Transfer – Forensic Nursing Home	6
Transfer – New Criminal Sentence	4
Departure - Death	5
Departure – Court Order Discharge/Dismissal	6
Total Departure/Transfers	40
Net change (Admissions – Departures/Transfers)	+3

When civil commitment is pursued for an individual, upon expiration of a DOC sentence or a supervised release date, he or she is placed on a judicial hold while the petition is pending. Individuals on judicial holds have the option to remain in a DOC facility (210 days maximum) or to be admitted to MSOP.

Clients Pending Civil Commitment	Count
Clients on judicial hold status in the MSOP	9
Clients on judicial hold status in the DOC/Jails	5
Total on judicial hold status	14

The civil commitment process in Minnesota is started by a county attorney, in the area the crime occurred, by filing a petition for commitment. During the commitment hearing, the county court will determine if the individual meets the statutory criteria for civil commitment. If this burden is met and the client was not already admitted, the individual is committed and transferred to MSOP.

Many clients civilly committed to the MSOP remain under DOC commitment on DOC supervised release status ("dually committed"). If these clients engage in actions or criminal behaviors resulting in the DOC revoking their supervised release status, or resulting in a new conviction, the clients are returned to DOC to serve a portion or all other criminal sentences. Even in DOC custody, these clients remain under civil commitment and will return to the MSOP upon completion of their periods of incarceration.

As of December 31, 2020, there were 17 clients dually committed and currently residing in DOC or federal prison.

Dually-Committed Clients:	Count
Clients who are under civil and DOC commitment in the MSOP	135
Clients who are under civil commitment and in a DOC or federal prison	17
Clients who are under civil and DOC commitment on Provisional Discharge	1
Total number of dually committed clients as of December 31, 2020	153

Clinical Statistics

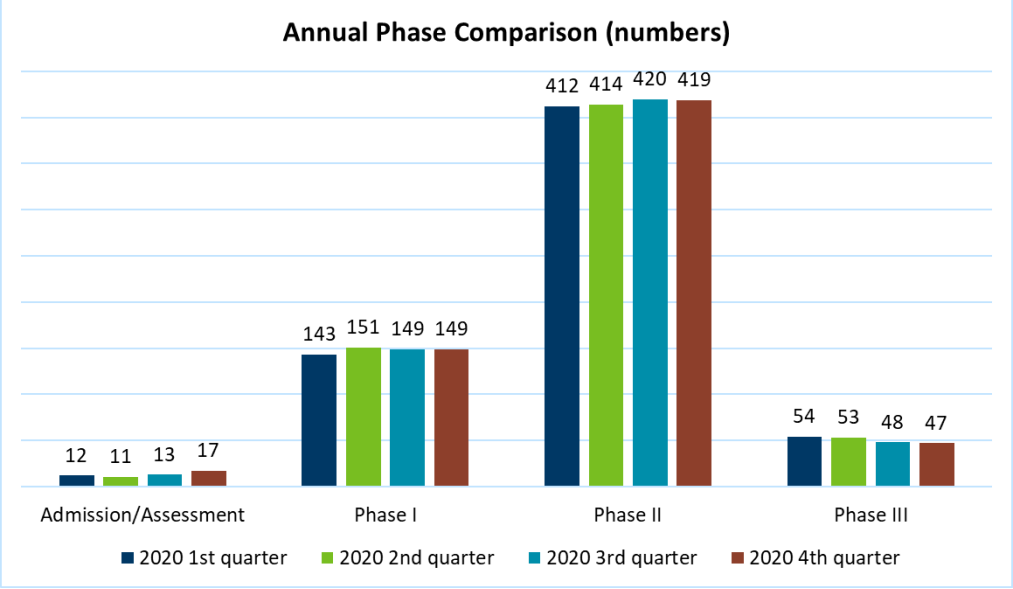
Treatment Participation

All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients can participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment (720), 85.4 percent were participating at the end of 2020.

Once the civil commitment process is finalized, an individual is encouraged to participate in treatment. If the individual chooses to engage in treatment, a sex offender assessment is completed, and an Individualized Treatment Plan is developed to address unique needs.

Treatment Progression

The phase progression data show how clients are progressing through the three treatment phases. The chart below represents the treatment progression of clients over the past calendar year. Note, clients granted provisional discharge are not included in this chart.



The following chart illustrates the 2020 distribution of clients across the treatment units. The MSOP population is diverse with 20 percent of the clients residing on units that provide specialty programming while 78 percent reside on units providing conventional treatment. The remaining two percent of the population resides on the Admissions/Assessment unit, which does not provide sex-offender specific treatment.

Treatment Unit	Location	Count	Percentage
Admission/Assessment	Moose Lake	17	2.3%
Alternative Programming	St. Peter	95	12.9%
Assisted Living	Moose Lake	22	3.0%
Behavioral Therapy	Moose Lake	29	3.9%
Conventional Programming	All 3 sites	574	77.9%
Total		737	100.0%

IX. MSOP Evaluation Report Required Under Section 2468.03

Site Visitors:	Robert McGrath, McGrath Psychological Services Middlebury, Vermont
	William Murphy, University of TN Health Science Center Memphis, Tennessee
	Jason Smith, Assessment & Counseling Associates West Des Moines, Iowa and Middleton, Wisconsin
Location:	Minnesota Sex Offender Program, St. Peter, Minnesota
Dates of Visit:	September 21, 22, 23, and 25, 2020
Date of Report:	September 29, 2020

Purpose and Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program. The consultation was a component of MSOP's quality improvement program. The present site visit was a follow-up to our previous site visits. The last Moose Lake site visit was in November 2018.

During the several months prior to the present visit, the MSOP has had to adapt to the significant challenges of operating programs during the COVID-19 pandemic, which has included reductions in staffing levels due to budget restraints and COVID-19 staff leaves.

We conducted the present three and one-half-day review remotely rather than onsite due to COVID-19 pandemic travel restrictions. We used the facility's Skype for Business and VidyoDesktop meeting platforms to conduct individual and group interviews with staff across program disciplines and individual interviews with clients.

During the last day of the site visit, we reviewed and discussed our initial findings with Nancy Johnston, MSOP Executive Director; James Berg, MSOP Deputy Executive Director; and Jannine Hebert, MSOP Executive Clinical Director for one hour on September 25, 2020. Following this meeting, we again reviewed and discussed our initial findings with a larger group of senior managers at both sites via videoconference for one hour.

Evaluation Request

The MSOP requested that we evaluate two aspects of the program at Moose Lake.

We were asked to interview staff in each department regarding their current degree of engagement in the program.

I. We were asked to evaluate the Omega Unit program design and implementation, including step-down processes and the roles of clinical and operations staff.
II. A particular focus of the evaluation request was to examine the working relationships between operations and clinical staff.

Procedure

We reviewed the following written materials:

- MSOP Annual Performance Report 2019 (1/27/2020)
- Quarterly reports, second quarter 2020, for the following programs:
  - Reintegration
  - Moose Lake operations/facility
  - Moose Lake clinical
  - Moose Lake vocational and rehabilitation
- Organizational Charts for each department
- Unit Omega Unit Handbook (4/2017)
- Unit Omega 1, 2 and 3 Maps
- Unit Omega admission, referring unit, and length of stay data sheet (9/14/2020)
- Unit Omega client Weekly Schedules (effective 9/13/2020)
- Five Omega client Individualized Treatment Plans and 2 Individualized Program Plans
- Project Plan: Behavior Therapy Unit (BTU) Restructure (2019)
- Property List policy (420-5250d; 12/2019)
- Client Property policy (420-5250; 8/4/2020)
- Behavior Therapy Unit Clinical Handbook (undated)
- High Security Area policy (415-5087; 7/7/2020)
- Administrative Restriction Status policy (415-5084; 7/7/2020)
- Treatment Overview policy (215-5005; 3/3/2020)
- Recent MSOP Site Visit Reports

During the site visit, we engaged in the following activities:

- Met in small group and/or individual meetings with the following senior management staff:
  - Nancy Johnston, MSOP Executive Director
  - James Berg, MSOP Deputy Executive Director
  - Jannine Hebert, MSOP Executive Clinical Director
  - Peter Puffer, Clinical Director
  - Kevin Moser, Facility Director
  - Terry Kneisel, Assistant Facility Director
  - Ann Linkert, Security Director
  - Courtney Menten, Associate Clinical Director
  - Kathryn Schesso, Associate Clinical Director

  - Nancy Stacken, Associate Clinical Director
  - Chad Mesojedec, Rehabilitation Therapy Services Director
  - Steve Sajdak, Program Manager
  - Charlie Hoffman, Vocational Director

- Met with individuals in the following staff groups:

  - Assessment Unit Director (1 individual meeting)
  - Clinical Supervisor (1 meeting that included an Associate Clinical Director)
  - Clinicians (9 individual meetings)
  - Treatment Psychologists (2 individual meetings)
  - Unit Directors/Group Supervisors (4 individual meetings)
  - Security Counselors (8 individual meetings)
  - Teachers (2 individual meetings)
  - Rehabilitation Counselors (2 individual meetings)
  - Vocational Supervisor (1 individual meeting)
  - Skill Development Specialist (1 individual meeting)
  - Recreation staff (2 individual meetings)
  - Volunteer Services Coordinator (1 individual meeting)

- Met with 8 Unit Omega clients in 8 individual meetings

The administrative and clinical team provided site visitors with access to all documents requested and all staff and clients that the site visitors requested to interview.

Consultation Approach

We evaluated the program against best practice standards and guidelines in the field. These included the Association for the Treatment of Sexual Abusers (ATSA) Practice Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers and the sexual offender and general criminology "What Works" research literature. Concerning issues where relevant guidelines and standards do not exist, we evaluated the program against common practices in sex offender programs, in particular other sex offender civil commitment programs.

Findings and Recommendations

For each of the two program areas that MSOP requested that we review, we detail here are our findings, which focus on identified strengths and areas for further development.

I. Staff Engagement

This has been a challenging time for MSOP staff. During the several months prior to the present visit, MSOP staff have had to adapt to the significant challenges of operating programs during the COVID-19 pandemic, which has included reductions in staffing levels due to budget restraints and COVID-19 staff leaves.

Strengths

1. MSOP is commended for how it has managed the COVID-19 pandemic crisis. As of the date of this report, the Moose Lake site has had no reported cases of COVID-19.

2. Staff are to be further commended for their resiliency and commitment to providing services at the highest level allowable in the COVID-19 environment. As a group, staff rose to the challenge and worked collaboratively and effectively during a period of crisis.

3. Staff across departments consistently expressed the opinion that the facility's response to COVID-19 was handled well. Overall, staff reported that they believed that the facility administration had staffs' best interest at heart during the COVID-19 restrictions.

4. Staff consistently commended the facilities' use of the incident command post structure. In a rapidly-changing environment, it was successful in addressing the COVID-19 crisis. Overall, staff reported that there was good communication.

5. Staff generally reported good communication with the facility and general transparency in decision making processes. For the most part, staff at all levels and among all departments reported they were provided with information about changes in policies and procedures, rationale for why things were being done, and where to get answers if they had questions. Staff reported that they had access to multiple useful information sources, such as the facility "home page," email notices, staff meetings, and communication from supervisors.

6. Staff readily adopted the use of technology, such as remote communication strategies, for team meetings, program supervision, and oversite as well as other regular work tasks.

7. Although some staff who stayed working in the facility during the COVID-19 crisis expressed resentment towards some staff who were out on COVID-19 leave, it appears that overall staff have maintained professionalism, and there was no reported negative work impact.

8. In particular, staff consistently reported that they value and feel supported by their supervisors and work teams. Several staff reported that the close and supported relationships they have with their colleagues is a principle contributor to their job satisfaction.

9. Staff consistently reported enjoying and finding value in their work and that, overall, they felt they were making a difference in the lives of the clients in the program.

10. The facility response to COVID-19 was seen by some staff as evidence of how all departments can work collaboratively when needed. During the crisis, for example, several staff showed a willingness to fill in where needed, staggered shifts were used to expand services, staff learned other people's job roles through working out of class, and some staff felt a closer connection to co-workers who stayed working.

11. Staff generally reported having a manageable workload.

12. Staff overall believed that they work in a safe environment, while also acknowledging the potential for violence given the population being served. There was an acceptance of the potential risk of violence as being part of the job when one works in this type of facility.

II. Areas for Further Development

1. Although most units reported good collaboration and teamwork, operations and clinical staff on a few units could benefit from increased collaboration.

2. As the program begins to return to a relatively normal operating status, the staff engagement committee should begin meeting again.

3. Use of regularly administered staff satisfaction surveys may help provide the program direction to facilitate continued positive staff engagement.

4. The program should continue to provide staff with as much information as possible about the budget situation and how staffing decisions are made. Newer staff expressed concern about maintaining their positions. Supervisory staff expressed concerned about the impact on their ability to have adequate staffing levels and having input into staffing decisions. Both groups reported that the uncertainty was stressful.

5. As a result of COVID-19 restrictions, client programming and movement in the facility was restricted. The program is encouraged to continue its efforts to find opportunities for increased clinical contact with clients (structured and unstructured) and provide off unit activities within the COVID-19 restrictions. As time goes on, the impact of less clinical contact and client movement will undoubtedly increase tension and impact the therapeutic milieu.

III. Omega Unit Program Design and Implementation

The Omega Unit is the Moose Lake program's Behavior Therapy Unit (BTU). It consists of two four-bed units (Omega 1 and 2) and one 25-bed unit (Omega 3). All rooms are single occupancy. The original intent of the unit was to provide a more structured environment to address the needs of clients who posed a risk to the safety of other clients and staff, and clients who were disruptive to a positive therapeutic environment on other living units. Clients on the unit have higher levels of supervision, more limited movement, more restrictive property policies, and more structured programming than on most other living units in the facility. The original intent was for placement on Omega to relatively short term.

Operations and clinical staff recognize that the Omega Unit is not operating as initially planned. Client length of stay on the unit can be quite lengthy and the stay for a small number of clients is well over a year. Since Omega is the only major living unit with single occupancy rooms, some clients are intentionally acting out to be sent to Omega. Some clients refuse to return to their assigned living unit so that they can continue to avoid having a roommate. Some clients are recycling through the Omega Unit multiple times. Recently, there has been an increase in significant behavioral problems on Omega.

All inpatient psychiatric and correctional facilities face the common challenges of providing services to small subset of clients that require significant amount of care. Because of recognized difficulties in managing this population in the Moose Lake facility, draft project plans for restructuring Omega has been developed under the leadership of Terry Kneisel, Assistant Facility Director, and Courtney Menten, Associate Clinical Director for Omega. In the draft plan, Omega 1 and 2 would be for clients with serious and acute behavioral management problems and Omega 3 would be designed as a more long-term program for clients with less acute behavioral management problems.

Strengths

1. MSOP continues to maintain a culture that is committed to continuous quality improvement. Identification of the Omega Unit for an open, detailed, and transparent review process is an example of the MSOP's commitment to continuous quality improvement.

2. Even though Omega is serving a population that is difficult to manage, which includes clients with high levels of criminality, clinical staff reported they liked working on the unit.

3. Clinical staff value each other and are supportive of each other.

4. There is respect and an overall good working relationship between security and clinical staff.

5. During the COVID-19 pandemic, there have been more treatment opportunities (approximately 7 hours per week) on the Omega Unit than other living units.

6. Several staff noted that they value and appreciate having a Unit Director assigned to be onsite in the Omega Unit. The current Unit Director of Omega was assigned to this position about three months ago, and staff believe that this has improved the functioning of the program.

Areas for Further Development

1. There is currently considerable variation among staff about how they view the purpose and goals of Omega. The program should ensure that there is a clear statement of the purpose and goals of the BTU. Once the purpose and goals are clarified, the treatment model should be modified accordingly. Several types of information may help inform this process.

    a. Frequency data should be collected and analyzed about Omega program client length of stay to help, for example, identify subpopulations of clients and their varying treatment needs.

    b. Clinical characteristics of the Omega population (e.g., reason for referral, diagnoses, and reasons for not wanting to leave) should be identified to further determine and help meet the treatment needs of this population.

    c. Feedback from other stakeholders impacted by proposed Omega program changes should be sought (e.g., the High Security Area program)

2. Based on currently available data, there were 163 client admissions to Omega from 1/1/19 to 9/14/20. Of these 163 admissions, 107 were for unique individuals admitted to Omega during this time. Assuming an overall average Moose lake population of 455 clients, almost one-quarter (23.5%) of the Moose Lake client population was admitted to Omega during the last 19 months. Based on our experience with other civil commitment programs, this is a relatively high percentage of client admissions to a behavioral management unit. As there are currently rather broad admission and discharge criteria for the program, this may lead to more admissions to Omega than is necessary. The program should develop of more detailed admission and discharge criteria for the program.

3. At the current time there are two routes to admission to Omega. One is clinical where the referring unit team reviews a client and determines if the client is showing a pattern of behavior that is not responding to interventions on their assigned living unit and might benefit clinically by placement on Omega. In such cases, we recommend that there be a formal written referral process. This would include a referral form and referral package which would be reviewed by the Omega treatment team. The referral form should clearly specify reasons for the referral and what interventions have been attempted to avoid a more restrictive environment.

   The second route of admissions is administrative. This usually occurs in situations where the client is engaging in dangerous behavior to self or others and operations staff makes the decision to place the client directly on Omega or the client is placed in the High Security Area and then transferred to Omega. A referral form that states reason for referral to Omega should be used. In cases where the admission is administratively made, we recommend that the first approximately 5 days be considered a formal evaluation period. Following the evaluation period, the program should conduct a formal review that includes the Omega team, the assigned living unit team, and clinical and operational leadership staff to develop a treatment plan, which would include the most appropriate unit placement for the client.

4. The program should consider using a formal violence risk assessment instrument, such as the HCR-20, to assist in identifying factors related to identified client violent behavior. This along with other information available from the referring unit should be used to make a formal behavioral management plan for each client.

5. A review of a sample of five Omega client Individualized Treatment Plans (ITPs) and two Individualized Program Plans (IPPs) suggest that ITPs and IPPs could be more focused. They should be clearly related to the behaviors that led to placement on Omega, take into consideration the client's stage of change and be reasonably achievable. Broad goals such as follow all the rules of the MSOP are probably not initially achievable by many of the clients on Omega and should be broken down into smaller steps. Documents reviewed suggest that some clients refuse to cooperate in the treatment and program planning processes process, but every effort should be made for the client to identify goals that they are willing to work on.

6. Omega clients with prolonged Omega stays identified a lack of motivation to leave because of the value of the single man rooms, not being hopeful about an eventual release from the facility, and an expectation that they would have to room with individuals with more challenging behaviors if they return to a regular living unit. Additionally, clients noted that inconsistent rule implementation has resulted in the encouragement for some to engage in problematic behavior on the unit, such as taking unauthorized food items to their rooms, which has enabled their ability to make alcohol.

7. The program should conduct periodic formal reviews of client progress, such as every 30 days, and these reviews should include clinical leadership staff.

8. We support the policy that a clinical staff member from the referring living unit have continued involvement with the client while he is on Omega. The expectation is that the client will eventually return to the assigned living unit.

9. We support the program giving more attention to discharge planning and the transition process. In the past, at least among some units, clients would transition back by initially going to TC groups on the living unit and meeting with potential roommates. We encourage such gradual step-down processes.

10. Security and clinical staff could benefit from additional training in behavioral management and responding consistently to client behavior to address the challenging behavior presented by clients on Omega. Such training should include strategies for assisting clients who have high general criminality and those who are resistant to treatment.

11. It appears several clients are being discharged to 1-C rather than their previously assigned living unit or are being referred to Omega from 1-C. The two units share a large number of clients. Some of these clients have multiple Omega placements. There is some confusion regarding the purpose of 1-C versus Omega and the program could benefit from clarifying the relationship between the two programs.