DEPARTMENT OF CORRECTIONS

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February 19, 2019

Jason Donahue, Executive Director
Mille Lacs Academy
407 130th Avenue South
Onamia, MN 56359

**RE: Certification of Mille Lacs Academy Juvenile Sex Offender Treatment Program Under Minnesota Rule Chapter 2955**

Dear Mr. Donahue:

The certification of the Mille Lacs Academy Juvenile Sex Offender Treatment Program under Minnesota Rules Chapter 2955 expired on August 31, 2017. Due to scheduling conflicts, the on-site certification inspection could not be completed and the certificate issued before that date. This office sent a letter dated August 24, 2018 extending the certification of the Juvenile Sex Offender Treatment Program until the inspection is completed and the certificate issued by the commissioner.

The on-site inspection was conducted on August 27-31, 2018 and the exit interview was conducted on September 5, 2018. This office apologizes for the delay in issuing this report and certificate.

**Based on the findings of the inspection, the Mille Lacs Academy Juvenile Sex Offender Treatment Program is approved for certification under Minnesota Rules Chapter 2955 under the conditions listed below for the term from September 1, 2018 to August 31, 2020. The certification includes Program 1 (The Castle), Program 2 (The Navigators), Program 3 (The Ship), and Program 4 (The Safari).**

## ON-SITE INSPECTION

This office thanks you, your staff, administration, and program residents for the courtesy and cooperation extended to me throughout the inspection. The process consisted of the following activities.

1. Review of the application for certification, thorough discussion of the rule and the self-rated rule compliance in Form D of the application and of the responses to previous correction orders with Executive Director Jason Donahue, Clinical Director Kevin Bolin, and Quality Improvement Coordinator Stacie Valentine.

2. Review of relevant documentation for rule compliance, including the program policy and procedures manual, a sample of personnel and client files, and quality assurance/program improvement information.

3. Structured interviews with the executive director, the two clinical directors, quality improvement coordinator, parent-partner, vocational manager, admission coordinator, nurse, unit clinical supervisors, unit coordinators, psychologist, clinicians and a sample of case managers and youth care professionals.

4. Structured interviews conducted with the residents in the four program units.

5. Informal conversations with residents, staff and a teacher.

6. Observation of a clinical supervision session and a staff meeting.

7. Observation of each unit on one evening.

8. Inspection of the program facility and the school.

9. An exit interview conducted on September 5, 2018.

Residents were informed that (a) all formal interviews and informal conversations with the inspector were voluntary, and (b) there were no consequences to their residency or treatment if they did not want to participate in the interviews or informal conversations with this inspector. Residents and staff were informed of the limits of confidentiality in the inspection procedure. All residents and staff persons who spoke with this inspector stated that they understood the terms and were willing to participate.

This report summarizes the information regarding rule compliance and program operation gathered during the inspection procedure and discussed at the exit interview.

## OVERALL FINDINGS

The Mille Lacs Academy Juvenile Sex Offender Treatment Program (JSOTP) has a maximum capacity of 94 residents. The census at the time of this inspection in was 71 (including the transition group home).

As in past inspections, the JSOTP has continued to experience significant turnover in administrative positions. At the time of the previous inspection, the two clinical director positions were vacant and the associate director was fulfilling the duties of that position as well as of the two clinical director positions. One of the clinical director positions was filled in June 2017 and the second in November 2017. This means that over the past two and the current inspection periods, there have been seven different persons in the clinical director positions, along with gaps between hiring. In January 2018, the associate director resigned and at the time of this inspection, the position had not been filled. The continued instability of the clinical leadership of the JSOTP and its impact on the staff and programming has been a significant concern to this inspector and, of course, to the certificate holder. As the two new clinical directors have settled into their jobs, they have demonstrated a commitment to establishing a secure and quality-oriented leadership team and strengthening the organizational culture, programming, and therapeutic community.

There has again been significant turnover with the youth care staff, occurring even as this inspection was in process. Both current staff and residents commented on the need for more youth care staff and this inspector reviewed the significant effort the certificate holder has been making to relieve this situation.

The referral population continued to present with significant mental health and behavioral disturbance issues. The number of verbal and physically aggressive incidents increased significantly in the previous inspection period, but the quality assurance data show that the number of incidents and physical holds has decreased during this period. While it is still higher than the certificate holder would like, there are definite indicators of progress in this area and the administration continues its efforts to deal with the different facets

underlying this issues.

A significant data point is the licensing inspection and investigation conducted by the Department of Human Services in April 2018. The subsequent Correction Order cited 22 rule violations – mostly for missed target dates for supervision meetings and training, but also for the use of restrictive procedures as well as incomplete or missing information/documentation in resident and personnel files. In June 2018, the certificate holder reported full compliance with the correction orders.

A significant strength of the JSOTP is the inclusion of resident families as part of the treatment programming. The Parent Partner program has received very good feedback and the number of staff assigned to this function has been increased. The aftercare coordinator continues to engage community resources to support the reentry and aftercare process.

Another strength is the vocational and recreational component. During this certification period, this component received grant funding to further develop vocational programming. In addition, a staff person has been added to bolster and expand the recreational programming.

This inspector reviewed the data and outcomes of the Nexus Clinical Review and the surveys conducted with residents, families, staff, leadership, and referral sources. The record of the amount of treatment delivered shows the JSOTP is delivering significantly more treatment than the minimum required by Chapter 2955, subpart 1.

## TREATMENT PROGRAMMING

No treatment groups were observed during this inspection. The inspection relied on the policies and procedures for the basic treatment protocol and therapeutic milieu, review of the treatment materials and delivery structure, and information provided by staff and residents, supplemented by quality assurance data.

As noted at the previous inspection, due to the turnover at the clinical director level, the policies and procedures of the basic treatment protocol and therapeutic milieu had not been revised or updated. During this inspection period, the former associate director was instrumental in revising and updating the policies and procedures for the basic treatment protocol and therapeutic milieu and initiating training of staff in them and their application to programming. Subsequent to the associate director's departure, the two clinical directors were learning these policies and procedures and starting to make modifications and updates of their own to them. At the time of this inspection, the clinical directors had not yet begun in-depth training of staff and oversight of the application of the treatment protocol and model of the therapeutic community. Both clinical directors noted the importance of these policies and procedures as the foundation of the treatment programming and its implementation.

Senior clinical staff reported the previous assistant director had trained them the basic treatment protocol and milieu policies and procedures and they were applying them to their therapeutic work with clients. They noted the protocol has been expanded to include trauma-focused cognitive behavioral therapy and some specific training in this approach had been provided. In particular, several staff noted their use of the risk-need-responsivity principles and the good lives model in their assessments and treatment plans. Several other clinicians mentioned they had been trained in eye movement desensitization and reprocessing therapy and had begun to use in with some of their clients with great success.

The four program units in the JSOTP differ significantly in their target populations which are distinguished by their levels of intellectual/emotional functioning and their delinquent and mental health issues. As such, the treatment programming has a common core defined by the basic treatment protocol, but is adapted to the needs of the residents in each program unit.

Most of the residents in the four units agreed that the treatment programming and its contents were helpful and they "learned a lot" about the reasons why they acted out sexually and how to cope with stress better. Several residents questioned the relevance of the content of the assignments and workbooks and sought more help in applying what they were learning. Most of the residents also agreed that their respective clinicians "knew their stuff" and worked well with them. In one of the units, there had been a change in the clinicians and several residents grieved over the loss of one of their clinicians.

Most of the older residents discussed their current treatment objectives and what they were doing to accomplish those objectives. The younger and lower-functioning residents were less able to describe their treatment objectives or their treatment plan but were able to discuss their assignments and what was useful in them.

The consulting psychiatrist was not available at the time of this inspection. However, the nurse noted the psychiatrist meets regularly with staff, school representatives and nurses to review each resident's medication history, symptoms, and behavior.

**STAFF**

During this inspection, the residents in all four program units said the youth care professional (YCP) staff were mostly respectful and cared about them. However, in each unit, some residents cited certain YCPs as behaving disrespectfully to them and sometime "setting [them] up" to get in trouble. In several units, residents commented that "too many" staff have left, the units were "always short-staffed," and the replacement staff had little experience – it was their "first job."

At the time of this inspection, the YCP staff had a diverse range of work experience and therapeutic expertise. The YCP job-orientation is a structured 80-hour process with an additional 40 hours of job-shadowing. The YCPs commented that their orientation to their job was "very thorough" and intensive. On two units, the YCPs said that they received very good supervision from their unit coordinators and clinical supervisor. On the other two units, the YCPs said there had been some issues with a unit coordinator and clinical supervisor, resulting in several staff resignations. At the time of this inspection, the clinical directors were addressing these issues.

Overall, the YCPs in all four units said that communication between day and evening shifts had improved. They also said that their communication with the clinicians was very active and very informative.

The staff cultures varied across the units, from relatively open and safe, to less trusting and somewhat closed. As noted, the clinical directors were addressing the on-going issues in all units.

The clinical staff on all four units reported they met regularly and communicated well with the YCPs. The clinicians also met regularly for clinical supervision and additional input from the clinical directors. The clinicians agreed that they were part of a team and felt they had a healthy culture which could tolerate the current issues and remain strong.

## THERAPEUTIC COMMUNITY

While this inspector spent an evening on each unit, observation of the therapeutic communities in action was limited. The main sources of information are the residents, the staff and the policies and procedures for the therapeutic milieu, supplemented by quality assurance data.

While a number of YCPs had been in the JSOTP for years and understood the dynamics of a therapeutic community, the newer YCPs reported little if any experience and a limited amount of training in this key element of residential treatment. This is an on-going training and supervision issue especially for the unit coordinators and clinical supervisors. The clinical directors reported they have been providing more oversight of the therapeutic communities in the units and planned to implement more training in this area.

As noted earlier, each unit has a resident population with somewhat different developmental, medical, and mental health treatment needs. This variability affects the stability and health of the therapeutic community and resident cultures across the units. In the units with developmentally disabled and younger residents, the YCPs and unit coordinators have to build and maintain the culture of accountability and model the JSOTP core values. With this level of resident, the staff discussed the challenges and frustrations of this work on a daily basis. Nonetheless, at the time of this inspection, the staff said they felt safe with the residents most of the time, although there were occasions when they were "put to the test."

Residents in these units were the most critical of their YCPs in terms of respect and trust. These residents acknowledged often "acting-out" to such an extent that they had to be put in physical holds for safety. They were critical of the manner in which staff placed and maintained them in physical holds. These residents had mixed opinions about their safety in their units. With their peers, residents rated their safety at an average of 9.0 out of 10 (with 10 as high) but qualified this by noting that with certain residents, their rating would be much lower, such as one or zero. Resident ratings of safety with staff had same qualification – high with most staff (average 8.8) but much lower with certain staff.

The YCPs on the two units with more developmentally mature and older residents believed their therapeutic communities were operating "pretty well" at the time of this inspection. They cited several instances of residents who presented significant behavioral disturbances. They noted these incidents were always processed with the unit coordinator and clinical supervisor. These staff reported feeling very safe with the residents. Residents in these units believed that they were accountable to each other – most of the time – but on one of the units, some felt that there was not enough structure and the shortage of staff hurt their ability to self-regulate – and this negatively affected the therapeutic culture. These residents reported a high degree of safety (average 9.3 out of 10) with only minor degree of variability in their safety with their peers and with staff.

It is interesting to note that the units are no longer called by their designated names, but as Programs 1, 2, 3, and 4. In addition, throughout all of the discussions, only one or two staff and no residents mentioned the Cornerstone Values central to the mission and philosophy of the JSOTP. These finding suggest that the identity and values of the individual therapeutic communities have been diminished; they need to be re-established and reinforced.

## COMPLIANCE ISSUES

No compliance issues were found in any of the personnel files reviewed.

At the previous inspection, the state of the client files was so out-of-compliance that there was no point in citing individual files. Instead a blanket corrective action order was issued. At this inspection, the state of the client files has been improved but there were still issues with achieving target dates for intake assessments and individual treatment plans, as well as an issue with discharge summaries. A random sample of 20% of client files (11 files) representative of each psychologist and clinician were reviewed with dates of admission to the JSOTP during this inspection period. A random sample of seven files of clients who were discharged during this inspection period representative of each clinician were reviewed. Four of the seven files had dates of admission during this inspection period and were reviewed for compliance with discharge summary requirements and other content. The other three client files had dates of admission prior to this inspection period and were reviewed only for compliance for discharge summary requirements.

To maintain confidentiality the clients were assigned code numbers. An index with the code numbers and associated client names for those clients is provided in a non-public document under separate cover.

**1.** **Citation:** Intake assessment: Minnesota Rules, Chapter 2955.0100, subpart 1.

> *2955.0100, subpart 1. Admission procedure and new client intake assessment required. All clients admitted to a residential juvenile sex offender treatment program must have a written intake assessment completed within the first 30 days of admission to the program.*

Compliance Issue: Violation.

The intake assessments for the following clients were found to be dated past 30-days from the date of admission: C-1, C-3, C-6, C-8, C-10, and C-11. There is no indication that the quality assurance procedure tracked and responded to these violations.

**Corrective Action #1:**

Immediately upon receipt of this report, the certificate holder must ensure that intake assessments are completed within the 30-day requirement.

**2.** **Citation:** Initial individual treatment plan: Minnesota Rules, Chapter 2955.0110, subpart 1.

> *2955.0110, subpart 1. A written individual treatment plan for each client must be completed within 30 days of the client's entrance into the program.*

Compliance Issue: Violation.

The individual treatment plans for the following clients were found to be dated past 30-days from the date of admission: C-1, C-56, C-10, and C-11. It was found that the individual treatment plans for C-3, C-6, and C-8 were dated within the 30-day requirement but before the date of the intake

assessment for the respective clients. There is no indication that the quality assurance procedure tracked and responded to these violations.

**Corrective Action Order #2:**

Immediately upon receipt of this report and on an ongoing basis, the certificate holder must ensure that the initial individual treatment plan is completed within the 30-day requirement and that the plan is not dated prior to the date of the intake assessment for a specific client.

**3. Citation:** Discharge summary content: Minnesota Rules, Chapter 2955.0130, subpart 3.

*2955.0130, subpart 3. The discharge summary must include at least the following information:*
*E. the client's mental status and attitude at the time of discharge.*

Compliance Issue: Violation.

The following resident files contained discharge summaries that did not provide a discussion of the resident's mental status and attitude at the time of discharge: DC-3, DC-6, and DC-7. There is no indication that the quality assurance procedure tracked and responded to these violations

**Corrective Action #3:**

Immediately upon receipt of this report, the certificate holder must ensure that all discharge summaries provide a discussion of the residents' mental status and attitude at the time of discharge.

## CONDITIONS OF CERTIFICATION

The following rule requirements are on-going, developmental projects that both anchor and drive the treatment program. As such, they require continued review and evaluation. Consequently, issues in these areas as are not cited as rule violations – rather, they are considered conditions of certification.

**1. Rule Requirement:** Basic treatment protocol and policies and procedures for the therapeutic milieu: Minnesota Rules, Chapter 2955.0140, subparts 1A and 1B.

*2955.0140, subpart 1. Program policy and procedures manual. Each program must develop and follow a written policy and procedures manual. The manual must be made available to clients and program staff. The manual must include, but is not limited to:*
*A. policies and procedures for the basic treatment protocol.*
*B. policies and procedures for the therapeutic milieu.*

Current Status:

The policy and procedures for the basic treatment protocol is a dynamic document that grows and changes to accommodate relevant new theoretical and empirical research and resultant changes in the program itself. The basic treatment protocol involves both a general theory of the cause(s) of sexually abusive behavior and a theory of how client change is accomplished.

Given the lapses regarding the policies and procedures for the basic treatment protocol and therapeutic milieu during past inspections, the previous inspection report made clear that the JSOTP could not continue to operate without a strong commitment to developing a complete basic treatment protocol and policies and procedures for the therapeutic milieu that complies with the rule requirements.

During this certification period, the associate director made an extensive revision and update of these policies and procedures as contained in the document, *MLA's Treatment Protocol*, dated October 2017. This document provides a good initial discussion of the JSOTP's operating assumptions and brief description of theoretical frameworks used to analyze sexual offending behavior along with a basic logic model. The associate director also began training the clinical staff as well as unit coordinators in them.

Since then, the clinical directors have been reviewing the policies and procedures, discussing them with staff, and seeing how they have been applied in programming. During this inspection, the directors discussed modifications already made to these policies and procedures as well as plans to incorporate more in the future.

The policies and procedures for the therapeutic milieu are specified in the document, *Mille Lacs Academy Program Description*, dated June 6, 2017. This document discusses the therapeutic culture, sexuality treatment, family therapy, chemical health, therapeutic recreation, special needs clients, and adjunct services. The discussion of the therapeutic culture needs to be expanded and more detail about the theoretical basis of therapeutic community should be included. Also, there should be a discussion of how the operation of the therapeutic community will be measured.

**Condition of Certification #1**

No later than March 31, 2019, the certificate holder must also submit to this office a report that provides the following information.

1. A copy of the current version of the basic treatment protocol.

2. A discussion of any necessary and/or proposed additions and/or modifications. This includes the integration of more recent references and related refinement of theory and updating the research base. The logic model must be updated to be consistent with the changes in theory and treatment content.

3. A timeline for implementing those additions and/or modifications.

The criteria used to evaluate the policies and procedures for the basic treatment protocol and therapeutic milieu are described in Form D of the application for certification.

**2. Rule Requirement:** Quality assurance and program improvement: Minnesota Rules, Chapter 2955.0170.

*2955.0170. Each program must maintain and follow a quality assurance and program improvement plan and procedures to monitor, evaluate, and improve all components of the program. The review plan must be written and consider the:*

*A. goals and objectives of the program and the outcomes achieved;*
*B. quality of service delivered to clients in terms of the goals and objectives of their individual treatment plans and the outcomes achieved;*
*C. quality of staff performance and administrative support and their contribution to the outcomes achieved in items A and B;*
*D. quality of the therapeutic milieu, as appropriate, and its contribution to the outcomes achieved in items A and B;*
*E. quality of the client's clinical records;*
*F. use of resources in terms of efficiency and cost-effectiveness;*
*G. feedback from referral sources, as appropriate, regarding their level of satisfaction with the program and suggestions for program improvement; and*
*H. effectiveness of the monitoring and evaluation process.*

*The review plan must specify the manner in which the requisite information is objectively measured, collected, and analyzed. The review plan must specify how often the program gathers the information and document the actions taken in response to the information.*

Current status:

The JSOTP policies and procedures for quality assurance and program improvement are comprehensive. The JSOTP is supported by and supplies quality assurance data to Nexus: Youth and Family Solutions. The JSOTP has a Continuous Quality Improvement (CQI) Committee and each quarter three quality indicators are monitored and any indicator that is below established benchmarks is addressed through a plan of action to correct the deficiency. The process is overseen by the CQI committee and clinical, associate and executive directors.

Given the number of documentation issues cited by the DHS licensing inspection in April 2018 and subsequent compliance with DHS correction orders in June 2018, it is concerning that a significant number of client files were found that were not compliant with required target dates and the mental status requirement for discharge summaries. These items have been cited in previous certification inspections.

**Condition of Certification #2A:**

The current continuous quality improvement program and the on-going activities are sufficient to meet the requirements of 2955.0170. However, the monitoring of compliance with licensing and certification has not identified a number of violations.

Immediately upon receipt of this report, the certificate holder must ensure that the continuing quality improvement plan and subsequent activities as required by 2955.0170 are implemented, evaluated, and any performance deficiencies are addressed for correction and improvement.

No later than March 31, 2019, the certificate holder must submit to this office a written report outlining the specific measures and activities that address items A through H of 2955.0170. The report will also detail how compliance with all applicable requirements will be monitored and documented.

For informational purposes, the evaluation criteria for the policies and procedures for the quality assurance/program improvement plan are described in Form D of the application for certification.

**Condition of Certification #2B:**

**Carried over from the 2015 and 2016 inspections:** One item of the required plan that still needs attention is item D, *quality of the therapeutic milieu, as appropriate, and its contribution to the outcomes achieved in items A and B*. In discussions with the executive director and the clinical directors, it was suggested that the QA for the therapeutic milieu consider implementing one of the available instruments to assess therapeutic communities. Consequently, the same suggestion is made in this inspection.

No later than March 31, 2019, the certificate holder must submit to this office a review of several instruments to measure the operation of the therapeutic milieu and discuss the feasibility of incorporating one or more of the instruments into the continuing quality improvement plan.

**Condition of Certification #2C:**

On a quarterly basis for this inspection period, the certificate holder must submit to this office information and data regarding performance on items A through H of 2955.0170.

The criteria used to evaluate the policies and procedures for the basic treatment protocol and therapeutic milieu are described in Form D of the application for certification.

This office has a relatively up-to-date data base of current theorizing and research in psychotherapy, sex offender treatment, therapeutic milieu, program development and evaluation, continuing quality improvement, and more. This data base can be made accessible upon request. Technical assistance is also available on request.

Chapter 2955 requires programs providing residential treatment to adult sex offenders to be accountable for their operations, outcomes, and continuous quality improvement plans. This certification inspection has identified the compliance issues described above and prescribed the actions necessary to meet that accountability. This office remains at your service to discuss any issues or concerns about this report and to provide technical assistance in achieving compliance with Chapter 2955. Please do not hesitate to contact me at 651-361-7148 or Alan.Listiak@state.mn.us.

Yours truly,

Alan Listiak
Administrator of Sex Offender Program Certification
Inspection and Enforcement Unit

Under separate cover: Non-Public Resident Identification Key

cc. Kevin Bolin, Clinical Director, Mille Lacs Academy
Dina Nelson, Clinical Director, Mille Lacs Academy
Paula Minske, Vice President of Clinical Services, Nexus: Youth and Family Solutions
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