UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

JOHN R. VAN ORDEN, JOSEPH MILLER, MICHAEL MCCORD, MACON BAKER, CHANCE TYREE, WALTER W. RITCHEY, DAVID BROWN, ANTHONY AMONETTE, RICHARD TYSON, WADE A. TURPIN, MATTHEW KING, AND ANDREE COKES ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED,

Plaintiffs,

vs.

KEITH SCHAFER, RICK GOWDY, JOSEPH PARKS, M.D., ROBERT REITZ, MELISSA RING, JULIE INMAN, LINDA MOLL, HAROLD MEYERS, JUDY SUMPTER, DAMAN LONGWORTH, ALAN BLAKE, JAY ENGLEHART, M.D., MARK STRINGER, DONNA AUGUSTINE, DAVE SCHMITT, JUSTIN ARNETT, MARTY MARTIN-FORMAN, IAN FLUGER, SHERRY LEE, ERICKA L. KEMPKER, KRISTINA BENDER-CRICE, AND THE DOE DEFENDANTS.

Defendants.

Case No. 4:09-cv-00971 AGF

COMPLAINT FOR VIOLATION OF CIVIL RIGHTS PURSUANT TO 42 U.S.C. 1983, RELATED CLAIMS AND THE AMERICANS WITH DISABILITIES ACT
JURY TRIAL DEMANDED

FIFTH AMENDED COMPLAINT

COME NOW Plaintiffs John R. Van Orden, Joseph Miller, Macon Baker, Chance Tyree, Walter W. Ritchey, David Brown, Anthony Amonette, Richard Tyson, Wade A. Turpin, Matthew King, and Andree Cokes, on behalf of themselves and all others similarly situated (collectively hereinafter "the plaintiffs") and for their Fifth Amended Complaint against Defendants Keith Schafer, Rick Gowdy, Joseph Parks, M.D., Melissa Ring, Julie Inman, Linda Moll, Harold Meyers, Judy Sumpter, Daman Longworth, Alan Blake, Jay Englehart, M.D., Mark

Stringer, Donna Augustine, Dave Schmitt, Justin Arnett, Marty Martin-Forman, Ian Fluger, Sherry Lee, Ericka L. Kempker, Kristina Bender-Crice, and the Doe defendants (collectively "the defendants") state the following:

Introduction

1. Mismanaged, underfunded, understaffed, and in violation of the United States and Missouri Constitutions and Missouri statutory law, the Missouri Department of Mental Health ("DMH") Program known as The Sex Offender Rehabilitation and Treatment Service ("SORTS") is government at its worst.

2. As a result, the DMH, has put the citizens of Missouri at great risk and created the circumstances and claims, as set forth hereinafter, that 200 or more convicted rapists, child molesters, and other sexually violent predators must be immediately discharged at large without any restrictions or control pursuant to the relief sought in this Case.

3. The flawed calculus of the DMH in the operation of SORTS arose out of the belief that the imprisonment of those branded as sexually violent predators were so reviled that no one would notice nor care when tucked away in Farmington, Missouri. As often occurs when government steps so far over the line in its treatment of those that it reasons are at the bottom rung of society, such behavior is ultimately exposed and the consequences are immeasurably more injurious than if public officials had played by the rules at the beginning and had the courage to do the right thing.

4. SORTS is thus so far gone that it is irretrievably broken, cannot be salvaged and thus must immediately be shut down and all of its inhabitants set free. The constitution demands no other relief.

5. Paradoxically, the SORTS website states the following as its Mission, Vision, and Values:

> MISSION: Protect public safety by rehabilitating sexually violent predators in a respectful, safe and secure setting.
>
> VISION: "Offering hope, recovery, rehabilitation and support to live fulfilling lives."
>
> VALUES: People Deserve: Dignity, understanding, to be safe, to make decisions for themselves, hope, positive outcomes.
>
> We value: Respect, Cultural Competency, Teamwork and team members, Consumer opinions and input, Encouragement and Best Practices.

At one time, SORTS even claimed that its treatment program was "state of the art." Now, internal documents show that boast was just that and that DMH leaders can only hope to create such a program, somehow, sometime, with ill defined, unfocused words without action, activity without results or any accountable plan and execution. At one point, Felix Vincenz, who served as DMH Director of Psychiatric Care, when advised about a critical lack of space for the residents to live and be treated could only respond to this disaster by stating, *"Yikes, any suggestions?"*

6. Overcrowding has continually plagued SORTS and in a December, 2009 document (Exhibit 1 attached hereto) produced by the DMH in this case (a memo entitled *"SORTS Census, Bed Space and Funded Bed Projections – December, 2009"*), the consequences of that problem were described with these observations:

> "…in the current environment overcrowding results in practices that are violations of accreditation and life/safety standards, thereby placing accreditation efforts at risk. In addition, an unfunded ward lacks the staff needed to provide treatment, housekeeping, clerical and support services are not available, placing an additional burden on existing staff, thereby diluting services for several months. **This is all the more problematic as allegations of overcrowding and inadequate services are the subject of**

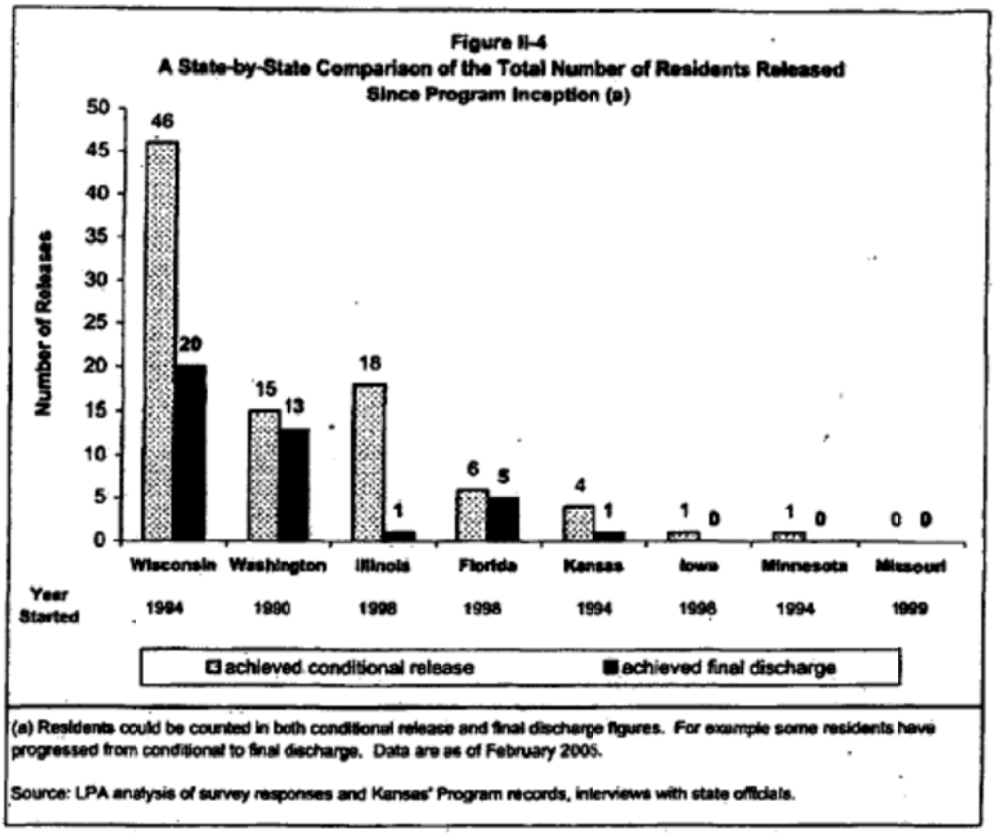
conditions of confinement lawsuits by residents." (Emphasis added).

7. As is set forth in detail below, the website pledges and declarations are so untrue that publishing them to the world representing them to be factual, only heightens the merits of the claim, as asserted in this Case, that SORTS is a fraud and its true mission misrepresented. In fact, following discovery in this case of sometimes "encrypted" emails, long since hidden in prior litigation in this federal district and the Eighth Circuit Court of Appeals, the real story emerges. What is now known is that when spanning the fourteen plus years of the operation of SORTS, it is now provable by competent evidence that the program was admittedly "bad" and "inadequately funded" at the start, had major problems during the middle years (underfunded, overcrowded, unjustified suspension of treatment, and the like), and in the recent years, subject to the same ills as noted by professionals hired just last year to try to reform, without success, SORTS. In short, SORTS (or as it called itself in the past, MSOTC) was from the start, continued throughout and still is a publicly run disaster, where the blame for such a mess falls at the feet of the highest levels of state government. What follows is a shocking display of government at its ghastliest, abusing the trust of the public, and causing more harm than good. These candid emails, which the DMH never thought would see the light of day, make a number of startling revelations, including this 2009 communication (Exhibit 2 attached hereto) by the Director of the DMH, Keith Schafer, who wrote:

> "No one has ever graduated from [SORTS} and somewhere down the line, we have to do that or our treatment processes become a sham."
>
> Keith Schafer, Ed.D.
> Director
> Department of Mental Health

More than five years later, still no one "has ever graduated;" not because they are not deserving, but because SORTS is a prison and the treatment processes are and have always been "a sham."

8. Even when compared to other states that have a SORTS like program, Missouri and its DMH are pitiful as illustrated by the following graph showing Missouri SORTS zero releases and other states achieving higher numbers; some materially so.



The End Game - Create a Prison Disguised as a Mental Health Facility

9. Plaintiffs occupy one of the lowest stations in society (the convicted sex offender) yet their rights after the completion of their sentences under the custody of the Missouri Department of Corrections are no less inviolate and their liberty no less important than the rights and liberties of the remainder of society. It is only by this Court's intervention that plaintiffs' constitutional rights may be vindicated, thus necessitating this action.

10. In 1998, then Missouri Governor Mel Carnahan wrote a letter to members of the General Assembly urging the legislative body to adopt a system of laws that would continue to incarcerate persons who had completed their sentences for their convictions of various sex offenses. Governor Carnahan noted in that communication that the General Assembly had two years earlier passed laws strengthening the sentencing options for persons convicted of sex crimes. But he lamented that those longer sentences could not be applied retroactively to those previously convicted. So, he urged the General Assembly to adopt laws that would allow those persons convicted of sex offenses that carried, at the time, lesser sentences to be held in "the criminal justice system" as civil committees.

11. He noted that a then recent decision of the United States Supreme Court, *Kansas v. Hendricks*, had found such civil commitment laws to be constitutional. He urged that those laws, at the time found to be constitutional in theory (but not as applied and as is now known after 14 years of the operation of SORTS), could be used to plug the gap, so to speak, between those sex offenders, like the plaintiffs and class members, who had served their time, but could remain imprisoned indefinitely as civil committees in the custody, not of the Department of Corrections, but instead in the custody and control of the DMH. Governor Carnahan made no mention that these civil committees, the plaintiffs and class members in this case, had a constitutional right to treatment so as to have a reasonable opportunity, following treatment, to be released. That was not the focus. In retrospect and reading between the lines of the Governor's letter, the focus was on locking up these persons, characterizing these persons as not being mentally ill, but having instead a "mental abnormality" that would allow the judicial system to conclude that they presented a risk of reoffending.

12. Almost a decade later this very strategy was reinforced and acknowledged in a memo dated March 24, 2008 (Exhibit 3 attached hereto) that Keith Schafer wrote to the General Assembly in which he stated, with remarkable consistency with the goal that Governor Carnahan wanted to accomplish, these words:

> "The "end game" related to MOSOTC is as follows:
>
> Avoid building new facilities for Sexual Predators as long as possible. New tougher sentencing laws will ultimately reduce the number of referrals to DMH, but this impact will not be felt until at least 10 years from now."

Today, more than five years after Director Schafer wrote about the "end game" for SORTS, proof has now surfaced that confirms what any commons sense person already knew intuitively.

13. And fundamentally and at its core, that proof, albeit imperfectly coded in the Governor's message to the General Assembly 14 years ago, but much more understandable today, can best be summarized with these words:

> ***SORTS IS A PRISON DISGUISED AS A MENTAL HEALTH FACILITY AND THE INTENT IS TO LOCK UP THE PLAINTIFFS AND THE OTHER MEMBERS OF THE CLASS WITH NO GENUINE INTENT TO TREAT AND RELEASE. ANY TREATMENT IS THUS A PRETEXT FOR WAREHOUSING IN VIOLATION OF THE PLAINTIFFS' AND THE CLASS MEMBERS' EIGHTH AMENDMENT RIGHTS TO BE FREE OF DOUBLE JEOPARDY AND CRUEL AND UNUSUAL PUNISHMENT.***

14. This conclusion is irrefutable and all those DMH employees involved with SORTS, either by reading this Fifth Amended Complaint or learning of these allegations, will then be on express, implied or constructive notice and their employment at SORTS makes them complicit in this unlawful conduct and subject to being joined in this lawsuit, converting them

from anonymous Doe defendants to defendants expressly identified by name and thereby forever linked to SORTS.

15. In 2006, an Assistant Attorney General presumably inadvertently divulged the State's intent in a federal court filing (Exhibit 3A attached hereto) opposing a writ of habeas corpus brought by Wade Turpin, now a plaintiff in this case, asserting that:

> "Turpin is currently **imprisoned** in the Missouri Sexual Offender Treatment Center [the former name of SORTS] in Farmington." (Emphasis added).

16. Missouri law provides that plaintiffs and the other class members unequivocally have "the right to be treated with dignity as human beings" and the DMH, in documents discovered in this case has acknowledged that that "right can **never** be limited."

17. Moreover, those present SORTS employees, who are licensed health care providers, have additional ethical duties beyond the constitution and other laws. This includes duties pronounced by the NAHO *Code of Ethics and Standards for Practice for Healthcare Quality Professionals* (adopted by DMH) that imposes this obligation to the plaintiffs and the other members of the class:

> "Healthcare Quality Professionals promote the dignity of the profession and are committed to practicing the profession with honesty, integrity, and accountability . . . respecting all laws and refusing to participate in or conceal any unethical, false, fraudulent, or deceptive activity. [Their] primary commitment is to the health, well-being, and safety of patients. They must take appropriate actions regarding any instances of incompetent, unethical, illegal, or impaired practice. They work to promote change that encourages the reporting of events that may result in actual or potential harm to patients or others."

18. Psychiatry possesses an inherent capacity for abuse that is greater than in other areas of medicine. A genuine diagnosis of mental disease can, under appropriate circumstances and proper intentions, legitimately give the state license to detain persons against their will and insist upon treatment and forced commitment both in the interests of the person committed and

in the broader interests of society. On the other hand, SORTS, now with maximum security facilities at the Missouri cities of Farmington and Fulton, treats residents with disdain, applying dehumanizing and infantilizing practices which are counter-therapeutic, which are hardly "Best Practices" or "State of the Art," and which destroy any hope residents may have of reforming, overcoming their mental abnormalities, and rehabilitating their lives in society.

19. As one indication of the failures of SORTS, not one person has been unconditionally released or realistically and genuinely released even conditionally that allows them to reside in conditions other than maximum security. There is absolutely no "hope," "recovery," "rehabilitation," or "support," and, as a result, there have been no "positive outcomes." The American Psychiatric Association Task Force report on the issue presented "a blistering critique" of SVP programs and demonstrated how "psychiatric commitment is being misused to cover a sentencing loophole created by the legal system [the very loophole Governor Carnahan proposed be closed]. [The SVP] process has been viewed as a perversion of legitimate psychiatric commitment, a violation of civil rights, and a dangerous precedent for the possible misuse of psychiatry to squelch other behaviors that have been regarded falsely as psychiatric problems…." Allen Frances & Shoba Sreenivasan, *Sexually Violent Predator Statutes: The Clinical/Legal Interface*, PSYCHIATRY TIMES (Dec. 1, 2008). The psychiatric community has also been critical of SVP programs using "definitions of mental illness that have no basis in psychiatry." Jennifer Jason, *Beyond No-Man's Land: Psychiatry's Imprecision Revealed by its Critique of SVP Statutes as Applied to Pedophilia*, 83 S. CAL. L. REV. 1319, 1319 (2010).

20. Bolstered and emboldened by a "victory" in a lawsuit styled *Strutton v. Meade*, which was decided in favor of the DMH by the Federal District Court of the Eastern District of Missouri and then affirmed by the Eight Circuit Court of Appeals, SORTS and the DMH now

believe that they answer to no one in their operation of SORTS and are free to implement the "end game" described above.

21. In fact, this case law house of cards built on discovery mischief, captioned *Strutton v. Meade*, is flawed legal precedent, perpetrated by the DMH, regrettably failing to understand what history consistently teaches – that public officials who violate the constitution will eventually be held accountable and that the truth will win out. Through compulsory legal process in this case, documents have been discovered that were buried by the DMH in *Strutton v. Meade*, with the erroneous claim that emails had been inadvertently purged from its computers and servers and were no longer available or protected by a bad faith assertion of peer review immunity.

22. In most, but not all cases, SORTS residents have been found by jurors in the state of Missouri to have "mental abnormalities" that prevent them from exercising judgment in sexual matters such that their release would create a safety hazard. As a result of such a finding, Missouri courts order the DMH to provide their care and treatment in theory in a manner that would allow them to overcome their mental abnormalities and behave normally in society.

23. Despite specific court orders requiring them to provide SORTS residents with care and treatment, defendants require plaintiffs to pay for their care and treatment themselves. The statutory scheme outlined below, however, deprives SORTS residents of their constitutional rights under the Federal and Missouri constitutions, rights that are fundamental to the American system of jurisprudence such as due process, equal protection, freedom from *ex post facto* laws, freedom from cruel and unusual punishment, and the right to leave their heirs their estate and savings when they die.

24. Disregarding constitutional requirements of treatment for the civilly committed, disregarding court orders requiring it to provide care and treatment, and notwithstanding the fact that they are requiring plaintiffs to pay for care and treatment, defendants systemically and unequivocally have refused to provide any meaningful care and treatment to plaintiffs.

25. Alan Blake, the former and longtime Chief Operating Officer of SORTS, wrote many candid emails to his superiors revealing that while he hardly is a champion for civil liberties and constitutional reverence, he did fight, for whatever motivations he might have had, with his DMH Central Office superiors for more resources, for SORTS, warning of the consequences of their failure to do so. Unfortunately, Mr. Blake, having lost the fight did not then do the right thing and "blow the whistle" on the disaster that he tried to manage. But for presumably a bureaucratic mentality and mindset long steeped in the grip of risk avoidance coupled by a fear of adverse consequences of a decision to advocate release of the residents and the maintenance of security of SORTS residents, and fear of litigation, Mr. Blake did a fair job in trying to do some things that happened to be consistent with the constitutional and statutory duties of the DMH in the operation of SORTS. His emails thus give a clearer picture than anything to date that confirms what all intuitively know to be the truth – that SORTS exists to warehouse and pretends to ostensibly treat the Residents, just enough so that the courts, without being told the truth, defer to questions of professional judgment by those SORTS health care practitioners, who were trusted to do their duty, but failed to so. What then do these electronics communications tell us of the SORTS story?

As Always and at the End of the Proverbial Day, the Defendants' Email Trial Discloses the Wretched Reality of SORTS

26. From time to time, Alan Blake made these telling observations in various emails (See Exhibits 4, 5, 6, 7, and 8 attached hereto) that he authored while serving as Chief Operating Officer of SORTS:

> **"Unfortunately DMH is not will to applying [sic] the values it espouses or things would be different.**
>
> **The state keeps trying to get by on the cheap.** (Emphasis added).
>
> This is no way to manage a system. Our facility has passed NWPRC [another DMH facility in Northwest Missouri] in census, and we have half the infrastructure and support. **We are [a] disaster waiting to happen.** We have older residents with major physical issues. We have a good full time general physician (by luck only), but we do not have the capacity to operate a skilled nursing facility or hospital wing. Conditional release of sex offenders, much less sexually violent predators, to a skilled nursing setting has recently been a state controversy. I fear are going to have some major care failure that will contribute to my early retirement."
>
> * * *
>
> "For many years we have been operating based on a decision that we could not ask for the numbers needed. We keep slowly pulling resources from APS and the region.
>
> **We are also now vulnerable to claims that we offer inferior treatment in that we are not staffed at a similar rate to other areas of the facility and thereby are providing inadequate treatment. The next lawsuit discovery may well ask from the whole facility and disparities will be evident to a good attorney."** (Emphasis added).
>
> * * *
>
> "I have a worried sense that the budget is being driven by Steve and the money people, not by policy and need.
>
> I estimate we will be over census before the ward is funded.
>
> I continue to be concerned that this ongoing minimal funding keeps us on the edge of adequate and inadequate, and in a federal court's view, even our adequate may be inadequate enough for an adverse ruling."
>
> * * *
>
> "I must protest [an email to Felix Vincenz regarding budget cuts].

If we move 3 wards out, we might get by with in 09, but we are averaging 20 referrals yearly for the past 3 years, and we anticipate…

As it is I am starting to have problems keeping management staff from getting discouraged and giving up. **They are worn out, frustrated distressed and wearing out.** (I try to have them take off to make up for all the extra hours because of the sign of burn out, but then they get further behind and adds to their sense of failure.) Because of the risk level and lack of experienced staff, we are considering changing our schedules so a senior manager is on duty evenings again, another way resulting in getting further behind.

Having reasonable resources is all they want. The comment at our risk management meeting was, "**We are the DMH redheaded stepchild and they don't care if we fail**." In arguing against that view, the reply is that what "they" do to let us do our job is what tells, not what is said. There is a lot of unhappiness here." (Emphasis added).

* * *

"[In turn, Vincenz responds] If **we reduce treatment to 1½ per week, we can greatly reduce needing to hire more psychologists and social workers.**

With the lawsuit(s), census, pressures associated with the detainee moves, and anticipatory stress associated with JCAHO/CMS accreditation. I can well appreciate that your staff feel beleaguered and besieged.

Asking for additional FTE in today's fiscal environment is a virtual non-starter."

* * *

"[Blake replies] You are right. It is a huge request. It is unreasonable because prior (to your present position) requests were unreasonably low and inadequate.

It is the request to do it right (or at least closer). **We have been getting farther and farther behind. That is why I initiated the behavioral health structure in order to reduce the impact of the inadequate funding of this facility for YEARS, and find a way to operate for less.**

If we are to seek accreditation with current staffing levels and patterns, we will need to significantly reduce treatment to assure that assessments, documentation and treatment plans are in place."

* * *

> "In further follow-up to discussions regarding the impact of the House core cut to MSOTC I offer these thoughts:
>
> Expense will increase Dr. Englehart will withdraw services from the facility due to ethical concerns, and we will not have a means to offer psychiatric services as the ANP will no longer be allowed to practice without a psychiatrist sponsor. **Being unable to offer psychiatric services opens us to a lawsuit for substandard care, as well as [sic] we will have several persons in psychiatric crisis and by law unable to refer to a DMH facility.**
>
> **All this opens us to a federal lawsuit for providing substandard care. A successful lawsuit in this area will cost the state millions.**
>
> However, this again places the Department at risk of legal action regarding substandard care.
>
> **The facility will take on the effect of a prison and be in violation of Supreme Court rulings. The residents will likely initiate legal action for which the department and state will have difficulty mounting a defense."** (Emphasis added).

* * *

In a series of emails by and between Alan Blake and a colleague (who runs a SORTS Program in another state – Exhibits 9 and 10 attached hereto) dated November 15, 2007, the colleague observes:

> "The whole mess is a bad situation all around. Not that I have a lot of sympathy for sex offenders, but I think the net has been cast way too wide, and, US Supreme Court notwithstanding, I think that locking people up after they've served their sentences is just wrong. If we want to keep them out of circulation, pass the laws that will keep them in prison. It's more honest. And as you point out, the community doesn't want them and can successfully keep them out. Seems shortsighted to me."

To which Blake replies and without disagreeing:

> "It is very short sighted, very expensive, and there is little effort to identify potential offenders and seek to intervene before there are offenses. I will say that we are making progress with some of our fellows. Others…"

* * *

"We are so far from JCAHO that I cannot conceive of it. For lawsuits, we have had over 50 filed – mostly [but not all] frivolous."

* * *

In other emails (Exhibits 11 and 12 attached hereto) Blake writes:

"We have been trying to find how to make a $600,000 core reduction and the ramifications.

[If that happens] most nursing and medical staff will leave, and most professional staff will follow. **At that point we become a prison."** (Emphasis added).

* * *

I am nagging you about the SVP DOR and getting it in place. We have a challenge from Tim Burdick [then a public defender in Missouri, who represented SORTS residents] **regarding the constitutionality of the release process and our lack of movement thereof**. I have asked Sheila to fax a copy to you.

Not having a procedure in place strengthens his argument, in addition to not having given agreement to any petition. Some of our inaction at this level is because we don't have a procedure, although we are getting ready to look at three residents for a conditional release path. (It would be helpful to have a step down unit in the fence and a cottage outside, but we don't have the funds for the step down unit any more, and SMMHC tells me they have full cottages.)" (Emphasis Added).

* * *

DMH memo (Exhibit 13 attached hereto) about SORTS for FY 2009 budget discussions and analysis states the following:

"Psychiatric inpatient facilities are backing up, admitting far more commitments than discharges. This, in turn, clogs acute care facilities, which must hold patients longer who are awaiting admission into state long-term psychiatric care. **This system "constipation" forces state facilities to operate beyond 100% of capacity for long periods of time, exhausting staff, causing staff overtime and high turnover rates, and inevitably increasing the risk of staff injuries and patient abuse and neglect."**

***

In an email dated as recently as October of 2012 (Exhibit 14 attached hereto), Dr. Jay Englehart, the Medical Director of the SMMHC (which includes SORTS) warns about a CO directed effort to try to overcome the shortage of physicians and save money by the hiring of Psychiatric APN's noting

"that this is "…**the model which the prisons are moving toward, but I really do not want have [sic] a standard of care or staffing which is equal to that of the prisons. I hope we are better than that."** (Emphasis added).

***

In an undated email (Exhibit 15 attached hereto), but likely authored in August of 2005, Dr. Jonathan Rosenboom, at the time Director of Behavioral Services for SORTS noted:

"Finally, I am often struck by the unsettling conclusion that direct patient care is one of the last priorities when stacked against all of the other expectations. (Emphasis Added).

27. Nor do the dollar numbers lie. The DMH spends less money on SORTS ("the redheaded stepchild" of the DMH) than it does on any other facility for which it has responsibility and jurisdiction to operate.

28. The DMH computes, from time to time, a dollar number that it calls *"Cost Per Bed Day."* This is a key financial metric within the DMH and illustrates conclusively that SORTS (or as it was formerly named, MSOTC), "…keeps trying to get by on the cheap," as Mr. Blake complained. All other programs are allocated substantially more dollars than SORTS.

DMH Facilities Cost Comparison FY 04 Actual Cost Per Bed Day	
Acute Care - Child Inpatient	$477
Acute Care - Adult Inpatient	$464
Residential Care - Child	$392
Correctional Treatment - Inpatient	$343
Long Term Care - Adult Inpatient	$285
MSOTC	$182

29. Paradoxically, the DMH attempts to justify the failure to discharge residents on the grounds that sex offenders are the most difficult to treat and therefore less likely to be

"cured." But all that excuse achieves is the obvious rebuttal that the DMH should then be spending more money on SORTS than other programs, especially given that SORTS is a "close call" constitutionally as a result of its severe liberty deprivations.

30. Nor does the DMH perform much better in comparison to what it spends on SORTS verses spending by other states for their SORTS programs as illustrated by the following internal chart prepared by the DMH.

Department of Mental Health
Missouri Sexual Offender Treatment Center
Cost Comparisons

State	Cost/Day*
Minnesota	$314
California	$293
Washington	$289
Wisconsin	$274
North Dakota	$268
Illinois	$227
Arizona	$220
Virginia	$220
Iowa	$182
Missouri	**$168**
New Jersey	$164
Kansas	$145
Florida	$137
Massachusetts	$137

*Data from Washington State Institute For Public Policy
"State by State Comparison of the Involuntary Civil Commitment of Sexually Violent Predators 2004"

31. Yet another financial metric, shown in the below chart, reveals that SORTS allocates only 15% of its budget on "Treatment Staff" verses, for example, "Unit Security," which is allotted 42% of the budget, almost three times as many dollars.

Medical	18%
Unit Security	42%
Housekeeping, Maintenance, External Security, Food Service, Accounting, Administration	25%
Treatment Staff: Psychology, Substance Abuse Counselor, Activity Therapy, Social Work, Academic Teacher	15%

Or as Alan Blake wrote in an email to the Central Office of the DMH:

> "…we cost $200-$220 per day per consumer when the other long term facilities cost much more.

32. Admittedly, part of the deleterious resource shortfall for SORTS arises out of resistance by the General Assembly to fund SORTS at levels that meet equal protection of the laws and other requirements of the constitution. No one likes SVP's, especially legislators. But this misplaced attitude cannot excuse underfunding what elected officials and DMH leadership might view as an unpopular state run program and consequently forgive adherence to the constitution and statutory law and their obligation to uphold both rules of law. The DMH appears to be committed to building more space to warehouse SORTS residents in anticipation of a growing population, but that commitment is not extended to spending money to better fund treatment methods and practices that will lead to release.

33. Moreover, the DMH is reticent in seeking greater funding from the General Assembly, concerned that its other programs will not be funded. The problem in some years is the perplexing and continuing resistance by the General Assembly to accept that SORTS cannot constitutionally exist as a prison or a jail. That attitude manifested itself in this internal email exchange amongst SORTS officials in 2009 (Exhibit 16 attached hereto) about a request by the Missouri House for a cost comparison between the Texas SVP Program and the current Missouri SORTS program:

> "…they [meaning the House Committee] want the cost for doing SVP on the Texas model vs. **keeping SVP committees in jail or prison**. They didn't seem able to hear our explanation that keeping SVP committees indefinitely in a jail or prison environment (cells) would lead to constitutional challenges." (Emphasis added).

34. The budget process is further corrupted to the prejudice of the rights of the plaintiffs and the class members because the DMH, again pandering to the powerful Senate and House appropriations committee members, wrongfully committed to certain members to "keep them in the loop" about potential conditional releases of SORTS residents. This was improper and a further breach of the teachings of *Kansas v. Hendricks*. No one sitting on the United States Supreme Court at the time *Hendricks* was decided would have envisioned that somehow state legislators would have a "say," albeit informally as to whether residents would be released or be alerted in advance that a resident release was under consideration. Not even the faulty statutory scheme that birthed SORTS would have dared to overtly include legislators in the release process. The following email (Exhibit 17 attached hereto) confirms that SORTS represents a political compromise at the expense of civil liberties.

> Email from Julie Inman, SORTS CFO to Senior DMH management.
>
> "Senator Lembke – Sen. Engler talked about his concerns with Senator Lembke and the fact that **Sen. Lembke "hates" SORTS.** He says he has his hands full trying to defend the program. (Emphasis added.)
>
> Rep. Tilley hasn't been hearing concerns from folks the way that Senator Engler has. Alan again talked about the process and that we would be sure to include him, Senator Engler, and others in the conversation when approval for a person to petition the court is to be given by the Director and before any court hearings."

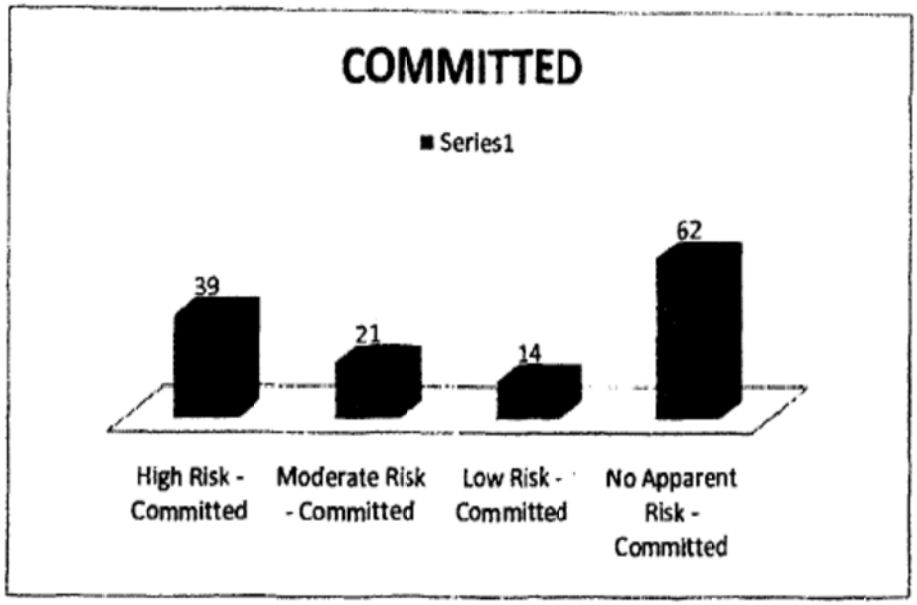
35. SORTS places each resident at one of four risk levels. They are "High Risk," "Moderate Risk," "Low Risk," and "No Apparent Risk." Almost half of the residents at Farmington (and presumably the numbers at Fulton are at or about the same level), are rated by SORTS personnel as "No Apparent Risk."

36. Yet all residents are incarcerated in the maximum security facilities at Farmington and Fulton. These "No Apparent Risk" residents, under long standing and readily recognizable sex offender treatment professionals and standards should be housed in the Least Restrictive Alternative ("LRA").

37. The following numbers and percentages reveal the failure of the DMH to comply with this elementary mental health treatment standard and confirm that substantial percentages of SORTS residents should not be incarcerated under maximum security conditions, since they present "No Apparent Risk."

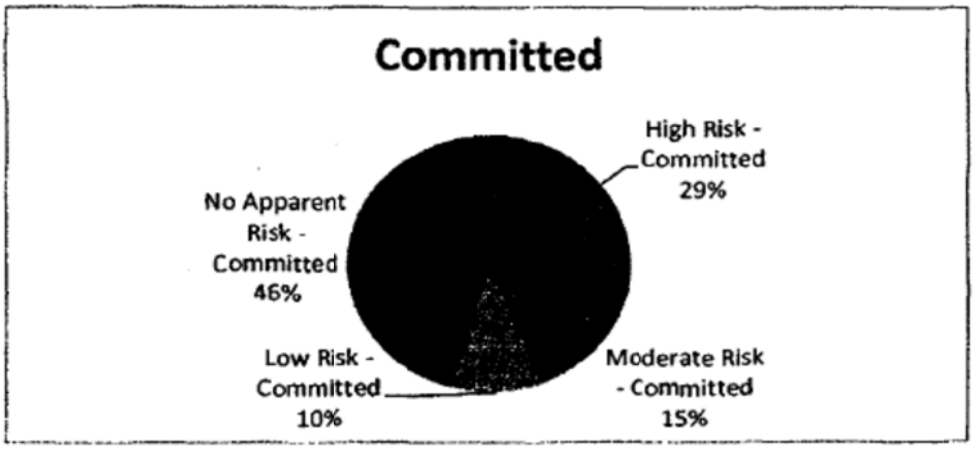
Current Distribution of Resident Level Assignments

High Risk - Committed	39
Moderate Risk - Committed	21
Low Risk - Committed	14
No Apparent Risk - Committed	62



Current Distribution of Resident Level Assignments

High Risk - Committed	29%	39
Moderate Risk - Committed	15%	21
Low Risk - Committed	10%	14
No Apparent Risk - Committed	46%	62
	100%	136



Three years ago, SORTS completed what it calls an "Annex," which allowed beds for eight residents and was touted as an LRA. It was not funded until 2013 and is still not yet being used as an LRA. At this time no residents have been assigned to the Annex. Tellingly, the structure itself was constructed inside "the wire." The most current number of "No Apparent Risk" residents, according to information provided to plaintiffs' counsel, is approximately 37% of the residents. Presumably if SORTS is effectively treating residents and treatment is not a sham, the number should be trending upward, although given the arbitrary and subjective process used by SORTS to classify residents, once challenged in this lawsuit and thus putting SORTS on notice, the number can be anything SORTS determines it to be consistent with what is most defensible in this lawsuit.

38. Even putting aside the fact that a significant number of SORTS residents present "No Apparent Risk" and that the LRA standard has been violated, internal documents show that

SORTS, purely as a budget saving ploy, as far back as 2008-2009 contemplated transferring as many as 24 residents to the St. Louis Psychiatric Rehabilitation Center ("SLPRC"), an LRA. This budget maneuver had nothing to do with care and treatment or adherence to the LRA standards. It was motivated solely to save money and yet, it also showed a ready recognition at the most senior levels of DMH management that a significant number of SORTS residents would and could have been moved to an LRA solely to save money; not for therapeutic reasons; not to satisfy the constitutional requirements that SVP's should be released if they no longer posed a danger; and not in consideration of security concerns.

39. This reality is described in multiple emails by and amongst Alan Blake, Felix Vincenz, Rick Gowdy, and Keith Schafer. It was defendant Schafer who initiated the gambit and who thus recognized that he and his senior management staff would readily allow SORTS residents to be released or housed in an LRA that was substantially less restrictive than the maximum security, double razor wired facility at Farmington. The plan was not implemented and so those 24 SORTS residents remained locked up at Farmington, unaware that the Director of the DMH could have allowed them to be transferred to SLPRC five to six years ago. Instead, they continue to be held in maximum security. In addition, the state court judges to whom annual reports are required by law to be sent about whether or not a resident should continue to be held at SORTS were not advised in those reports of the internal DMH belief about the unlucky 24. Here is the email trail (Exhibit 18 attached hereto) that documents the secret discussion about this DMH plan.

> MSOTC and Aged/Infirm
>
> **"Keith spoke with me yesterday afternoon about the possibility of selecting some 16 aged/infirm consumers from SORTS and developing a community alternative,** demonstrating that as a strategy for saving about 36% of the costs of a ward and reduce expansion costs for

another ward, and buying us a little breathing space in terms of census. Set up a meeting for the three of us to discuss this.

A projected population of 41 over the age of 65 in the next five years, and 92 in the next 10 years. If these numbers are accurate, we will need skilled care areas in the Hoctor building, which is planned in Hoctor central, as well as a new building and group homes. Higher levels of nursing care are best delivered in ward-type atmosphere, and intermediate levels of nursing care could more likely be delivered in a cottage-type setting.

However, this does not include potential offsets due to charging the consumers "rent" and expecting them to cover some portion of their outside services.

The attached document contains one tab that shows the cost of one Hoctor ward and a tab which shows the estimated cost of 16 residents in a group home setting.

Per staff on Hoctor it appears we only have 6 qualifying for SNF on Hoctor 1 per the criteria. I just asked if there are any others in the facility, and hope they may find some more.

At this time SNF candidates include: 6 men.
Schottel Wheeler
Arthur Bonine
Woods Coffman

[Blake writes] I am told we will have the SNF [Skilled Nursing Facility] number in about 45 minutes, and a list of names shortly after, as staff are reviewing with the idea we are estimating on having a nursing unit internally at the SNF level in a new building.

Currently we believe we can find 16 that could be place in the SLPRC option. We have a pool of 24 from which we can get the 16. The top 5 could go today to the SLPRC setting (and pass then neighbor test easily), if we had the court orders and conditions to go to SLPRC. The rest may need greater support/treatment, **but don't represent a risk to the community** in terms of compliance and appreciation of their situation. **The setting would likely enhance their treatment and provide motivation.** A few would be best engaged in the work program at SLPRC, and the focus would be on learning to live in a supported setting. **(A couple of them would make better employees at SLPRC than SLPRC has currently. Certainly they would be good peer counselors.)** (Emphasis added).

I just did some rough numbers related to earning potential for these individuals: I assumed minimum wage and full time employment for all 16 individuals (which is a large stretch) see below:

> As you can see, if we allow each person to maintain a $60 per month personal allowance and then take the rest of their funds for expenses we would generate a total of $193,568. This would increase the total savings to $291,793."

40. One of the few documents discovered in *Strutton* (most likely because it was an email exchange between two former SORTS employees and thus beyond the control of the DMH to suppress it) provides this candid view of SORTS (Exhibit 19 attached hereto):

> "I am glad you love your job. To me it sounds like a dream job. As for me, well I struggled with whether or not to leave [SORTS], but I think it is going to get worst [sic] before it gets better. **They stopped almost all treatment**. The only thing continuing was process groups and we were told they could be interfered with if they felt it was needed. I expressed my concern that the legislation that allowed us to exist was based on treatment being provided, but they hope to be able to increase treatment before that is caught by the wrong people….**It really is getting bad at [SORTS]."** (Emphasis added).

The other replies with these candid observations:

> "….I'm hearing the same thing from everybody that contacts me. I wish I could do something to help them. But, all I can do is pray. I feel so incredibly sad. I worked so incredibly hard to develop that program, but I could see it being destroyed. **I just could not tolerate watching it any longer. I feel so sad for the residents.**

41. Moreover, as a matter of policy, SVP Programs have largely been unsuccessful, expensive (except in Missouri), and a perversion of psychiatry, and consequently, in some states, efforts at reform are in the wind. Even at an institution as dysfunctional as SORTS-Missouri, the topic is under discussion as shown by this email:

> Email from SORTS staff psychologist Dr. Sujatha Ramesh dated July 22, 2013 to Jay Englehart, M.D. and Dr. Davinder Hayreh with attached study done by the chief researcher of the Department of Corrections Minnesota.
>
> "Interesting. Thought it might peek your interest."
>
> **Most civilly detained sex offenders would not reoffend, study finds.** (Emphasis added).

> At least three out of every four men being indefinitely detained as Sexually Violent Predators in Minnesota would never commit another sex crime if they were released.
>
> That's the conclusion of a new study by the chief researcher for the Department **of Corrections in Minnesota,** the state with the highest per capita rate of preventive detention in the United States.
>
> **The problem for the field of forensic psychology is that forensic assessment procedures have astronomical rates of false positives, or over-predictions of danger,** and it is difficult to determine which small proportion of those predicted to reoffend would actually do so.
>
> Ironically, as noted by other researchers, by the time an offender has done enough bad deeds to be flagged for civil commitment, his offending trajectory is often on the decline. Like other criminals, sex offenders tend to age out of criminality by their 40s, **making endless incarceration both pointless and wasteful.**

***

42. In sum, the Research Director of the Minnesota Department of Corrections, Dr. Grant Duwe, concluded:

> **"…existing research indicates the vast majority of sex offenders, including those with a relatively high sexual recidivism risk, can be safely managed in the community." (Emphasis added).**

Duwe's research further confounds efforts to sustain a sound empirical basis for the continued operation of SORTS. All health care providers in the employ of SORTS and licensed to practice their professions are obliged to be current on medical research and to react and respond in the best interests of their patients, speak out, and take other proactive steps as the case for SVP Program weakens and comes under attack as not being truly efficacious and lacking an empirical basis for its viability. Until 2012, SORTS participated in a survey, with other states, of the SVP civil commitment programs. It did not participate in 2012 because the comparison with other state programs was so bleak that SORTS did not want to be part of the survey. The survey is sponsored by the Sexual Offender Civil Commitment Programs Network ("SOCCPN"). With about 17 of 20 "SVP states" reporting outcomes, the annual surveys of programs have some

empirical basis. The 2011 Annual Survey reports that 75 more men had been fully released and there was no reported sexual or non-sexual recidivism. The 2012 Annual Survey reported that four "clients" were known to have sexually reoffended out of an apparent total of 159 discharges.

The Plaintiffs

43. Plaintiffs, sometimes called "residents," "patients," or "consumers" by the DMH, are in reality prisoners, incarcerated at all times mentioned herein in the custody of the DMH either as civilly committed individuals or detained and awaiting a civil commitment trial. Plaintiffs are currently confined in maximum security DMH operated facilities within rows of razor wires in the Missouri cities of Farmington or Fulton. Somehow, contrary to the requirements of *Kansas v. Hendricks*, plaintiffs, as "civilly committed sexually violent predators" have become a new class of citizens with markedly diminished civil rights.

44. Plaintiff John R. Van Orden is a citizen of the State of Missouri. He is a civilly committed resident of SORTS located in Farmington, Missouri ("SORTS-Farmington"). He has been confined at SORTS since October 29, 2005. He was civilly committed on May 17, 2007 in the Circuit Court for Webster County.

45. Plaintiff Joseph Miller is a citizen of the State of Missouri. He is a civilly committed resident of SORTS-Fulton. He has been confined at SORTS-Farmington and more recently SORTS-Fulton since October 29, 2005. He was civilly committed on May 17, 2007 in the Circuit Court for Webster County.

46. Plaintiff Macon Baker is a citizen of the State of Missouri. He has been confined at SORTS and then at the Ste. Genevieve County jail as a detainee since December 18, 2007. Mr. Baker has a pending civil commitment case, cause number 07PS-PR03273, in the Circuit Court for St. Louis County and since completing his sentence for his criminal conviction has been detained in maximum security, locked down in a cell for 23 hours day and night for almost

six years. He has been tried three times by the state in an effort to civilly commit him to SORTS; each time the jury could not come to a verdict. He is scheduled to once more be tried on the civil commitment petition brought by the State.

47. Plaintiff Chance Tyree is a citizen of the State of Missouri. He is a civilly committed resident of the SORTS. He has been confined at SORTS-Farmington and more recently at SORTS-Fulton since April 23, 2005. He was civilly committed in the Circuit Court for Cole County on June 19, 2008. In the Judgment and Commitment order signed on June 19, 2008, the Court ordered that Mr. Tyree "is committed to the custody of the director of the Department of Mental Health for control, care and treatment until such time as Respondent's mental abnormality has so changed that he is safe to be at large" and further ordered that he "shall be kept in a secure facility." The Judgment and Commitment Order does not require Mr. Tyree to pay any costs or expenses associated with his care and treatment; in fact, it specifically orders the Department of Mental Health to provide such care and treatment as is appropriate and necessary to treat his mental abnormality and, at a minimum by implication, bars payment by Mr. Tyree.

48. Plaintiff Walter W. Ritchey is a citizen of the State of Missouri. He is a civilly committed resident of the SORTS-Fulton. He has been confined at SORTS-Farmington and more recently at SORTS-Fulton since May 24, 2006. He was civilly committed in the Circuit Court for Jackson County on February 3, 2009. In the Judgment and Commitment order signed on February 3, 2009, the Court ordered that Mr. Ritchey "is committed to the custody of the director of the Department of Mental Health for control, care and treatment until such time as Respondent's mental abnormality has so changed that he is safe to be at large" and further ordered that he "shall be kept in a secure facility." The Judgment and Commitment Order does

not require Mr. Ritchey to pay any costs or expenses associated with his care and treatment; in fact, it specifically orders the Department of Mental Health to provide such care and treatment as is appropriate and necessary to treat his mental abnormality and, at a minimum by implication, bars payment by Mr. Ritchey.

49. Plaintiff David Brown is a citizen of the State of Missouri. He was confined at SORTS between November 17, 2008 and May, 2009, without the benefit of a trial. In May 2009, a jury in St. Louis City determined that Mr. Brown should not be civilly committed. He was released and now resides in the St. Louis area.

50. Plaintiff Anthony Amonette is a citizen of the State of Missouri. He is a civilly committed resident of the SORTS. He has resided at SORTS-Farmington since May 17, 2000. He was first confined to SORTS on September 18, 2001, without a trial. It was not until October 16, 2003, that he was formally civilly committed by the Circuit Court for St. Francois County, in Cause No. 24H060000387. In the Judgment and Commitment order signed on October 16, 2003, the Court ordered that Mr. Amonette "is committed to the custody of the director of the Department of Mental Health for control, care and treatment until such time as Respondent's mental abnormality has so changed that he is safe to be at large" and further ordered that he "shall be kept in a secure facility." The Judgment and Commitment Order does not require Mr. Amonette to pay any costs or expenses associated with his care and treatment; in fact, it specifically orders the Department of Mental Health to provide such care and treatment as is appropriate and necessary to treat his mental abnormality and, at a minimum by implication, bars payment by Mr. Amonette.

51. Plaintiff Richard Tyson is a citizen of the State of Missouri. He is a civilly committed resident of the SORTS. He has been confined at SORTS-Farmington since

September 3, 2004. He was civilly committed in the Circuit Court for Jackson County on December 9, 2005. In the Judgment and Commitment order signed on December 9, 2005, the Court ordered that Mr. Tyson "is committed to the custody of the director of the Department of Mental Health for control, care and treatment until such time as Respondent's mental abnormality has so changed that he is safe to be at large" and further ordered that he "shall be kept in a secure facility." The Judgment and Commitment Order does not require Mr. Tyson to pay any costs or expenses associated with his care and treatment; in fact, it specifically orders the Department of Mental Health to provide such care and treatment as is appropriate and necessary to treat his mental abnormality and ,at a minimum by implication, bars payment by Mr. Tyson.

52. Plaintiff Wade A. Turpin is a citizen of the State of Missouri. He is a civilly committed resident of the SORTS. He has been confined at SORTS-Farmington and more recently SORTS-Fulton since September 26, 2001. Mr. Turpin was civilly committed on February 26, 2004 in the Circuit Court for Cass County, in cause number CV-201-226P. In the Judgment and Commitment Order signed February 26, 2004, Judge Thomas Campbell ordered that Mr. Turpin was "committed to the custody of the director of the Department of Mental Health for control, care and treatment until such time as Respondent's mental abnormality has so changed that he is safe to be at large" and ordered that Mr. Turpin "shall be kept in a secure facility." The Judgment and Commitment Order does not require Mr. Turpin to pay any costs or expenses associated with his care and treatment; in fact, it specifically orders the Department of Mental Health to provide such care and treatment as is appropriate and necessary to treat his mental abnormality and, at a minimum by implication, bars payment by Mr. Turpin.

53. Plaintiff Matthew King is a citizen of the State of Missouri. He is a civilly committed resident of SORTS-Farmington.

54. Andree Cokes is a citizen of the State of Missouri. His is civilly committed resident of SORTS-Farmington.

The Defendants

55. Defendant Keith Schafer, a resident and citizen of the State of Missouri, is the Director of the Missouri Department of Mental Health, and is sued in his official capacity. He is responsible for and has been directly involved in the violations of the plaintiffs' constitutional and statutory rights as described in this Fifth Amended Complaint. His office is located at 1706 E. Elm St., P.O. Box 687, Jefferson City, MO 65102 (sometimes referred to herein as either "the Central Office" or "the CO"). At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Schafer acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally protected rights.

56. Defendant Rick Gowdy, a resident and citizen of the State of Missouri, is the Director of Forensic Psychiatry for the DMH and is intimately involved in SORTS issues and evaluations of detainees. He is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Gowdy acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

57. Defendant Joseph Parks, M.D., a resident and citizen of the State of Missouri, is the Chief Clinical Officer of the Office of the Director at the Central Office of the DMH and is intimately involved with SORTS. He serves as the DMH's senior clinical leader, provides

leadership and mentoring to DMH clinical staff and establishes and promotes professional, clinical, and ethical values and standards to which all clinical staff are expected to adhere. He also promotes quality of care and is responsible for establishing and maintaining the department's standards of care on both clinical and programmatic levels. Dr. Parks is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Parks acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

58. Defendant Robert Reitz, a resident and citizen of the State of Missouri, is the Director of Psychiatric Facilities and also Chief Executive Officer of the Fulton State Hospital, which includes the SORTS program within the hospital. He is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Reitz acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

59. Defendant Melissa Ring, a resident and citizen of the State of Missouri, is or was the Chief Operating Officer of Adult Psychiatric Services at the Southeast Missouri Mental Health Center ("SMMHC"), as well as the Chief Operating Officer of SORTS, or, at minimum has a managerial and operational responsibility at SORTS and is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. SORTS is a division or office of the

SMMHC. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Ring acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

60. Defendant Julie Inman, a resident and citizen of the State of Missouri, is the Regional Executive Officer of the Southeast Missouri Mental Health Center ("SMMHC") and is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. SORTS is a division or office of the SMMHC. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Inman acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

61. Defendant Linda Moll, a resident and citizen of the State of Missouri, is the Director of Treatment Services, Adult Psychiatric Service at SMMHC and is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. SORTS is a division or office of the SMMHC. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Moll acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

62. Defendants Harold Myers and Judy Sumpter operate, day to day, the efforts to obtain reimbursement from the plaintiffs and the members of the class, the cost of SORTS residents' room and board and treatment. Myers is the Reimbursement Officer for SMMHC.

Sumpter's title is uncertain, but she too works for the DMH and specifically at the SMMHC. Upon information and belief (because personnel seemingly change from day to day at SORTS and the SMMHC) Myers and Sumpter are under the supervision of the Chief Financial Officer of the SMMHC, Daman Longworth. All are sued in their official capacity, but only for the actions, claims, and relief asserted in Count II of this Fifth Amended Complaint. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, they acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

63. Defendant Alan Blake is the former Chief Operating Officer of SORTS and now serves as a consultant (officially and unofficially) and is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Blake acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

64. Defendant Jay Englehart, MD is the Medical Director at SMMHC and thus SORTS, as well, and is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Englehart acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

65. Defendant Mark Stringer is the Director of Behavioral Services of the DMH and a Division Director, which includes responsibility for a number of facilities within the DMH, included, at a very senior level, SORTS. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Stringer acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

66. Defendant Donna Augustine is the Interim Chief Operating Officer of Adult Psychiatric Services at the SMMHC, including SORTS and she is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Augustine acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

67. Defendant Dave Schmitt is Quality Improvement Director for SMMHC. He is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Schmitt acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

68. Defendant Justin Arnett is the Chief Nurse Executive for Adult Psychiatric Services at SMMHC, which includes SORTS. He is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his

official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Arnett acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

69. Defendant Marty Martin-Forman is the Chief Operating Officer of the Fulton State Hospital, which includes the SORTS program located at Fulton. He (she) is sued in his (her) official capacity. At all times pertinent herein, he (she) acted under color of law and his (her) conduct as described herein, was within his (her) official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Martin-Forman acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

70. Defendant Ian Fluger, a resident and citizen of Missouri, is Program Coordinator for SORTS Fulton. He is sued in his official capacity. At all times pertinent herein, he acted under color of law and his conduct as described herein, was within his official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Fluger acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

71. Defendant Sherry Lee, a resident and citizen of the State of Missouri, is the Chief Nurse Executive for Fulton State Hospital, which includes SORTS and is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. In depriving plaintiffs of

the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Lee acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

72. Ericka L. Kempker, a licensed psychologist and resident and citizen of the State of Missouri, is an employee of the DMH and SORTS and prepares and authors the SVP Statute required and court ordered individual annual reviews of the plaintiffs and the members of the class, and has done so since on or about April of 2011. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Kempker acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

73. Defendant Kristina ("Krissy") Bender-Crice, a resident and citizen of the State of Missouri, is a Unit Program Supervisor at SORTS and is sued in her official capacity. At all times pertinent herein, she acted under color of law and her conduct as described herein, was within her official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, Bender-Crice acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights. In particular, she is sued, in part, because she is a managerial level SORTS employee at the front lines of treatment and exemplifies the mindset of SORTS professionals that resist reform and labels those who do attempt, although doomed to failure, "morons." See Exhibit 28 attached hereto. At the top of the DMH, there exists the Director, who will not change SORTS and at the lower end of

management there are those like Bender-Crice, who likewise are staunch and arrogant in impeding reform.

74. Defendants John Doe and Jane Doe (collectively "the Doe defendants"), whose true names are unknown, are residents and citizens of the State of Missouri, who have been responsible for violating plaintiffs' rights in connection with incidents described in this complaint as actors for the state. The Doe defendants are past, present, or future employees, vendors, and independent contractors of the DMH, whose names and identities are not known to the plaintiffs at this time, but who have in the past or will during the course of this case act under color of law and their conduct as described herein were within their official capacity with the requisite state action. In depriving plaintiffs of the rights, privileges, and immunities secured under the Federal and Missouri Constitutions, the Doe defendants acted willfully and maliciously, with evil motive and intent, and with reckless and callous indifference to plaintiffs' federally and state protected rights.

75. Defendants named above are being sued in their official capacities. At all times relevant hereto, all defendants were acting under color of state law and acted in concert with each other, aided and abetted each other in the commission of the acts and conduct giving rise to the claims asserted herein and each was an agent of the other, so that the actions of any one defendant created vicarious liability for the other defendants. Moreover, their conduct and behavior as alleged herein will shock the conscience of the court.

Jurisdiction and Venue

76. This is a civil action authorized by the Reconstruction Civil Rights Act of 1871, 42 U.S.C. § 1983, based on violations of their federal constitutional rights, including the First, Fourth, Eighth, and Fourteenth Amendments. Plaintiffs' further allege supplementary claims under the Missouri State Constitution, other state laws, and administrative rules and internal

DMH policies. This Court has the authority to grant declaratory relief pursuant to 28 U.S.C. §2201 as an actual controversy exist regarding the rights, privileges and immunities to which Plaintiff is entitled. Moreover, pursuant 28 U.S.C. §2201, this Court has authority to grant injunctive relief and any other necessary and proper relief that is deemed just and proper by the Court. Plaintiffs further seek monetary, compensatory and punitive damages.42 U.S.C. § 1983 to address the deprivation, under Color of State Law, of rights secured by the Bill of Rights of the United States.

77. This Court has jurisdiction under 28 U.S.C. § 1331, 28 U.S.C. § 1343(a) (1), 28 U.S.C. § 1343(a) (2), 28 U.S.C. § 1343(a) (3), 28 U.S.C. § 1343(a) (4), and 42 U.S.C. § 1983. This Court has supplemental jurisdiction over plaintiffs' claims under Missouri law based on 28 U.S.C. § 1367, as the state law claims are so related to the federal claims that they form part of the same case and controversy under Article III of the United States Constitution.

78. This Court has personal jurisdiction over each defendant, in that, among other things, they are employees of the state of Missouri or facilities or agencies of the state of Missouri that are located within Missouri. Moreover, the defendants regularly and routinely conduct business in Missouri, working primarily at either the cities of Jefferson City, Farmington, or Fulton. Finally, the defendants initially named in the Complaint and subsequent amendments thereto, other than this one, have voluntarily submitted to this Court's jurisdiction and thereby waived any objection to personal jurisdiction.

79. The relevant acts and omissions occurred in the Eastern District of Missouri. Therefore, venue is proper in this Court under 28 U.S.C. § 1391(b) (2).

Class Action Certification

80. On September 30, 2012, this Court entered a Certification Order certifying a "Treatment Class," defined as "persons who are, or will be, during the pendency of this action,

residents of SORTS of the state of Missouri as a result of being civilly committed," and a "Charging Class," defined as "all persons who are, or will be, during the pendency of this action residents, and former residents, of SORTS of the State of Missouri as a result of civil commitment, and who have been, or will be, billed or charged for care, treatment, room or board by SORTS or by the SMMHC." In doing so, this Court recognized that the predominate common questions of the class were and are: (1) whether SORTS is a prison disguised as mental health facility in violation of, *inter alia*, the 8th Amendment to the United States Constitution prohibiting cruel and usual punishment and additional jeopardy after having once been punished for the same crime or crimes ; (2) whether the treatment at SORTS is a pretext for warehousing the plaintiffs without adequate treatment so as to prevent them from having a reasonable opportunity to be released; (3) whether the mental health treatment and care provided by defendants or those acting under their control or direction comports with Constitutional requirements; and (4) whether the scheme to charge class members for their own care and treatment is consistent with the United States and Missouri Constitutions.

The Missouri Law That Spawned SORTS

81. The representative Plaintiffs and all members of the proposed class have been or continue to be confined at SORTS pursuant to Missouri Revised Statute §§ 632.480 through 632.513, sometimes called the "Missouri Sexually Violent Predators Act" or "MSVPA.". The statutory scheme outlines the commitment process for all members of the proposed class. §§ 632.483-495 RSMo. (Whether it is followed substantively and faithfully post commitment is, of course, the key factual issue in this litigation).

82. When a prisoner found guilty of a sexually violent crime is suspected of meeting the criteria of a sexually violent predator ("SVP"), the agency with jurisdiction provides notice to the Attorney General within 360 days prior to the prisoner being released from prison. § 632.483.

A potential SORTS resident is evaluated by the Prosecutor's Review Committee and a multidisciplinary team established by the Department of Corrections and Department of Mental Health. § 632.483. Tellingly, the Prosecutor's Review Committee can overrule the multidisciplinary team's determination and recommendation, creating a law enforcement bias to the process that, together with other aspects of the process and as it is applied, renders this statutory scheme and the way it is applied unconstitutional under both the United States and Missouri Constitutions. If the State Department of Mental Health determines that the person is a "sexually violent predator" as defined by the statute, the Director of Mental Health forwards a request for a petition for commitment to be filed in the probate division of the circuit where the individual was convicted of the offense for which he was committed to the jurisdiction of the Department of Corrections. § 632.486 RSMo. A copy of the petition is forwarded to a multidisciplinary team. *Id.*

83. A court then determines whether there is probable cause to believe that the individual is likely to engage in sexually violent predatory criminal behavior upon his or her release. § 632.489 RSMo. If the court finds that probable cause does exist, it must order that the individual remain in maximum security custody pending trial to determine whether the individual is a sexually violent predator. *Id.* If the court or jury determines by clear and convincing evidence that the person is a sexually violent predator, the individual is committed to the custody of the State Department of Mental Health for treatment and confinement in a facility designated by the Director of Mental Health. § 632.495. During the trial, the State consistently takes the position that no evidence is permitted to be offered by the defendants about the real facts regarding what is occurring in the SORTS Program, including the fact that no one has been released, unconditionally. At the same time, the State argues to the jury that the defendant, if

committed, will receive treatment, failing to also disclose to the jury that the treatment is a pretext and sham for imprisoning the committee.

84. All individuals who have had a probable cause hearing and/or been committed pursuant to the statutory scheme are confined at and become a resident of SORTS. The resident then is entitled, by law, to an annual review, to be done objectively and in good faith, to determine whether the mental condition the resident allegedly has will require that he remain confined or be conditionally released. § 632.498 RSMo. Again, whether that annual review has any meaning and is conducted in good faith and consistent with the professional standards of psychiatry is an issue of fact that plaintiffs request be litigated fully and completely in the trial of this matter after full and complete discovery.

85. The Missouri State Legislature enumerated rights to persons committed in any mental health facility in § 630.110 and § 630.115 RSMo. The state then authorized the Department of Health to promulgate rules related to patient's rights described in § 630.110 and § 630.115 RSMo. § 630.135 RSMo. The Department of Mental Health lists the "Rights Which Cannot Be Limited" on its website at http://dmh.mo.gov/cps/ClientRights/ClientRights.htm, declaring:

> Each individual has basic rights to humane care and treatment that cannot be limited under any circumstances. The following rights apply to all settings:
>
> 1. To receive prompt evaluation, care and treatment;
>
> 2. To receive these services in the least restrictive environment;
>
> ***3. To receive these services in a clean and safe setting;***
>
> 4. To not be denied admission or services because of race, gender, sexual preference, creed, marital status, national origin, disability or age;

> 5. To confidentiality of information and records in accordance with federal and state law and regulation;
>
> 6. To be treated with dignity and addressed in a respectful, age appropriate manner;
>
> 7. To be free from abuse, neglect, corporal punishment and other mistreatment such as humiliation, threats or exploitation;
>
> 8. To be the subject of an experiment or research only with one's informed, written consent, or the consent of an individual legally authorized to act;
>
> 9. ***To medical care and treatment in accordance with accepted standards of medical practice***, if the certified substance abuse or psychiatric program offers medical care and treatment; and
>
> 10. To consult with a private, licensed practitioner ***at one's own expense.*** (Emphasis Added).

86. These "Rights" do not merely provide as this Court will hear the defendants argue in this case and as they always argue in similar lawsuits, that care and treatment need only be at some level that "does not shock the conscience of the court." And how can a program that publishes these seemingly commendable standards have failed to have one person successfully complete the program and be released?

87. The Department of Mental Health Director enumerates "prompt . . . treatment" and "treatment in accordance with accepted standards" in the first and ninth rights respectively. These rights are not listed in the "Client's Rights" Department Operating Regulations, DOR 2.205 effective March 1, 2006, which are the procedures used by facilities. The SORTS Handbook lists the rights as, "Residents are MSOTC and DMH clients. Thus, you are entitled to the following without limitation… ***to the extent that the facilities, equipment and personnel are available***, to medical care and treatment in accordance with the highest standards accepted in medical practice . . . to receive prompt evaluation, care and treatment." Missouri Sexual Offender Treatment Center Handbook 43 (July 3, 2002) (Emphasis Added). Of course, the

obvious qualifier "to the extent . . . available" is meaningless and cannot comport with the Supreme Court's mandate that adequate treatment be provided in all instances, not "to the extent . . . available." From that perspective alone, the written description of the SORTS program violates the obligations of the defendants to administer the SORTS program consistent with the Constitution of the United States and Missouri.

The Prison Known as SORTS

88. From the time of Governor Carnahan to the present, defendants justify SORTS and the confinement of the plaintiffs and the member of the class by citing *Kansas v. Hendricks*, 521 U.S. 346 (1996), where the Supreme Court upheld the facial constitutionality of civil commitment laws relating to sexual offenders in a narrow 5-4 decision based on a hypothetical, superficial analysis of a relatively new statute.

89. But conspicuously, the Supreme Court did not have the benefit of a full, complete, and long period of an expansive evidentiary record. Now, 14 years after SORTS was established, this Court has the benefit of experience to guide its decision. That experience—*i.e.*, SORTS's failure to successfully treat even a single patient such that he can be released—will inform this Court's decision in a way that renders the superficial analysis of statutory language in *Hendricks* largely irrelevant or for that matter, as noted in earlier passages of this Complaint, the lack of precedential value of the *Strutton* case. As Justice Holmes observed many years ago, "The life of the law has not been logic: it has been experience." O.W. HOLMES, JR., THE COMMON LAW 1 (1881), *available at* http://biotech.law.lsu.edu/books/ holmes/claw03.htm. The logical review of statutory language is one thing, but the actual experience of the parties under that system and the statute's implementation and application must define the Court's decision in this case.

90. In looking back at the early days of SORTS, the defendants and other DMH employees associated with SORTS made these observations (again only recently disclosed in this case and hidden in *Strutton*):

> In an email from Ann Dirks-Linhorst on February 6, 2002 (Exhibit 20 attached hereto), she wrote to Rick Gowdy, Marty Bellew-Smith and Victoria Johnson, these words:
>
> I know that yesterday you indicated that you all had inherited a 'bad' program." (Emphasis added).
>
> ***
>
> **"In Minutes** (Exhibit 21 attached hereto) **of a May 22, 2001 SORTS Staff Meeting, it was noted that "SVP was not budgeted adequately."** (Emphasis added).

So, the internal and secret DMH records indicate that from the very start, it was acknowledged among top echelon management and health care providers that SORTS was a "bad" program that was not "budgeted adequately" and that even the most elementary and critical standards of an SVP Program did not exist at SORTS. Yet the DMH persisted with the program as it was then and is now, without any material changes to meet constitutional and statutory requirements. The only thing that SORTS has done well is fulfill what appears to be its covert mission – the "end game" of warehousing the residents. In that respect and perversely it has been a great success.

91. At some point in time, an as yet unidentified SORTS official reviewed certain "Sex Offender Treatment Program Standards and Measures" that were established by a respected accrediting body named *The Special Commitment Center* and published in August of 2000. In insightful, but devastating handwritten notes that are depicted below and were made by the official as he or she reviewed these Standards, he assessed whether SORTS "measured up." The person's candid comments surfaced on two key standards – the need for a credible program to have a "transition [i.e. release/discharge] component" and secondly regular "feedback…to

participants [the SORTS residents]. As to the first, "the transition component, which is necessary to achieve "a core purpose of sex offender treatment… [of] the eventual release of persons…and establish program credibility," the official wrote:

"We don't have this at all as best I can see & need to develop it." (Emphasis added).

As to the second standard, *The Special Commitment Center* remarked that "feedback to participants" is critical to "motivation," "proper risk assessment" and" decision-making." As to that standard, the official assessed SORTS' compliance with these observations:

"Needs major work."

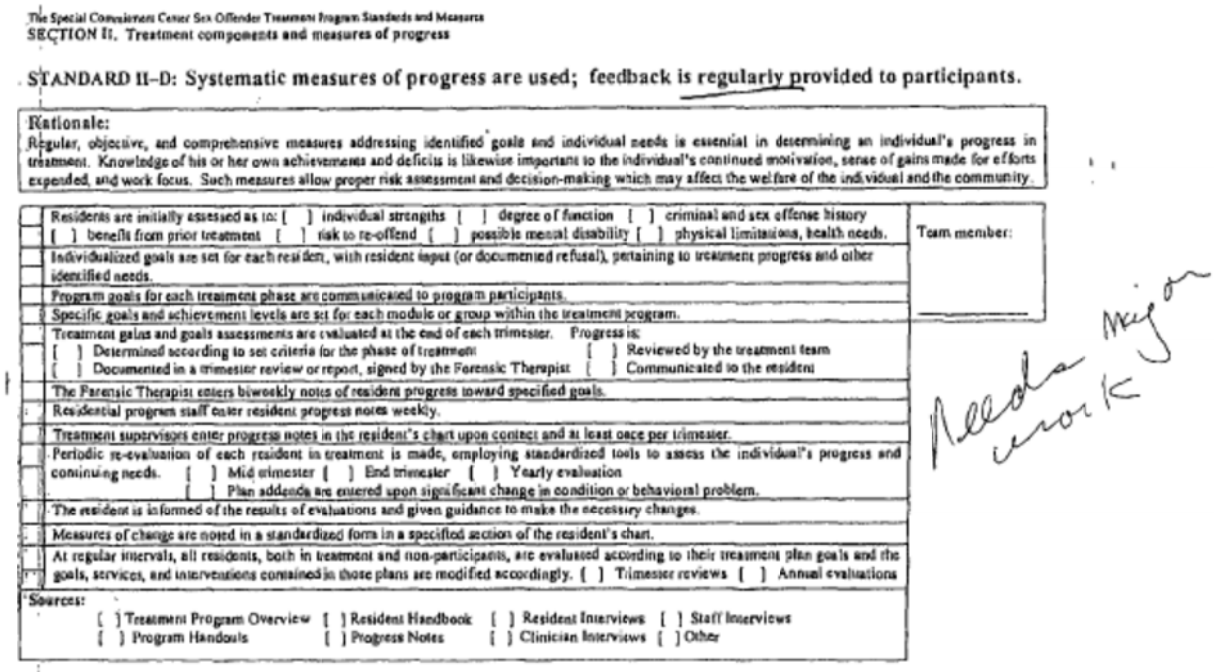
The Special Commitment Center Sex Offender Treatment Program Standards and Measures
SECTION II. Treatment components and measures of progress

STANDARD II – E: The program has a systematic transition component.

Rationale:
A core purpose of sex offender treatment is the eventual release of persons who have experienced success within the program. Having in place a systematic approach to community transition, geared to known and likely variables in the needs of persons released, allows focus in treatment planning, motivates those in treatment, permits efficient planned allocation of resources, and establishes program credibility.

	The treatment program has components preparing individuals for eventual placement in a Less Restrictive Alternative (LRA).	Team member:
	The program has identified those approaching completion of the institutional phase and nearing readiness for an LRA.	
	A full-time staff person is assigned to develop facilities and supports for community transition.	
	Housing suitable to the needs of persons transitioning from the treatment facility is currently available.	
	Services for supervision and treatment are in place for those in transition prior to their release date.	
	A process for community notification is in place and functional.	
	A process for establishing community placements, contacting local law enforcement, and developing residential, treatment, and security components of Less Restrictive Alternatives is in place.	
	The program has recommended release to an LRA for persons successfully completing treatment.	
	The program currently has persons in LRA settings.	
Sources: [ ] Treatment Program Overview [ ] Manager Interview [ ] Resident charts [ ] Court orders [ ] Other		

We don't have this at all as best I can see & need to develop it.



The Special Commitment Center Sex Offender Treatment Program Standards and Measures
SECTION II. Treatment components and measures of progress

STANDARD II–D: Systematic measures of progress are used; feedback is regularly provided to participants.

Rationale:
Regular, objective, and comprehensive measures addressing identified goals and individual needs is essential in determining an individual's progress in treatment. Knowledge of his or her own achievements and deficits is likewise important to the individual's continued motivation, sense of gains made for efforts expended, and work focus. Such measures allow proper risk assessment and decision-making which may affect the welfare of the individual and the community.

Team member:

Residents are initially assessed as to: [ ] individual strengths [ ] degree of function [ ] criminal and sex offense history [ ] benefit from prior treatment [ ] risk to re-offend [ ] possible mental disability [ ] physical limitations, health needs.

Individualized goals are set for each resident, with resident input (or documented refusal), pertaining to treatment progress and other identified needs.

Program goals for each treatment phase are communicated to program participants.

Specific goals and achievement levels are set for each module or group within the treatment program.

Treatment gains and goals assessments are evaluated at the end of each trimester. Progress is:
[ ] Determined according to set criteria for the phase of treatment [ ] Reviewed by the treatment team
[ ] Documented in a trimester review or report, signed by the Forensic Therapist [ ] Communicated to the resident

The Forensic Therapist enters biweekly notes of resident progress toward specified goals.

Residential program staff enter resident progress notes weekly.

Treatment supervisors enter progress notes in the resident's chart upon contact and at least once per trimester.

Periodic re-evaluation of each resident in treatment is made, employing standardized tools to assess the individual's progress and continuing needs. [ ] Mid trimester [ ] End trimester [ ] Yearly evaluation
[ ] Plan addenda are entered upon significant change in condition or behavioral problem.

The resident is informed of the results of evaluations and given guidance to make the necessary changes.

Measures of change are noted in a standardized form in a specified section of the resident's chart.

At regular intervals, all residents, both in treatment and non-participants, are evaluated according to their treatment plan goals and the goals, services, and interventions contained in those plans are modified accordingly. [ ] Trimester reviews [ ] Annual evaluations

Sources:
[ ] Treatment Program Overview [ ] Resident Handbook [ ] Resident Interviews [ ] Staff Interviews
[ ] Program Handouts [ ] Progress Notes [ ] Clinician Interviews [ ] Other

Perhaps sensing that these quotes and others referenced throughout this Complaint were predictive of the future reality of SVP Programs, the psychiatric community has consistently and vigorously opposed programs like SORTS at the start and later then pressed for fundamental reform, when it was apparent that these programs were failing, pointless, wasteful, and detrimental to the mental wellbeing of the residents. As often happens, the only place where reform can take place is through judicial intervention, as Alan Blake noted in a more earthy way when he was inadvertently overheard to whisper in a Jackson County, Missouri Circuit Court room during a hearing on a conditional release of a SORTS resident in 2012:

"We wouldn't be here, but for that f……lawsuit."

The "lawsuit" to which he was referring? – this CASE. Throughout the history of SORTS the fixation and obsession on the filing of lawsuits is palpable. One wonders what SORTS would be like if the federal courthouse was not open.

92. Justice Kennedy acknowledged in his concurring opinion in *Hendricks* that future courts will need to assess the psychiatric underpinnings for civil commitment of sexual offenders because "if it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it." *Hendricks*, 521 U.S. at 373.

93. Then Chief Justice of the Missouri Supreme Court Michael Wolff wisely noted in his concurring opinion in *In re Care & Treatment of Norton*, 123 S.W.3d 170, 176 (Mo. 2003):

> The purposes of civil commitments are incapacitation-to protect society or the patient-and treatment. The idea behind such confinements is that a patient is "sick" and dangerous, that he must be locked up to be treated, and that when he gets "well," he will be released.
>
> **While the statutory scheme is constitutional as written, I am doubtful about its constitutionality as applied. I concur in these cases, however, because I believe we should defer the constitutional questions to another day after seeing how the "sexually violent predator" law works in practice. The practices of the state over the next few years will show whether there is a meaningful attempt to treat those previously determined to be sick and dangerous, or whether these offenders will simply be warehoused without treatment and without meaningful efforts to re-integrate them into society.** (Emphasis added.)
>
> For those labeled as "sexually violent predators," the question is whether this confinement is likely to be a life sentence, without meaningful treatment, and without an attempt to tailor the infringement on liberty to that needed to effect treatment and to protect society. . . .
>
> Most importantly, the state must show through its confinement and treatment under the statute that the statute serves a proper non-punishment purpose. A principal premise of their confinement is treatment. If an inmate is at all susceptible to treatment, the state has a duty to provide that treatment. If the state simply warehouses these men, without appropriate treatment and without a meaningful means to achieve re-integration with society-rights that are accorded to other mental patients-their constitutional rights will be violated. . . . **[I]f this statute is used simply to impose life sentences of confinement based upon a labeling of the inmates' thoughts; this Court will have a constitutional duty to take another look.** (Emphasis added.)

94. Thus this case seeks to answer the questions asked and concerns poised by Justice Kennedy and by Chief Justice Wolff. Both were concerned that the statutes which appeared constitutional on their face would in the end be implemented in a manner that demonstrated that the purported treatment provisions of the statutes were merely a sham or pretext, and that the true intent of the statutes was to warehouse sexual offenders after they have served their sentences. Their concerns were justified. Moreover, what would Justice Kennedy or Chief Justice Wolff have said if they knew that some 14 years after SORTS was begun, the release rate for Missouri would be zero?

95. SORTS is modeled after a maximum security penitentiary in many ways, but in other ways its practices are harsher and more restrictive of civil liberties than prisons. SORTS cannot be independently accredited as a standalone mental health facility by the "Joint Commission on Accreditation of Health Care Organization," whereas nearly all other treatment facilities in the state of Missouri are accredited. Instead, the DMH has grafted SORTS onto the SMMHC, not with the intent that the two should operate collaboratively or in any sense together for the better of mental health treatment, but purely as an artifice to gain accreditation and help pay for the costs of SORTS. Yet, in every other unwholesome sense, SORTS stands alone and has different priorities and missions.

96. In 2013, against a backdrop of this litany of failings summarized by 14 years of no one being found to be cured or healed, the number one initiative for SORTS was not patient driven, i.e. "*Why has no one been released and how can we hold ourselves out as health care providers to these men?*" Instead, the priority for SORTS was inward and selfish - protection of staff; not treatment, not neglect or abuse of the residents, not releases, or better living conditions, not human dignity, or endeavoring to achieve a state of the art facility or fix SORTS' sorry

record. Ironically, perhaps the SORTS leadership and staff sensed that they were operating a prison, providing "treatment" as a pretext and sham, and that they genuinely should be fearful for their own safety given what they knew they had done to the residents of SORTS. After all, who are humanity's most desperate and condemned souls, but those, who have no hope and many of whom had their psyche damaged over the years behind "the wire?"

97. Despite the purported focus of SORTS on resident treatment, and not on their punishment, SORTS operated and still operates under arbitrary, counter-therapeutic rules that are more restrictive than being confined in prison under the authority of the Missouri Department of Corrections, such as:

(a) SORTS Residents are compelled to wear full restraints, including: handcuffs, leg irons, and a waist chain belt anytime they are required to leave the secured area.

(b) Residents are subjected to unwarranted searches of the body without reasonable suspicion being established. Unannounced searches of a Resident's living area occur often and result in a complete minute search of a Resident's property looking for "contraband," which, under the rules can include dental floss and tea bag strings. SORTS staff minimizes assaults and confrontations among the Residents, and instead are consumed with their own safety.

(c) Prisoners may visit the library, gym, or yard anytime per day, seven days per week. Depending on the resident's level, SORTS permits residents to visit the library and gym only one or two hours per week.

(d) Prisoners may sleep as late as they wish, whereas SORTS residents must be awake by 7:00 AM every day.

(e) Prisoners may decide for themselves if they will eat a particular meal, and are allowed to skip meals if they deem it appropriate. On the other hand, SORTS residents must attend all meals, without exception.

(f) In prison, one may spend $300 per month, $75 per week, on items from the canteen, whereas a SORTS resident may spend $10 to $50 per month depending on his level.

(g) Prisoners may store their own items; SORTS residents can only request one drink and two food items per day, but SORTS staff maintains custody of all other items.

(h) Prisoners may cook and eat in their room; SORTS residents may not have food or drinks in their rooms.

(i) Prisoners may bathe as often as they deem appropriate and for as long as they like if no one is waiting. In SORTS, a resident is allowed one time-limited shower per day without exception.

(j) SORTS has a much more restrictive curfew policy than prison, and even sets bedtimes for residents.

(k) In prison, you may buy your own television, stereo, and typewriter. In SORTS, you must share a television with others in your day room. Typewriters are prohibited at SORTS.

(l) Prisoners may have 100 postage stamps, whereas SORTS residents are permitted no more than 10 stamps at a time.

(m) Prisoners may walk freely to meals, while SORTS residents must be escorted.

(n) In prison, staff count prisoners five times a day; in SORTS, staff conduct counts every 15 minutes.

(o) Prisoners have two men to a room and may choose roommates to a certain extent, whereas SORTS residents have up to 4 men to a room and the SORTS management determines with whom residents room.

(p) Prisoners may have a key to their room, depending on their level, whereas SORTS residents do not have a key to their room regardless of level.

(q) Whereas prisoners may have visitors four days per week without advanced notice, SORTS allows visits only on weekends and requires advance notice of two weeks.

(r) Silly and maddening restrictions on the length of dental floss and whether tea bags with strings are "contraband."

98. The holding in *Wyatt v. Stickney*, 334 F. Supp. 1341 (M.D. Ala. 1971); 344 F. Supp. 373, (M.D. Ala.1972) demonstrates the minimum constitutional standard for confinement in treatment centers. The U.S. Supreme Court in *Youngberg v. Romeo*, 457 U.S. 307, 322, 102 S. Ct. 2452, 73 L. Ed 2d 428(1982) referred to *Wyatt v. Stickney* as a controlling case regarding constitutional standards for civil commitment. The Eighth Circuit in *Coley v. Clinton*, 635 F. 2d 1364, 1375 (8th Cir. 1980) has adopted and recognized these rights. In *Wyatt*, the court stated: "The Patients for the most part, were involuntarily committed through non-criminal procedures and without the constitutional protections that are afforded Defendants in criminal proceedings. When Patients are so committed for treatment purposes they unquestionably have a

constitutional right to receive such individual treatment as well as give each of them a realistic opportunity to be cured or to improve his or her mental condition. Adequate and effective treatment is constitutionally required. 'Treatment efforts must be directed to that aspect of his behavior which caused him to be classified as dangerous so that he has a reasonable opportunity to be eventually discharged from maximum security confinement. To hold otherwise would certainly 'transform the hospital into a penitentiary where one could be held indefinitely for no convicted offense.'"

99. SORTS, unlike the treatment programs described in *Wyatt*, does not offer a realistic opportunity to be cured, improve patients' condition or be released. In SORTS, the plaintiffs and other class members are held in penitentiary conditions that violate their constitutional rights. The treatment program offered falls short. In fact, in its 14 year history only three Residents have been granted a conditional release and a reasonable inference is that that was done only because this lawsuit was filed. Moreover, the conditional releases have so many impossible and burdensome conditions that the conditions literally swallow any benefits of release. Those three individuals, who were released, return nightly to the maximum security confinement of SORTS behind the two rows of razor wire, instead of the Least Restrictive Alternative.

100. The real mission of SORTS is institutionalization, preventative, indefinite detention and punishment. There is no rehabilitative purpose and SORTS is actually counter therapeutic. SORTS residents not only receive no real treatment for their mental abnormalities, their civil commitment to such a deficient system leaves them embittered, without hope of recovery, with little chance of successful re-entry into society, and worsens their overall psychological status and well-being.

101. The one time Director of Behavioral Services at SORTS, Dr. Jon Rosenboom, described the plight and predicament of the SORTS residents in this email (Exhibit 22 attached hereto):

> "From a natural progression in the treatment of our more advanced residents, some increased responsibility and personal freedom is crucial. We now have 4-6 residents within 1-2 years of a recommendation to CO for partial conditional release. After over 7 years of these individual's treatment and progress, they continue to be supervised 24/7, have no personal monies on their person, cannot buy a soda or candy bar from vending machines that they pass 10 times a day, and have now lost a good deal of the benefits of personalization of their room through the life safety interpretations/restrictions associated with TJC accreditation. **They are becoming more institutionalized and the potential that their work in treatment will bring fruit is subject to fading."** (Emphasis added).

102. In addition, Mary Weiler, then SORTS Director of Social Services, in a plea for help to other officials operating SORTS programs in other states wrote in an email (Exhibit 23 attached hereto):

> "We are moving toward conditional release of several residents. All of these men have been out of mainstream society (jail, prison, SVP residential treatment) for at least 20 years. I would appreciate references to articles or other resources that would be helpful in teaching reintegration skills to these men (i.e. imagine the changes in telephonic communication over 20 years!). Thank you."

103. In 2006, the 8th Circuit Court of Appeals ruled that " Neither the Supreme Court nor this court has determined the extent to which the Constitution affords liberty interests to indefinitely committed dangerous persons under the *Matthews* balancing test. Since a person has been civilly committed as a dangerous person, his liberty interests are considerably less than held by members of a free society. As compared to a prison inmate, however, a committee was entitled to more considerate treatment and conditions of confinement. Civilly committed sex offenders retain certain rights. In particular, they have a right to receive treatment or other training that will give them an opportunity to regain some or all of their rights to liberty."

104. So long as genuine treatment that affords a reasonable opportunity for release and honest, full disclosure periodic review are provided in good faith and with candor, civil commitment laws do not violate offenders' fundamental rights to liberty and Due Process. While civilly committed sex offenders therefore, have a right to adequate treatment. In Missouri, the SORTS treatment program has so departed from minimal professional standards that the treatment professionals could not have based their treatment decisions on their professional judgment. Some of the conditions as documented in DMH records ultimately disclosed in this case, but not in earlier litigation include inadequate staffing, inadequate training of staff regarding the clinical mission of the facility, the lack of individualized treatment, the absence of arrangements for residents to transition to being released, inadequate provisions to allow their families to participate in treatment, no effort to place residents in the Least Restrictive Alternative and a punitive treatment environment. As a result, it is important that any civil commitment program for sex offenders offer adequate treatment to those in the program so as to enable them to be released in a meaningful way. Failure to do so permits an express finding that inadequate treatment is being provided or that the purpose of the program is punitive rather than to rehabilitate.

105. Despite the superficial justifications supplied by the State, "care and treatment" is essentially non-existent at SORTS. There is, in fact, no "care and treatment" provided to SORTS in any realistic sense and, to the extent, the defendants undertake to provide care and treatment to effect a "cure" of the alleged mental abnormalities of the plaintiffs and the other class members, it is a pretext for imprisoning the plaintiffs and the other class members in violation of, most notably, their rights as defined by the 8th Amendment to the United States Constitution, its

counterpart in the Missouri constitution, and the statutory requirements of Missouri law that created the legal structure for SORTS and defined its purpose and mission.

106. SORTS established "progress" levels, wherein residents are classified using a color-coded system, in order to portray to residents and to the outside world the illusion that residents have some hope of "recovery" as a result of the "care and treatment" received at SORTS. The system is in practice and effect nothing more than a disciplinary device used by SORTS to keep residents in line and to prevent behavioral disruptions. It has nothing to do with psychological or psychiatric care, treatment, or progress relating to a resident's "mental abnormality." SORTS has an undocumented, unofficial policy to utilize certain of its staff, who have the temperament, guile, callousness, malice, and will to carry out a covert strategy to target residents that are making progress and getting close to what objectively would qualify them for Least Restrictive Alternatives ("LRA") and integration into the outside world and, then, through stringent, unreasonable and calculated enforcement of the myriad of silly and petty rules and the wizardry of psychiatry, to cause those residents to be set up for failure, artificially demoted, and thereby maintain them in custody all as part of the intent to warehouse.

SORTS Tries a New Program – Called SOS

107. In 2012, SORTS began introducing what its leadership heralded as a new treatment program on a piecemeal trial basis. It was called the Safe Offender Strategies Program or ironically "SOS."

108. While it was a new program to SORTS, it was not a new program for DMH. It had existed in the Fulton State Hospital (sometimes called "Fulton Proper") since approximately 2007 (internal documents confirm this with the words "…it's what the rest of the hospital [meaning DMH] has been doing since '07 at Fulton, but not Farmington"), found to be efficacious in treating sex offenders diagnosed with mental illnesses, not mental "abnormalities,"

the statutorily defined standard used to justify incarceration of those sentenced to SORTS and criticized by the APA and others as not really a diagnosable illness.

109. SOS was also used as a treatment modality at the Adult Psychiatric Services side of the SMMHC starting in approximately 2009.

110. SOS was conceived by the then Director of Sex Offender Treatment Programing at the Fulton State Hospital, a DMH employed psychologist (now a DMH consultant) and used by her and other DSM health care providers at Fulton Proper with remarkable success at achieving releases. During that five year period, those who were in charge of the day to day operations of SORTS had actual knowledge that SOS, a treatment program for sex offenders, was in place and successfully treating those sex offenders in Fulton Proper.

111. During the five years that SOS was used at "Fulton Proper" the DMH employee in charge of the program testified in 2012 as follows:

> **"And I know that over the course of the five years that we've been doing Safe Offender Strategies, there have been 150-some-odd clients that have received that treatment at Fulton Proper for at least one year and of those about 95 have been released from Fulton."**

112. Blake and Jon Rosenboom, the then Director of Behavioral Services at SORTS in those years had expressly rejected SOS and rebuffed overtures by the Fulton State Hospital health care providers using SOS. At one point, according to deposition testimony by the Director of Sex Offender Treatment at Fulton, she was told by Dr. Rosenboom that:

> **"I hear that you are developing a treatment manual and I am here to tell you that we want nothing to do with it."**

But Blake and Rosenboom either knew that the SOS treatment regime was efficacious or failed to adequately and objectively assess SOS. What was remarkable about SOS was that it was being used at "Fulton Proper" to treat sex offenders, who had been diagnosed with mental illnesses and then were released with promising low recidivism rates.

113. SORTS clung to a sex offender treatment program that later, when SOS was introduced to SORTS, was described in the Farmington SOS Patient Handbook (Exhibit 24 attached hereto) with this candor:

> **"Traditional sex offender treatment programs [meaning Missouri SORTS as it was run for 14 years] have utilized harsh, punitive, and confrontational approaches for dealing with sex offending behavior….."** (Emphasis added).

It was almost as if the mentality of SORTS was so dysfunctional that those who were writing the "Farmington SOS" manual could not grasp the implications of what they were writing – that the movement away from the old treatment modes to SOS meant that SORTS had been using the, in the words of Exhibit 24, "harsh, punitive, and confrontational approaches" that resulted in "…clients [not] consistently benefitting from such approaches" for 14 years. And so SORTS proposed to start over as if there would be no consequences for running a program that imprisoned residents using not only a treatment program that might not have been genuinely in place, but one that was admittedly, under the best of circumstances, "harsh" and "punitive" and did not work. In doing so, SORTS engaged in the all too familiar tactic, that once having been found to have violated the civil rights of its citizens, government attempts to escape the consequences by changing its practices in the hope that the courts will rule that the wrongdoing has stopped and the legal wrong mooted. The DMH uses this artifice often, but efforts to do so given what has been unearthed in this case by discovery, should be rejected. Instead, the DMH and the defendants must be held accountable and the mischief enjoined. Recently, Dr. Carich told a group of residents that even with the reforms he was attempting to introduce, the expectation was that SORTS residents would have to held in custody for 6-10 years before having any chance at release. Additionally, in SORTS-Farmington training materials (Exhibit 24 attached hereto) in which SOS was introduced in March of 2013, these uncomplimentary

comments were made about the old sex offender treatment methods – methods, which failed to yield any discharges for 14 years:

> **"Sex offending clients have not consistently benefitted from such approaches,** which often have had difficulty with client compliance and lasting treatment effects. Therefore, Safe Offender Strategies [SOS] is based on the fundamental premise that people with deficits in self-regulatory functioning will sometimes engage in maladaptive behaviors in order to regulate themselves….These persons will continually struggle with effectively and safely managing their sexual urges emotions, beliefs and expectations, and interactions with other people. These are the clients for whom Safe Offender Strategies was developed." (Emphasis added).

Another Farmington based SORTS insider offered these written observations (Exhibit 25 attached) about SOS and its pluses following his visit to Fulton to observe SOS:

> "Our trip to Fulton was quite educational…and were able to see the entire core process of SOS….There was a distinct ambience notable upon entry to the wards….The language of the staff and residents was one of the DBT – origin, speaking of skills used, skills that could be used, and no talk of thinking errors, or other CBT carryovers from other programs….
>
> ***
>
> The staff and residents were interacting as one large treatment team, or treatment community, and we could detect no "us – verses – them" attitudes on either part….The residents report 'staff talks to us, like people, and treat us like human beings.'"
>
> ***
>
> "We have to be careful to not fall back into the CBT/correctional format, as my history for example, was MoSOP-based in Corrections, then repeated here….
>
> Their staffing, of course, makes us drool."
>
> ***
>
> "In summary, the benefits of our program [meaning Farmington SORTS] can realize from what we and the other staff attending have learned can also be divided into two programs"
>
> The whole staff need[s] to get on board regarding respect and humankind's intrinsic nature of being."
>
> ***

> "While everything we learned at Fulton is obviously approved by the Department of Mental Health, we need as a staff to get away from the attitude of 'we can't do it here in Farmington because…' and move on to 'how do we get this done here and in the near future?'"
>
> ***
>
> "[A key] is how the humanity of all is respected."

114. In sum, since 2007, the DMH has been operating a relatively successful sex offender treatment program at Fulton that has resulted in substantial numbers of releases over a five year period or, at least transfers of patients to Less Restricted Alternatives, including cottages and nursing homes – patients, who were more sick with diagnoses recognized officially by psychiatry than the great majority of SORTS residents, who were found to have something called mental abnormalities, a term that has no meaning in psychiatry, but by definition under the law is substantially less serious than mental illness. Yet, not only did those in charge of the SORTS program not implement a successful program, they expressly rejected it for the reason that the clandestine purpose of SORTS, it's end game, was and is to warehouse the residents of SORTS. Somehow, because one program was in Fulton and another in Farmington, the fuzzy logic of the DMH was that this was acceptable.

115. Any efforts at reform are tardy, insincere, and done because of this *"f……lawsuit."*

116. Following Alan Blake's retirement in 2012, the DMH hired Dr. Mark Carich for the position of Director of Treatment Services for SORTS, heralding him in the hiring announcement as a "pioneer in sex offender treatment programs." From South Carolina, where he had retired, Mr. Blake offered this advice via email (Exhibit 26 attached hereto) to Dr. Carich soon after he started at SORTS:

> "Sheila [meaning Sheila Light, a long time administrative assistant at SORTS] knows where the bodies are buried. Take good care of her."

117. Upon being employed, Dr. Carich familiarized himself with SORTS and, not surprisingly, came to some unflattering conclusions about its "treatment program." He noted that a critical goal of SORTS or any SVP treatment program "…is to shift [mental] states from dysfunctional to functional." When a colleague from another state SVP Program sought from Dr. Carich something as fundamental as the SORTS' "goals grid" for residents and treating staff, he had to acknowledge in an email as recently as July of 2013 (Exhibit 27 attached hereto) that he could not provide the grid because in his words:

> "The current goals grid is dysfunctional & is why we are developing something new."

How important are functional goals to Dr. Carich? In his words:

> "The goals are directly or indirectly related to dynamic risk factors associated in varying degrees with risk and recidivism."

Paradoxically, the very thing that Dr. Carich noted was so critical to treatment – the shifting of the resident from a dysfunctional state of mind to a functioning one - was a major fault of the SORTS program itself; a program that can only exist by law if it presents a realistic chance of release and yet its goals were judged to be "dysfunctional" by the recently hired Director of Treatment Services.

118. So appropriately, as the new hire and filled with optimism and faith in his ability to make a difference, Dr. Carich called for changes, not realizing that all the plans, new manuals, new treatment regimes, goals, and modalities, and similar measures that he might author could not turn around 14 years of a dysfunctional institution. Today he is left with a stack of power points and manuals and new beginnings and missions and visions and futile, but good intentions, all of which are inconsistent with the "end game" of warehousing.

119. At another time in presenting his vision for reform, Dr. Carich called upon the SORTS therapists to alter their focus and view of their relationship with the residents, urging them to take "responsibility to create context for change" by the resident and was so bold as to press for the perspective that "The Responsibility for change [lies] equally between the therapist and client." In an email (Exhibit 28 attached hereto, one long time professional staff member called him a:

> "…moron! I have officially given up on this guys [sic] ability to do ANYTHING!!"

Further highlighting the disgraceful state of SORTS and the problem with identifying patient goals, in an August of 2013 email (just seven months ago and after SORTS had been in "business" for almost a decade and a half), Dr. Jay Englehart, M.D., the Medical Director at SMMHC (wherein, as noted above, SORTS is assigned) acknowledged in an email (Exhibit 29 attached hereto) this candid remark:

> **"Unfortunately, we [meaning SORTS] do not have a good, comprehensive risk assessment and needs analysis document on each patient** which summarizes the goals of their treatment **and** [his emphasis] their individual traits which lead to risk. The ITP does some of this, at least on the goals side, but we don't have an ongoing needs assessment which deals with highly individualized risk into which we can fit some of the states people are in when they commit a violation." [Emphasis Added].

Constitutional Violations Arising from SORTS being a Prison, not a Mental Health Facility

120. SORTS, for the reasons previously plead in this Fifth Amended Complaint, is a prison and not a mental health facility because the DMH and the defendants are warehousing the

plaintiffs and the class, either intentionally or through sloth and lack of commitment to treat. Moreover, the treatment is a sham to cover that intent, or, in the alternative, treatment is so defective and devoid of any meaningful effort to meet SVP treatment standards and professional health care standards that there is no meaningful opportunity for the plaintiffs and the class to be ever released. Fundamentally, this is a violation of the Eighth Amendment to the United States Constitution and common or related rights under the Missouri Constitution, as well as Missouri statutory law, in that the defendants and those in concert with them operate the SORTS program so that it is cruel and unusual punishment and/or double jeopardy for the reason that the plaintiffs and the class have already been punished for their convictions in the criminal justice system, served their sentences, and been discharged by the Missouri Department of Corrections, only to be detained by an illegal and constitutionally defective process that then lands them in the custody of the DMH under maximum security indefinitely with no realistic prospect for release and the very real potential that their mental health could be negatively compromised. If ever released, it is so conditional that it is meaningless and amounts to, at best, lifetime parole. Having been "institutionalized" by SORTS, failure and a return to SORTS or prison is likely. This should, taken as a whole, be shocking to the conscience of the Court.

121. The DMH and the defendants have an obligation to provide adequate treatment for SORTS residents regardless of their intent, excuses, or reasons. Those obligations arise as follows:

(a) From the Missouri and United States Constitutions, as well as from Missouri statutory laws, i.e. Sections 632.483-495 RSMo., as well as the Commitment Orders for each resident, to provide adequate and genuine treatment for the mental abnormalities suffered by the residents.

(b) The Fourteenth Amendment Due Process Clause requires states to provide civilly committed persons with access to mental health treatment that is at least minimally adequate and gives them a realistic opportunity for their conditions to improve so that they can be released. Further, because the plaintiffs and others similarly situated are not prisoners, they are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.

(c) Even if the State claims that the SORTS program is "civil" in nature, its civil status merely increases the burden on the State to provide adequate treatment. "Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Youngberg v. Romeo*, 457 U.S. 307, 321-322 (1982).

(d) Defendants, in their official capacities, are collectively responsible for the policies and procedures controlling the manner and method of plaintiffs' confinement and manner and method of their mental health treatment.

122. This Complaint attempts to list the most prominent, but certainly not all, of the constitutional inadequacies of the treatment program at SORTS. Discovery in this case will tell the tale of all the myriad inadequacies in treatment suffered by persons confined to SORTS.

123. A constitutionally adequate treatment program requires individualized treatment, a demonstrated method for improvement and release, exercising judgment within the bounds of accepted professional standards, offer a realistic opportunity to be cured or improve the mental condition for which they are confined, offer less restrictive alternatives to residents to provide a

path toward eventual release, and oversight by independent experts. *See, e.g.*, Douglas G. Smith, *The Constitutionality of Civil Commitment and the Requirement of Adequate Treatment*, 49 B.C. L. Rev. 1383, 1402 (2008).

124. Consequently, in the alternative to the claim that the DMH and the defendants intentionally set out to create a prison disguised as a mental health facility and intended to use treatment as pretext and a sham, plaintiffs and all others similarly situated are being denied meaningful mental health care treatment that gives them a realistic opportunity for their conditions materially to improve because, among other things, defendants have failed:

(a) To properly train staff regarding the treatment of mental abnormalities relating to sex;

(b) To provide a treatment program that includes individualized care and treatment, including individual meetings with psychologists, psychiatrists, clergy, and other experts in mental health;

(c) To provide a coherent and meaningful individualized treatment program for each resident with understandable goals and a road map showing steps necessary for improvement and release;

(d) To make adequate provisions for the participation of detainees' family members in rehabilitation efforts, including permitting family visits with reasonable frequency and ensuring telephone access to residents;

(e) To draft and implement fair and reasonable grievance procedures and behavior management plans;

(f) To afford reasonable opportunities to all residents for educational, religious, vocational, and recreational activities;

(g) To provide adequate funds for treatment programs;

(h) To cease requiring, as a precondition to participation in the meager and inadequate "treatment" offered to residents, and therefore, as a predicate to release, that plaintiffs and all other similarly situated residents to admit to a laundry list of real and imagined crimes for which they were not convicted, and thereby place themselves in jeopardy of future criminal prosecution for other crimes in violation of the plaintiffs' Fifth Amendment right against self-incrimination applied to the states by the Fourteenth Amendment, or impair their ability to convince the supervising courts that they are entitled to be released; and

(i) To institute a procedure to guarantee appropriate therapist/patient confidentiality.

(j) To adopt and faithfully implement the *Sex Offender Treatment Program Standards and Measures* promulgated in August of 2000 by The Special Commitment Center Sex Offender Treatment Program.

125. Defendants' failure to provide constitutionally adequate treatment is a substantial departure from accepted professional judgment, practice or standards and demonstrates that the defendants do not base their treatment decisions on such professional judgment. And the defendants are well aware of that duty. In a 2005 memo to the General Assembly, DMH officials reminded the Missouri legislature of the requirements to legally operate SORTS:

> Memo from the DMH to the Missouri House and Senate Appropriations staff responding to October 25, 2005 Request for Information on MSOTC.
>
> "Thus, in order for such commitments to pass constitutional scrutiny, the Department must provide care and treatment that is consistent with

> existing professional standards and practice, and consistent with case law."

126. Defendants, both in creating and instituting rules within SORTS and the DMH, as well as through the statutory scheme that initially created the SVP civil commitment program and as subsequently amended by the General Assembly and signed into law, so that regardless of what a SORTS Resident does, he will only be conditionally released and never discharged, erect one arbitrary barrier after another to prevent plaintiffs from progressing to the point where the program will recommend their release, including, in some instances, pressuring participants in the program to confess to crimes which they did not commit as evidence of their treatment progress.

127. This Court has wide latitude in entering and enforcing equitable relief concerning the conditions at SORTS. Plaintiffs and the class seek immediate release from SORTS and the custody of the DMH. Plaintiffs also seek the dismantling and end to the SORTS Program and an injunction and declaration that the DMH and the defendants and those in concert with them have acted unconstitutionally, most importantly, in violation, as described heretofore in subjecting them to cruel and unusual punishment and double jeopardy, as well as outright defiance and disobedience of the mandate of Missouri statutes.

128. In the alternative, and if the Court determines not to outright release the plaintiffs and the class and give them their freedom, the plaintiffs seek the remedies and relief the same as or similar to those described in the leading case on this subject *Turay v. Weston*, No. C91-64WD (W.D. Wash. June 6, 1994). In that case Federal District Judge William L. Dwyer, of the United States District Court for the Western District of Washington entered an injunction (the "*Turay* Injunction").

(a) In the *Turay* Injunction, Judge Dwyer required the State of Washington to provide adequate treatment for inmates at Washington's Special Commitment Center ("SCC"), including the following:

(i) Adopting and implementing a plan for hiring and training competent therapists;

(ii) Implementing strategies to rectify the lack of trust between the residents and SCC staff;

(iii) Implementing a treatment program that involved residents' spouses and family members and contained other generally accepted therapy components;

(iv) Developing individual treatment plans for each resident to measure progress; and

(v) Providing an expert in sex offender treatment to supervise and consult with SCC staff.

(b) Because Washington officials were slow in complying with the *Turay* Injunction, the district court subsequently appointed a special master, to oversee the SCC and provide the court with periodic reports regarding the SCC's compliance. Four years after entering the initial injunction, Judge Dwyer conducted an evidentiary hearing and issued an order demanding that the SCC:

> (a) Carry out additional staff training at the SCC, with new residential care staff to finish the orientation training before beginning work on the unit, residential care and clinical staff to complete mental health training within four months of commencing their employment, and advanced training on the treatment of sexual deviance to be provided.

(b) Provide a coherent and individualized treatment program for each resident complete with understandable progress goals and a road map showing the way to improvement and release, such plan to include the components recognized as necessary for maximum treatment potential.

(c) Make adequate provision for participation by residents' families in rehabilitation efforts, including setting aside a room for visits by family members, permitting family visits with reasonable frequency and allowing prompt telephone access to residents in cases of family emergency, consistent with security.

(d) Pending the construction of a separate treatment-oriented facility, to reduce the negative effects of the current connection with MICC by taking the following steps:

(1) Eliminate the routine strip searches of SCC residents following every visit;

(2) Eliminate the monitoring of residents' telephone calls and the bar on outgoing calls (other than collect);

(3) Negotiate with MICC management to obtain better meal and activity schedules, and to eliminate harassment of residents by prisoners;

(4) Acquire more adequate space within the MICC complex, e.g., by taking over all of a unit when new space is needed, with yard space adjacent thereto.

(e) To improve the treatment environment in the following respects:

(1) Use new living space to provide some separation between residents in treatment and those who have harassed treatment recipients;

(2) Draft and implement fair and reasonable grievance procedures and behavior management plans; and

(3) Afford reasonable opportunities to all residents for educational, religious, vocational/work, and recreational activities.

(f) To initiate and implement program oversight both by an internal review process and by an external body, either through a licensing organization or another entity.

> (g) In the foregoing respects, and in others previously ordered, to take all reasonable steps to bring a constitutionally adequate program into reality rather than merely describing it on paper.

129. In making these findings and ordering the institution of these remedies, Judge Dwyer recognized a heightened duty on the State, when persons who have served their time for their criminal conduct are then subject to "civil commitment" because of "mental abnormalities." Moreover, indefinite sentences are particularly dangerous when grounded upon potentially ill-defined psychiatric findings.

Annual Reports to the Courts – Misleading and Untruthful

130. As previously described above in this Fifth Amended Complaint, the Missouri Sexually Violent Predators Act and more specifically § 632.498 RSMo. requires that Director Schafer or his designee to provide a "yearly report" to "the court that committed" the SORTS' resident of his "mental condition." Since April of 2011, Defendant Erica L. Kempker, Psy.D, licensed by the state of Missouri as a Psychologist has had the primary duty of completing these yearly reports. Upon receipt of the report, the court is then required by law to "…conduct an annual review of the status of the committed person." The report must, of course, be honest and exact and have full disclosure because, as Dr. Carich commented:

> "The key point is completing an assessment of the patient's progress or lack of progress and sending the report to the court."

131. If the report, in assessing "the progress or lack of progress," is not honest and accurate then whether the patient is progressing or not is a faulty, unreliable judgment or is based upon factors that are not within the control of the patient (more correctly the plaintiffs and the class members) or (even more cruel and injurious) that the DMH is impeding the progress of the patient. So, each report, since the beginning of SORTS, has not been truthful and accurate because the courts assume in reviewing the annual reports that the committed person is receiving

treatment. Whereas the truth is that SORTS is a prison disguised as a mental health facility and the DMH fails to tell the courts any or all of the following undisputed facts that buttress that conclusion:

> That Director Schafer has stated that "No one has ever graduated from [SORTS] and somewhere down the line, we have to do that or our treatment processes become a sham."
>
> That Director Schafer has stated that "The 'end game' related to MOSOTC is to[a]void building new facilities for Sexual Predators as long as possible. New tougher sentencing laws will ultimately reduce the number of referrals to DMH, but this impact will not be felt until at least 10 years from now."
>
> That, from time to time, Alan Blake, the former COO of SORTS, has offered these opinions and facts about SORTS:
>
> "Unfortunately DMH is not will to applying [sic] the values it espouses or things would be different."
>
> "The state keeps trying to get by on the cheap."
>
> "We are [a] disaster waiting to happen."
>
> "I fear [we] are going to have some major care failure that will contribute to my early retirement."
>
> "We are also now vulnerable to claims that we offer inferior treatment in that we are not staffed at a similar rate to other areas of the facility and thereby are providing inadequate treatment."
>
> "I have a worried sense that the budget is being driven by Steve and the money people, not by policy and need."
>
> "I continue to be concerned that this ongoing minimal funding keeps us on the edge of adequate and inadequate, and in a federal court's view, even our adequate may be inadequate enough for an adverse ruling."
>
> "As it is I am starting to have problems keeping management staff from getting discouraged and giving up. They are worn out, frustrated distressed and wearing out."
>
> "We are the DMH redheaded stepchild and they don't care if we fail."
>
> "We have been getting farther and farther behind. That is why I initiated the behavioral health structure in order to reduce the impact

> of the inadequate funding of this facility for YEARS, and find a way to operate for less."
>
> "If we are to seek accreditation with current staffing levels and patterns, we will need to significantly reduce treatment to assure that assessments documentation and treatment plans are in place."
>
> "All this opens us to a federal lawsuit for providing substandard care. A successful lawsuit in this area will cost the state millions."
>
> "However, this again places the Department at risk of legal action regarding substandard care."
>
> "The facility will take on the effect of a prison and be in violation of Supreme Court rulings. The residents will likely initiate legal action for which the department and state will have difficulty mounting a defense."
>
> "We are so far from JCAHO [accreditation] that I cannot conceive of it. For lawsuits, we have had over 50 filed – mostly [but not all] frivolous."
>
> "We have been trying to find how to make a $600,000 core reduction and the ramifications."
>
> "[If that happens] most nursing and medical staff will leave, and most professional staff will follow. At that point we become a prison."

Or Jon Rosenboom's observation:

> "Finally, I am often struck by the unsettling conclusion that direct patient care is one of the last priorities when stacked against all of the other expectations."

Or Dr. Joseph Park's insights:

> "Psychiatric inpatient facilities are backing up, admitting far more commitments than discharges. This, in turn, clogs acute care facilities, which must hold patients longer who are awaiting admission into state long-term psychiatric care. This system "constipation" forces state facilities to operate beyond 100% of capacity for long periods of tie, exhausting staff, causing staff overtime and high turnover rates, and inevitably increasing the risk of staff injuries and patient abuse and neglect."

Or Dr. Jay Englehart, the Medical Director of the SMMHC (which includes SORTS) warning about a CO directed effort to try to overcome the shortage of physicians and save money by the hiring of Psychiatric APN's noting that this is…

> "…the model which the prisons are moving toward, but I really do not want have [sic] a standard of care or staffing which is equal to that of the prisons. I hope we are better than that.

Or the candid admission as far back as 2002 by Ann Dirks-Linhorst that:

> "I know that yesterday you indicated that you all had inherited a 'bad' program."

Or the unknown SORTS employee, who acknowledged that SORTS had no release/integration program in place, nor did it account for the need to have LRA's.

132. Consequently, the state courts have been for over 14 years and are currently deprived of all the facts in these annual reports and lead to believe by the DMH that SORTS is meeting its statutory and constitutional mandate. In turn, the "annual review" of the courts to objectively determine if the committed person should continue to remain in DMH custody and not be released, either conditionally or otherwise, is compromised and results in a decision based upon insufficient or misleading facts in contravention of § 632.498 RSMo. In turn, the committed person does not receive due process that includes a full and fair review by a court that is not presented with an accurate annual report. Thus the annual review process is corrupt and the courts, unknowingly, are making decisions about continuing commitments without all the facts and with the wrong facts.

Constitutional Violation of the "Care and Treatment" Reimbursement Program

133. Under the statutory regime imposed upon plaintiffs, SORTS residents are paying for adequate treatment, which is a fundamental prerequisite to any civil commitment program. Without adequate treatment providing a path to their potential release, the civil commitment becomes state-imposed punishment lacking individual procedural protections guaranteed by the Constitution and state statutory law.

134. Even if this Court concludes that the State has the legal and constitutional ability to charge SORTS residents, their families, and their estates, for the supposed "care and treatment," there has been a failure of consideration and any charge must be rescinded. Reimbursement for "care and treatment" is not owed by the plaintiffs and the class or their families when the truth is that SORTS is a prison and not a mental health facility because the DMH and the defendants are warehousing the plaintiffs and the class, either intentionally or through sloth and with no intent to genuinely treat. Moreover, the treatment is a sham to cover that intent, or, in the alternative, treatment is so defective and devoid of any meaningful effort to meet SVP treatment standards and professional health care standards that there is no meaningful opportunity for the plaintiffs and the class to be released ever. The right to reimbursement by the DMH, whether it is constitutionally or statutorily grounded, is lost under those circumstances. No collections or reimbursement should be allowed in the future, any accrual of debt should be cancelled, and all monies collected should be repaid with interest.

135. The statutory framework, and the defendants' policies, practices, and conduct, violate several provisions of the United States and Missouri Constitutions, both facially and as applied, as well as Missouri statute.

136. Cruel and Unusual Punishment

(a) By confining an individual against his will, the Government assumes the responsibility to provide for that person's welfare. As the Supreme Court has explained:

> [W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care

> for himself, and at the same time fails to provide for his basic human needs-e.g., food, clothing, shelter, medical care, and reasonable safety-it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause. The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act on his own behalf. (*DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189, 199-200 (1989) (internal citations omitted)).

(b) Similar to the Supreme Court's mandate, the courts ordering civil commitment ordered the Department of Mental Health, not the individual patient, to provide for the patient's care and treatment.

(c) The Eighth Amendment prohibits the infliction of "cruel and unusual punishments" and double jeopardy. U.S. Const. amend. VIII.

(d) The Court should also exercise its own independent judgment about the acceptability of the practice to hold that it is unconstitutional. *See, e.g.*, *Roper v. Simmons*, 543 U.S. 551, 562-63 (2005).

(e) The actions of defendants have been wanton, evinced a deliberate indifference to the rights of plaintiffs, and the defendants knew of and disregarded the threats to defendants' rights.

(f) The actions of defendants violate basic standards of decency and are cruel.

(g) The actions of defendants are also unusual.

(h) As an unfortunate consequence of the supposed "care and treatment," the SORTS program actually worsens the mental abnormality and psychological conditions suffered by residents, further compounding the cruel nature of the punishment.

(i) The failure to provide care and treatment, and defendants' placing unreasonable conditions on the provision of care and treatment, violate the Eighth Amendment and the Due Process Clause.

137. Equal Protection

(a) The United States Constitution prohibits any state from denying "to any person within its jurisdiction the equal protection of the laws." U.S. Const., amend XIV.

(b) The Missouri Constitution provides that "all persons have a natural right to life, liberty, the pursuit of happiness, and the enjoyment of the gains of their own industry" and "that all persons are created equal and are entitled to equal rights and opportunity under the law." Mo. Const., art. I, § 2.

(c) The policies, practices, and conduct of defendants treat plaintiffs differently than they treat other civilly committed patients of the Department of Mental Health.

(d) Among other things, defendants do not charge the same or similar fee to patients who were civilly committed due to mental abnormalities not related to sex. There is no rational basis for charging civilly committed patients with mental abnormalities relating to sex but not charging civilly committed patients with mental abnormalities not relating to sexual conduct. The fees, rather, are imposed against plaintiffs and other civilly committed patients with mental abnormalities relating to sex out of a desire to exact punishment for the sexual nature of the mental abnormality with which plaintiffs have been thought to suffer.

(e) Moreover, defendants do not charge the same or similar fee to inmates of jails who have been convicted of crimes, even criminals convicted of crimes relating to sex. There is no rational basis for charging civilly committed patients with mental abnormalities relating to sex more than the State of Missouri charges criminal convicts. The fees, rather, are imposed against plaintiffs and other civilly committed patients with mental abnormalities relating to sex out of a desire to exact punishment for the sexual nature of the mental abnormality with which plaintiffs have been thought to suffer.

(f) In addition, the fees are imposed without regard to what services, care, or treatment, is provided to an individual patient. There is no rational basis for charging a patient more than the actual cost of the care and treatment provided to that individual patient. In addition, the alleged "care and treatment" claimed by defendants to be provided to plaintiffs is inadequate or nonexistent and there is no genuine effort by the defendants to expend medical resources to "cure" the plaintiffs. Instead, the civil commitment is simply another punitive measure imposed on the plaintiffs after they have completed their respective sentences for the crimes for which they were charged and convicted. In addition, to the extent plaintiffs are provided medical treatment to bring about a cure, such treatment is insubstantial and inferior to the treatment provided to others under the care of the Missouri Department of Mental Health, who are civilly committed for mental abnormalities unrelated to sex. In fact, defendants have

conditioned the receipt and quality of care and treatment on the plaintiffs' willingness to comply with the deprivation of their constitutional rights. Moreover, defendants have even used the supposed "care and treatment" programs to intimidate and suppress the exercise of plaintiffs' constitutional rights and the filing of this and other lawsuits challenging the constitutionality of their treatment.

(g) As such, the policies, practices, and conduct of defendants deprive plaintiffs of the equal protection of the law, in violation of the United States and Missouri Constitutions.

138. Procedural Due Process

(a) The United States Constitution provides that individuals are entitled to "due process of law." U.S. Const., amend. XIV.

(b) The Missouri Constitution provides that "No person shall be deprived of life, liberty or property without due process of law." Mo. Const., art. I, § 10.

(c) The fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner.

(d) Plaintiffs have a protected property interest in their money and in the money of their family and those property interests have been taken from the defendants without due process of law.

(e) Plaintiffs have not been provided a reasonable opportunity to be heard in a meaningful manner concerning the fees imposed for care and treatment.

(f) In fact, defendants and their agents have refused to answer even the simplest and most straight-forward of questions posed by the plaintiffs concerning this program and its failure to comply with the United States and Missouri Constitutions and its failure even to comply with the statutory framework.

(g) Defendants and their agents have refused to allow plaintiffs to contact attorneys before signing forms, have refused to allow plaintiffs to read the forms and documentation fully and comprehensively, and have sought to deprive them of any meaningful way of challenging the fees imposed on them.

(h) Moreover, the civil commitment is simply another punitive measure imposed on the plaintiffs after they have completed their respective sentences for the crimes for which they were charged and convicted. In addition, to the extent plaintiffs are provided medical treatment to bring about a cure, such treatment is insubstantial and inferior to the treatment provided to others under the care of the Missouri Department of Mental Health, who are civilly committed for mental abnormalities unrelated to sex. In fact, defendants have conditioned the receipt and quality of care and treatment on the plaintiffs' willingness to comply with the deprivation of their constitutional rights. Moreover, defendants have even used the supposed "care and treatment" programs to intimidate and suppress the exercise of plaintiffs' constitutional rights and the filing of this and other lawsuits challenging the constitutionality of their treatment.

(i) As such, the policies, practices, and conduct of defendants deprive plaintiffs of due process of the law, in violation of the United States and Missouri Constitutions.

139. Substantive Due Process

(a) The due process clauses prevent a civilly committed patient from being punished prior to any adjudication of criminal guilt.

(b) The policies, practices, and conduct of defendants are not calculated to effectuate the detention or the purposes of detention as described in the court orders committing the plaintiffs to civil detention.

(c) The due process clauses further prevent a civilly committed patient from being punished by the Department of Mental Health in contravention of the court order mandating that he be civilly committed.

(d) As explained above, the court orders uniformly require the Department of Mental Health to provide the care and treatment of plaintiffs. The orders make no mention of any obligation or requirement that plaintiffs pay for their own care and treatment. Moreover, the civil commitment is simply another punitive measure imposed on the plaintiffs after they have completed their respective sentences for the crimes for which they were charged and convicted. In addition, to the extent plaintiffs are provided medical treatment to bring about a cure, such treatment is insubstantial and inferior to the treatment provided to others under the care of the Missouri Department of Mental Health, who are civilly committed for mental abnormalities unrelated to sex. In fact, defendants have conditioned the

receipt and quality of care and treatment on the plaintiffs' willingness to comply with the deprivation of their constitutional rights. Moreover, defendants have even used the supposed "care and treatment" programs to intimidate and suppress the exercise of plaintiffs' constitutional rights and the filing of this and other lawsuits challenging the constitutionality of their treatment.

(e) Defendants' actions violate the court orders imposing the requirement of civil commitment and violate the plaintiffs' fundamental rights to due process of law.

(f) As such, the policies, practices, and conduct of defendants deprive plaintiffs of due process of the law, in violation of the United States and Missouri Constitutions.

140. Protection against Unreasonable Seizure of Property

(a) The United States Constitution provides that "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated . . . ." U.S. Const. amend. IV. The Fourth Amendment applies to the states through the Due Process Clause of the Fourteenth Amendment.

(b) The Missouri Constitution provides "[t]hat the people shall be secure in their persons, papers, homes and effects, from unreasonable searches and seizures . . . ." Mo. Const., art. I, § 15.

(c) Defendants have unlawfully seized plaintiffs' property by meaningfully interfering with plaintiffs' possessory interests in their property.

(d) The policies, practices, and conduct of defendants amount to an unreasonable and unconstitutional seizure of money, in violation of the United States and Missouri Constitutions.

141. Ex Post Facto Clause

(a) The United States Constitution prevents any state from passing an ex post facto law. U.S Const., art. I, § 10.

(b) The Missouri Constitution provides that "no ex post facto law . . . can be enacted." Mo. Const., art. I, § 13.

(c) At the time plaintiffs were civilly committed, perhaps the Court could have imposed conditions on their confinement, including the payment of fines, and the payment of costs and expenses of their care and treatment.

(d) The courts ordered the Department of Mental Health to provide for the plaintiffs' care and treatment.

(e) The care and treatment fees were only later imposed by the defendants, in a manner that increases the burdens of the civil commitment substantially.

(f) These care and treatment fees were imposed upon plaintiffs and their families after they had fully served their criminal sentences.

(g) Section 630.205, by requiring payment of excessive fines and exorbitant costs and expenses for their care and treatment, was enacted and applied to civilly committed patients for punitive purposes.

(h) Section 630.205 is an ex post facto law because it adds a new punishment for plaintiffs' crimes in addition to the punishment already imposed upon

plaintiffs in the criminal proceeding in violation of the United States and Missouri Constitutions.

(i) The imposition of the fees and fines on plaintiffs after their courts determined not to impose such fees and fines amounts to a retroactive imposition of law, in violation of the United States and Missouri Constitutions.

Count I – Deprivation of Rights Guaranteed by the United States and Missouri Constitution and Prayer for Injunctive and Declaratory Relief

142. Plaintiffs incorporate by reference all allegations contained in Paragraphs 1 through 141.

143. Federal law provides that every person who, under color of state law, custom, or practice, subjects any other person to deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable at law, in equity, and in any other proceeding necessary to obtain redress for such deprivation. *See 42 U.S.C. § 1983*.

144. All defendants were acting pursuant to state law and were acting under color of state law at all pertinent times.

145. The federal and state constitutional deprivations outlined herein were caused by the exercise of rights and privileges created by the State, by a rule of conduct imposed by the State, or by a person for whom the State is responsible, and all defendants may fairly be said to be state actors.

146. As established above, the policies, practices, and conduct of defendants amount to a deprivation of a right guaranteed by the Constitutions and laws of the United States and Missouri.

147. The defendants' conduct threatens a protected interest of the plaintiffs and class members in that the conduct complained of herein resulted in an unlawful loss of their liberty rights, most notably to be free of cruel and unusual punishment and double jeopardy. The Missouri SORTS Program simply does not meet the constitutional standards required by *Kansas v. Hendricks*, a 5-4 decision and fragile precedent that requires the state to meet extraordinary standards in order to pass constitutional muster.

148. Each and every defendant had actual knowledge of the policies, practices, and conduct at issue, as well as what the law requires of them as state actors in their operation and management of the SORTS Program.

149. The conduct of the defendants is truly irrational, arbitrary, capricious, pursued in bad faith, and done with the intent to punish plaintiffs and the class members and to punish them twice.

150. Plaintiffs seek preliminary and permanent injunctive relief to protect their rights and to prevent any further deprivation of rights by defendants.

151. Plaintiffs have standing to obtain an injunction because, among other things, plaintiffs' constitutional rights are being and will be deprived by the continuation of the challenged conduct of defendants.

152. As established above, the policies, practices, and conduct of defendants have deprived and will deprive plaintiffs and the class members of their constitutional rights, both under the United States and Missouri Constitutions.

153. Defendants know that their policies, practices, and conduct deprive plaintiffs and the class of their constitutional rights in violation of the United States and Missouri Constitutions, yet they persist and refuse to abate said conduct.

154. The challenged action is presently occurring and certain to occur in the immediate future.

155. Plaintiffs will continue to suffer irreparable harm absent injunctive relief.

156. Defendants will suffer no harm if an injunction issues.

157. The balance of harms weighs in favor of entry of an injunction.

158. It is in the public interest to enter an injunction that prevents defendants from continuing to deprive plaintiffs and the class of their rights as secured by the United States and Missouri Constitutions.

159. No previous injunctive relief has been awarded with respect to this matter.

160. Defendants' ongoing actions in violation of the United States and Missouri Constitutions present an actual and existing controversy regarding the claim by the plaintiffs and the class that the DMH and the defendants intentionally set out to create a prison disguised as a mental health facility and intended to use treatment as a pretext and a sham to indefinitely incarcerate the plaintiffs and the class in a maximum security, penal environment with no reasonable opportunity to ever be unconditionally released. As a consequence, plaintiffs and all others similarly situated are being punished in a cruel and unusual way, subject to double jeopardy for the same criminal conviction, and denied meaningful mental health care treatment that gives them a realistic opportunity for their conditions materially to improve and to then be released.

161. This controversy is of sufficient immediacy and reality to warrant the issuance of a declaratory judgment, and is complementary to the injunctive relief requested below.

162. This Court's intervention is necessary to declare the rights and other legal relations of the interested parties.

163. Plaintiffs have standing to obtain a declaration of their rights because plaintiffs and defendants are in a dispute regarding their rights.

164. Plaintiffs have no adequate remedy at law.

WHEREFORE, plaintiffs, on behalf of themselves and the class respectfully request this Court to enter its decree and judgment on Count I of their Fifth Amended Complaint, including findings of fact and conclusions of law against the defendants and those acting in concert, which result in the following remedies and relief by way of a preliminary and permanent injunction and declaratory relief:

(a) Dismantle and close down SORTS and the Farmington and Fulton facilities and order the immediate discharge of all SORTS residents and detainees, so that they are unconditionally free and in conjunction therewith enter a mandatory injunction against the defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction immediately and unconditionally releasing the plaintiffs and the certified class of SORTS residents from being held in custody of the DMH at the SORTS facilities with no further obligation or duties to SORTS, the DMH, and the statutory scheme that was used to imprison the plaintiffs and the other class members, both residents and detainees;

(b) Declare the statutory scheme that set up the SVP Civil Commitment unconstitutional, to wit §§ 632.480 through 632.513 RSMo., sometimes called the "Missouri Sexually Violent Predators Act" or "MSVPA.",

facially and as applied to plaintiffs and the class on the grounds that it is a pretext for warehousing and a prison disguised as a mental health facility that can thus no longer be operated and can no longer imprison present and future residents and detainees in the custody of the DMH and is thus unenforceable, void, and of no effect;

(c) Preliminarily during the pendency of this Case and thereafter permanently enjoin the SVP Civil Commitment Program, including the detaining and evaluation of those about to be released from the custody of the Department of Corrections, having once completed their prison sentences, as well as the conduct by the DMH of subsequent judicial proceedings, quasi-judicial proceedings, and governmental sponsored meetings of DMH employees, independent contractors retained as psychiatric experts and prosecuting attorneys acting as evaluators, to determine the eligibility of detainees to be subject to the filing of a civil commitment petition and subsequent prosecution in a civil commitment trial, wherein the State of Missouri seeks to commit detainees to the custody of the DMH and SORTS or any other similar program;

(d) Declare that §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo, violate the United States Constitution and are thus unenforceable, void, and of no effect;

(e) Declare that §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo, violate the Missouri Constitution and are thus unenforceable, void, and of no effect;

(f) Declare that the policies, practices, and conduct of defendants deprived plaintiffs and the class of their rights and liberties under the United States and Missouri Constitutions;

(g) In the alternative, declare unconstitutional the adequacy of the "care and treatment" provided to plaintiffs by defendants at SORTS and the conditions of their confinement;

(h) Declare that the "care and treatment" and "room and board" are inadequate, penal in nature, and not reasonably related to the rehabilitation of plaintiffs and to the treatment of their mental abnormalities and that the inadequacy of the "care and treatment" provided to plaintiffs renders unconstitutional the conditions of their confinement and must be remedied and reformed by the DMH to comply with constitutional standards;

(i) Enjoining defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction by personal service or otherwise from engaging in the conduct alleged in this Complaint and from enforcing and applying to plaintiffs and others similarly situated the provisions of §§ 473.398, 473.399, 630.205, 630.215, 630.305, and 632.483-495 RSMo;

(j) Pursuant to the authority granted by F.R.P.C. 54 appoint a neutral, qualified, and objective special master and medical monitor with superior expertise and experience in the law, civil rights matters and the care and treatment of SVP's to oversee defendants' compliance with the aforesaid

injunctive relief, with the constitutional requirements described in this Complaint, and to report the status and implementation to the Court, with the appropriate powers and duties to bring about full, complete, and with urgency implementation of the injunctive relief;

(k) In the alternative, with oversight, authority, and powers by the aforesaid special master and medical monitor to the fullest extent permitted by F.R.C.P. 54, answerable only to the Court, enter a mandatory injunction requiring defendants, their officers, agents, servants, and employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of the injunction by personal service or otherwise to fully, completely, and with urgency undertake and implement the following requirements, obligations, duties, and mandate:

- Operate SORTS as a mental health facility and not as a prison;
- Operate SORTs with the intent to treat and release and not to imprison and warehouse;
- Establish a “cap” on the time that a resident can be held in the custody of the DMH pursuant to the SORTS laws to not exceed three years, or whatever term the Court deems reasonable and appropriate;
- Faithfully, equally, and fairly implement the same conditions for treatment and standards, procedures, and policies for release as those DMH patients held in custody pursuant to
- programs that were established by nonSORTS statutes:

- Cease informal “alerts” and “heads up” to members of the General Assembly about planned releases of residents and eliminate inappropriate communications with the General Assembly, inconsistent with treatment and care and ending unwarranted, politically motivated intrusion;
- Practice what SORTS preaches and create and maintain a state of the art program and create a culture where people want to be;
- Expend the same resources for SORTS as for other DMH facilities and programs and cease treating SORTS as a “red headed step child;”
- Adopt and implement a plan for hiring and training competent, ethical psychological and psychiatric counselors and therapists;
- Employ an adequate number and quality of medical doctors, psychologists, psychiatrists, behavioral therapists, clergy, and other professional staff and provide SORTS residents meaningful access to such staff;
- Terminate all unlicensed or untrained staff, and staff determined by the special master or medical monitor to be incompetent or unable or incapable of providing ethical, up to date, adequate, truly therapeutic, and humane care and treatment to the residents;

- Implement a treatment program that involves individual counseling sessions and contains other generally accepted therapy components;
- Develop individual treatment plans for each resident to measure progress based on psychological and psychiatric, medically-relevant criteria rather than on day-to-day disciplinary issues, and which provides understandable progress goals and a road map showing the way to improvement and release, such plan to include the components recognized as necessary for maximum treatment potential;
- Hire or contract with a qualified and competent expert in sex offender treatment to supervise and consult with SORTS staff;
- Satisfy professional standards relating to credentialing, staff training and supervision, including employing program staff who are adequately trained to provide residential care and treatment components, clinical direction and supervision consistently provided by qualified professionals, staff who understand the treatment model, structure, ethical obligations, and their roles, and treatment planning and clinical decisions consistent across and among patients and residents of SORTS;
- Establish treatment programs that are individualized, comprehensive, and based on “Best Practices”;

- Establish safeguards including systematic measures of progress and ongoing monitoring of services to ensure quality and consistency;
- Establish a treatment facility housed in a mold-free environment;
- Establish and provide a treatment-oriented facility under the Least Restrictive Alternative with adequate space for living, treatment, other activities, and for separation among resident groups;
- Treat residents with respect and offer meaningful and genuine opportunities to have resident grievances addressed;
- Address long-term health and other behavioral and emotional needs of the residents;
- Establish a mental health program that is medically-based and consistent with psychological and psychiatric standards of care, including the "Sex Offender Treatment Program Standards and Measures" as adopted by *The Special Commitment Center Sex Offender Treatment Program Standards and Measures*;
- Protect residents' privacy and medical information rights;
- Establish testing programs to objectively and fairly measure the progress of residents, including but not limited to the Violence Risk Appraisal Guide, the Sex Offender Risk Appraisal Guide, the Sexual Violence Risk-20, the Rapid Risk Assessment for

Sex Offence Recidivism, STATIC-99, STATIC 2002, the Minnesota Sex Offender Screening Tool - Revised, the Sex Offender Needs Assessment Rating, and the Hare Psychopathy Checklist - Revised;

- Ensure that the SORTS program has external oversight through an authoritative licensing and accreditation organization widely-respected in the field of sexual disorder treatment;
- Establish a system of external peer review to ensure the quality and effectiveness of the SORTS treatment program;
- Implement strategies to rectify the lack of trust between the residents and SORTS staff;
- Implement a treatment program that involves residents' spouses and family members and contains other generally accepted therapy components;
- Make adequate provision for participation by residents' families in rehabilitation efforts, including setting aside a room for visits by family members, permitting family visits with reasonable frequency and allowing prompt telephone access to residents in cases of family emergency, consistent with security;
- Eliminate the treatment of SORTS residents as if they were criminal prisoners in the custody of the Department of Corrections, such as banning strip searches unless absolutely

necessary for safety, eliminating monitoring of residents' telephone calls and meetings with non-residents, eliminating harassment of residents by SORTS staff, allowing at least the amount of outdoor recreation time as permitted in prison if not more, ending the policy of monitoring each resident every 15 minutes especially where such policy requires an invasion of privacy in the shower or toilet stall, and allowing complete access to telephone services;

- Afford reasonable opportunities to all residents for educational, religious, vocational/work, and recreational activities, including the right to contribute money to religious institutions;
- Develop and implement a plan to integrate residents into society, including realistic, not overly restrictive, conditional release programs, and take all reasonable steps to implement that plan in a timely manner;
- Faithfully require the adherence by all SORTS health care providers to the NAHO *Code of Ethics and Standards of Practice for Healthcare Quality Professionals* and discipline those who violate the Code;
- Eliminate overcrowding;
- Provide more timely, consistent treatment, less downtime, and eliminate repeated therapy session cancellations;

- Accurately and fully disclose to the Missouri circuit courts the status of the progress of residents committed to SORTS and honestly provide to those courts the residents' true status with respect to their mental abnormalities and risk of reoffending;
- Develop and implement a plan and take all reasonable steps to bring a constitutionally adequate program into reality rather than merely describing it on paper;
- Develop and implement a plan to insure full and complete compliance with the aforesaid reforms and remedies, including the right level of funding;
- Stop the deliberate, casual, "slow walk" of treatment and instead accelerate the pace of treatment; and
- Periodically, as required by the Court and with recommendations and reports by the special master and the medical monitor on the compliance by the DMH and the defendants of the above injunctive requirements to report the status and implementation to the Court, with the appropriate powers and duties to bring about full and complete implementation of the injunctive relief in a speedy matter, or failing that to recommend to the Court the dismantling and closing of SORTS and the Farmington and Fulton facilities and ordering the immediate discharge of all SORTS residents and detainees, so that they are unconditionally free and in

conjunction therewith enter a mandatory injunction against the defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction immediately and unconditionally releasing the plaintiffs and the certified class of SORTS residents from being held in custody of the DMH at the SORTS facilities with no further obligation or duties to SORTS, the DMH, and the statutory scheme that was used to imprison the plaintiffs and the other class members, both residents and detainees;

(l) Awarding plaintiffs and their counsel all attorney's fees, expenses, and costs herein; and

(m) Award such other and further relief the Court deems appropriate.

Count II – Deprivation of United States and Missouri Constitutional Rights and Prayer for Injunctive and Declaratory Relief

165. Plaintiffs incorporate by reference all allegations contained in Paragraphs 1 through 141.

166. All defendants were acting pursuant to state law and were acting under color of state law at all pertinent times.

167. The deprivations outlined herein were caused by the exercise of rights and privileges created by the State, by a rule of conduct imposed by the State, or by a person for whom the State is responsible, and all defendants may fairly be said to be state actors.

168. As established above, the policies, practices, and conduct of defendants amount to a deprivation of rights guaranteed by the Federal and Missouri Constitutions and laws of the State of Missouri.

169. The defendants' conduct threatens a protected property interest of defendants in that the conduct seizes plaintiffs' pensions, disability benefits, personal funds and other assets, as well as the funds and assets of their relatives.

170. Each and every defendant had actual knowledge of the policies, practices, and conduct at issue.

171. The conduct of defendants is truly irrational, arbitrary, capricious, pursued in bad faith, and done with the intent to punish plaintiffs.

172. Defendants' ongoing actions in violation of the Federal and Missouri Constitutions present an actual and existing controversy regarding the reimbursement and payment of expenses from plaintiffs to defendants purportedly to pay the costs of "care and treatment."

173. The controversy is of sufficient immediacy and reality to warrant the issuance of a declaratory judgment, and is complementary to the injunctive relief requested below.

174. This Court's intervention is necessary to declare the rights and other legal relations of the interested parties.

175. Plaintiffs have standing to obtain a declaration of their rights because plaintiffs and defendants are in a dispute regarding their rights.

176. Plaintiffs have no adequate remedy at law.

WHEREFORE, plaintiffs respectfully request this Court to enter its decree and judgment in favor of said plaintiffs and the class on Count II of said plaintiffs' Fifth Amended Complaint, findings of fact and conclusions of law against the defendants and those acting in concert, which result in the following remedies and relief by way of a permanent injunction and declaratory relief:

(a) Declare unconstitutional, facially and as applied to plaintiffs and the class, the statutory scheme and conduct described herein relating to the reimbursement, payment and collection of "care and treatment" costs;

(b) Order the return of all property seized by defendants from plaintiffs, their estates, or their families relating to that program and declare that no collections should be allowed in the future, any accrual of debt should be cancelled, and all monies collected should be repaid with interest.;

(c) Declare unconstitutional, facially and as applied to plaintiffs and the class, the adequacy of the "care and treatment" provided to plaintiffs by defendants at SORTS and the conditions of their confinement and thus unenforceable, void, and of no effect;

(d) Declare the statutory scheme that set up the SVP Civil Commitment unconstitutional, facially and as applied to plaintiffs and the class, a pretext for warehousing and a prison disguised as a mental health facility that can no longer be operated;

(e) Declare that §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo, violate the United States Constitution and are thus unenforceable, void, and of no effect;

(f) Declare that §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo, violate the Missouri Constitution and are thus unenforceable, void, and of no effect;

(g) Declare that the policies, practices, and conduct of defendants deprived and will in the future deprive plaintiffs and the class of their rights and liberties under the United States and Missouri Constitutions;

(h) Declare that any and all forms or agreements signed pursuant to the program, policies, practices, and conduct of defendants, are not contracts, and do not bind plaintiffs, their families, or their estates, and may not be used by defendants to obtain money, other assets, and pensions and other benefits and disability awards from plaintiffs, their families, or their estates;

(i) Declare that the "care and treatment" and "room and board" are inadequate, penal in nature, and not reasonably related to the rehabilitation of plaintiffs and to the treatment of their mental abnormalities;

(j) Declare that that the inadequacy of the "care and treatment" provided to plaintiffs invalidates the charges extracted from them for failure of consideration;

(k) Declare that the inadequacy of the "care and treatment" provided to plaintiffs renders unconstitutional, facially and as applied to plaintiffs and the class, the conditions of their confinement and must be remedied and reformed by the state to comply with constitutional standards;

(l) Enter a mandatory injunction against the defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction immediately unconditionally releasing the plaintiffs and the

certified class of SORTS residents from being held in custody of the DMH at the SORTS facilities with no further obligation or duties to SORTS, the DMH, and the statutory scheme that was used to imprison the plaintiffs and the other class members and thereby, as a practical matter, eliminate any need for the defendants to seek reimbursement for "care and treatment;"

(m) Enjoining defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction by personal service or otherwise from engaging in the conduct alleged in this Complaint, from enforcing and applying to plaintiffs and others similarly situated the provisions of §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo;

(n) Requiring defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction by personal service or otherwise to immediately cease and desist any and all efforts, plans, practices, policies, and conduct which would seek to obtain the costs of care and treatment from plaintiffs, their families, or their estates;

(o) Awarding plaintiffs and their counsel all attorney's fees, expenses, and costs herein; and

(p) Award such other and further relief the Court deems appropriate.

Count III – Violations of §§ 632.483-495 RSMo. and Prayer for Injunctive and Declaratory Relief

177. Plaintiffs incorporate by reference all allegations contained in Paragraphs 1 through 141.

178. All defendants were acting pursuant to state law and were acting under color of state law at all pertinent times.

179. The deprivations outlined herein were caused by the exercise of rights and privileges created by the State, by a rule of conduct imposed by the State, or by a person for whom the State is responsible, and all defendants may fairly be said to be state actors.

180. As established above, the policies, practices, and conduct of defendants amount to a deprivation of rights and privileges under §§ 632.483-495 RSMo. granted and guaranteed by the laws of the State of Missouri and only allow the plaintiffs and the members of the class to be detained and civilly committed in the SORTS Program if the statutes are obeyed and not violated.

181. Instead, defendants have violated and are violating the requirements of §§ 632.483-495 RSMo. by using the rights granted them to illegally detain and civilly commit convicted sex offenders in the custody and control of the DMH. More specifically, the statutory scheme that allows such detention and civil commitment is a pretext for warehousing convicted sex offenders, including the plaintiffs and the members of the class, so that they are illegally incarcerated in a prison disguised as a mental health facility that can thus no longer be operated and can no longer imprison present and future residents and detainees in the custody of the DMH and is thus unenforceable, void, and of no effect. Any efforts at treatment, as required by the statutes of the state of Missouri, are a sham and a pretext, not designed nor intended to be real and genuine so as to present a realistic opportunity for release of the plaintiffs and the class members.

182. All defendants were acting pursuant to state law and were acting under color of state law at all pertinent times.

183. The state law statutory violations and deprivations outlined herein were caused by the exercise of rights and privileges created by the State, by a rule of conduct imposed by the State, or by a person for whom the State is responsible, and all defendants may fairly be said to be state actors.

184. As established above, the policies, practices, and conduct of defendants amounts to a deprivation of a right guaranteed and granted by statutes of the state of Missouri and an outright violations of those statutes.

185. The defendants' conduct threatens a protected interest of the plaintiffs and class members in that the conduct complained of herein resulted in and continues to result in an unlawful violation of Missouri statutory law that requires the Missouri SORTS Program to comply with §§ 632.483-495 RSMo.

186. Each and every defendant had actual knowledge of the policies, practices, and conduct at issue, as well as what the law requires of them as state actors in their operation and management of the SORTS Program.

187. The conduct of defendants is truly irrational, arbitrary, capricious, pursued in bad faith, and done with the intent to punish plaintiffs and to punish them twice.

188. Plaintiffs seek preliminary and permanent injunctive relief to protect their rights and to prevent any further deprivation of rights by defendants and violations of the statutes.

189. Plaintiffs have standing to obtain an injunction because, among other things, plaintiffs' statutory rights are being and will be deprived by the continuation of the challenged conduct of defendants.

190. As established above, the policies, practices, and conduct of defendants have deprived and will deprive plaintiffs and the class of their statutory rights under Missouri law, including genuine treatment with adequate resources and staffing and the resultant honest and professional judgment of qualified health care providers to recommend the release of the plaintiffs and the members of the class, who are objectively and genuinely entitled to consideration of such a recommendation.

191. Defendants know that their policies, practices, and conduct deprive plaintiffs and the class of their statutory rights in violation of §§ 632.483-495 RSMo., yet they persist and refuse to abate said conduct and obey the law.

192. The challenged action is presently occurring and certain to occur in the immediate future.

193. Plaintiffs will continue to suffer irreparable harm absent injunctive relief.

194. Defendants will suffer no harm if an injunction issues.

195. The balance of harms weighs in favor of entry of an injunction.

196. It is in the public interest to enter an injunction that prevents defendants from continuing to deprive plaintiffs and the class of their rights as secured by §§ 632.483-495 RSMo.

197. No previous injunctive relief has been awarded with respect to this matter.

198. Defendants' ongoing actions in violation of Missouri statutory laws present an actual and existing controversy regarding the claim by the plaintiffs and the class that the DMH and the defendants intentionally set out to create a prison disguised as a mental health facility and intended to use treatment as a pretext and a sham to indefinitely incarcerate the plaintiffs and the class in a maximum security, penal environment with no reasonable opportunity to ever be unconditionally released.

199. The controversy is of sufficient immediacy and reality to warrant the issuance of a declaratory judgment, and is complementary to the injunctive relief requested below.

200. This Court's intervention is necessary to declare the rights and other legal relations of the interested parties.

201. Plaintiffs have standing to obtain a declaration of their rights because plaintiffs and defendants are in a dispute regarding their rights.

202. Plaintiffs have no adequate remedy at law.

WHEREFORE, plaintiffs respectfully request this Court to enter its decree and judgment, findings of fact and conclusions of law against the defendants and those acting in concert in favor of the plaintiffs and the class on Count III of the Fifth Amended Complaint, which result in the following remedies and relief by way of a permanent injunction and declaratory relief:

(a) Dismantle and close down SORTS and the Farmington and Fulton facilities and order the immediate discharge of all SORTS residents and detainees, so that they are unconditionally free and in conjunction therewith enter a mandatory injunction against the defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction immediately unconditionally releasing the plaintiffs and the certified class of SORTS residents from being held in custody of the DMH at the SORTS facilities with no further obligation or duties to SORTS, the DMH, and the statutory scheme that was used to imprison the plaintiffs and the other class members, both residents and detainees;

(b) Preliminarily during the pendency of this case and thereafter permanently enjoin the operation of the SVP Civil Commitment Program adopted and authorized by §§ 632.480 through 632.513 RSMo., sometimes called the "Missouri Sexually Violent Predators Act" or "MSVPA.," the detaining and evaluation of those about to be released from the Department of Corrections, having once completed their prison sentences as well as the conduct by the DMH of subsequent judicial proceedings, quasi-judicial proceedings, and governmental sponsored meetings of DMH employees, independent contractors retained as psychiatric experts and prosecuting attorneys acting as evaluators, to determine the eligibility of detainees to be subject to the filing of a civil commitment petition and subsequent prosecution in a civil commitment trial, wherein the State of Missouri seeks to commit detainees to the custody of the DMH and SORTS or any other similar program;

(c) Declare that the policies, practices, and conduct of defendants deprived plaintiffs of their rights and liberties under the statutory laws of the state of Missouri, including the breach and violation of the requirements set forth in §§ 632.483-495 RSMo.;

(d) In the alternative, declare the adequacy of the "care and treatment" provided to plaintiffs by defendants at SORTS and the conditions of their confinement violate §§ 632.483-495 RSMo. in that the DMH and the defendants intentionally set out to create a prison disguised as a mental health facility and intended to use treatment as pretext and a sham to

indefinitely incarcerate the plaintiffs and the class in a maximum security, penal environment with no reasonable opportunity to ever be unconditionally released;

(e) Declare that the "care and treatment" and "room and board" are inadequate, penal in nature, and not reasonably related to the rehabilitation of plaintiffs and to the treatment of their mental abnormalities; that the inadequacy of the "care and treatment" provided to plaintiffs renders the DMH and the defendants in violation of §§ 632.483-495 RSMo. with respect to the conditions of confinement and treatment of the plaintiffs and the class members that must be remedied and reformed by the state to comply with the statutory requirements and standards;

(f) Enjoining defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction by personal service or otherwise from engaging in the conduct alleged in this Complaint, from enforcing and applying to plaintiffs and others similarly situated the provisions of §§ 473.398, 473.399, 630.205, 630.215, 630.305, RSMo;

(g) Pursuant to the authority granted by F.R.P.C. 54 appoint a neutral, qualified, and objective special master and medical monitor with superior expertise and experience in the law, civil rights matters and the care and treatment of SVP's to oversee defendants' compliance with the aforesaid injunctive relief, with the requirements §§ 632.483-495 RSMo., and to report the status and implementation to the Court, with the appropriate

powers and duties to bring about full, complete, and with urgency implementation of the injunctive relief;

(h) In the alternative, with oversight, authority, and powers by the aforesaid special master and medical monitor to the fullest extent permitted by F.R.C.P. 54, answerable only to the Court, enter a mandatory injunction requiring defendants, their officers, agents, servants, and employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of the injunction by personal service or otherwise to fully, completely, and with urgency undertake and implement the following requirements, obligations, duties, and mandate, all of which are consistent with the express and implied requirements and intent of §§ 632.483-495 RSMo.:

- Operate SORTS as a mental health facility and not as a prison;
- Operate SORTs with the intent to treat and release and not to imprison and warehouse;
- Establish a “cap” on the time that a resident can be held in the custody of the DMH pursuant to the SORTS laws to not exceed three years, or whatever term the Court deems reasonable and appropriate;
- Faithfully, equally, and fairly implement the same conditions for treatment and standards, procedures, and policies for release as those DMH patients held in custody pursuant to programs that were established by nonSORTS statutes:

- Cease informal “alerts” and “heads up” to members of the General Assembly about planned releases of residents and eliminate inappropriate communications with the General Assembly, inconsistent with treatment and care and ending unwarranted, politically motivated intrusion;
- Practice what SORTS preaches and create and maintain a state of the art program and create a culture where people want to be;
- Expend the same resources for SORTS as for other DMH facilities and programs and cease treating SORTS as a “red headed step child”;
- Adopt and implement a plan for hiring and training competent, ethical psychological and psychiatric counselors and therapists;
- Employ an adequate number and quality of medical doctors, psychologists, psychiatrists, behavioral therapists, clergy, and other professional staff and provide SORTS residents meaningful access to such staff;
- Terminate all unlicensed or untrained staff, and staff determined by the special master or medical monitor to be incompetent or unable or incapable of providing ethical, up to date, adequate, truly therapeutic, and humane care and treatment to the residents;

- Implement a treatment program that involves individual counseling sessions and contains other generally accepted therapy components;
- Develop individual treatment plans for each resident to measure progress based on psychological and psychiatric, medically-relevant criteria rather than on day-to-day disciplinary issues, and which provides understandable progress goals and a road map showing the way to improvement and release, such plan to include the components recognized as necessary for maximum treatment potential;
- Hire or contract with a qualified and competent expert in sex offender treatment to supervise and consult with SORTS staff;
- Satisfy professional standards relating to credentialing, staff training and supervision, including employing program staff who are adequately trained to provide residential care and treatment components, clinical direction and supervision consistently provided by qualified professionals, staff who understand the treatment model, structure, ethical obligations, and their roles, and treatment planning and clinical decisions consistent across and among patients and residents of SORTS;
- Establish treatment programs that are individualized, comprehensive, and based on “Best Practices”;

- Establish safeguards including systematic measures of progress and ongoing monitoring of services to ensure quality and consistency;
- Establish a treatment facility housed in a mold-free environment;
- Establish and provide a treatment-oriented facility under the Least Restrictive Alternative with adequate space for living, treatment, other activities, and for separation among resident groups;
- Treat residents with respect and offer meaningful and genuine opportunities to have resident grievances addressed;
- Address long-term health and other behavioral and emotional needs of the residents;
- Establish a mental health program that is medically-based and consistent with psychological and psychiatric standards of care, including the "Sex Offender Treatment Program Standards and Measures" as adopted by *The Special Commitment Center Sex Offender Treatment Program Standards and Measures*;
- Protect residents' privacy and medical information rights;
- Establish testing programs to objectively and fairly measure the progress of residents, including but not limited to the Violence Risk Appraisal Guide, the Sex Offender Risk Appraisal Guide, the Sexual Violence Risk-20, the Rapid Risk Assessment for

Sex Offence Recidivism, STATIC-99, STATIC 2002, the Minnesota Sex Offender Screening Tool - Revised, the Sex Offender Needs Assessment Rating, and the Hare Psychopathy Checklist - Revised;

- Ensure that the SORTS program has external oversight through an authoritative licensing and accreditation organization widely-respected in the field of sexual disorder treatment;
- Establish a system of external peer review to ensure the quality and effectiveness of the SORTS treatment program;
- Implement strategies to rectify the lack of trust between the residents and SORTS staff;
- Implement a treatment program that involves residents' spouses and family members and contains other generally accepted therapy components;
- Make adequate provision for participation by residents' families in rehabilitation efforts, including setting aside a room for visits by family members, permitting family visits with reasonable frequency and allowing prompt telephone access to residents in cases of family emergency, consistent with security;
- Eliminate the treatment of SORTS residents as if they were criminal prisoners in the custody of the Department of Corrections, such as banning strip searches unless absolutely

necessary for safety, eliminating monitoring of residents' telephone calls and meetings with non-residents, eliminating harassment of residents by SORTS staff, allowing at least the amount of outdoor recreation time as permitted in prison if not more, ending the policy of monitoring each resident every 15 minutes especially where such policy requires an invasion of privacy in the shower or toilet stall, and allowing complete access to telephone services;

- Afford reasonable opportunities to all residents for educational, religious, vocational/work, and recreational activities, including the right to contribute money to religious institutions;
- Develop and implement a plan to integrate residents into society, including realistic, not overly restrictive, conditional release programs, and take all reasonable steps to implement that plan in a timely manner;
- Faithfully require the adherence by all SORTS health care providers to the NAHO *Code of Ethics and Standards of Practice for Healthcare Quality Professionals* and discipline those who violate the Code;
- Eliminate overcrowding;
- Provide more timely, consistent treatment, less downtime, and eliminate repeated therapy session cancellations;

- Accurately and fully disclose to the Missouri circuit courts, the status of the progress of residents committed to SORTS and honestly provide to those courts the residents' true status with respect to their mental abnormalities and risk of reoffending;
- Develop and implement a plan and take all reasonable steps to bring a constitutionally adequate program into reality rather than merely describing it on paper;
- Develop and implement a plan to insure full and complete compliance with the aforesaid reforms and remedies, including the right level of funding;
- Stop the deliberate, casual, "slow walk" of treatment and instead accelerate the pace of treatment; and
- Periodically, as required by the Court and with recommendations and reports by the special master and the medical monitor on the compliance by the DMH and the defendants of the above injunctive requirements to report the status and implementation to the Court, with the appropriate powers and duties to bring about full and complete implementation of the injunctive relief in a speedy matter, or failing that to recommend to the Court the dismantling and closing of SORTS and the Farmington and Fulton facilities and ordering the immediate discharge of all SORTS residents and detainees, so that they are unconditionally free and in

conjunction therewith enter a mandatory injunction against the defendants, their officers, agents, servants, employees, and attorneys, as well as those persons in active concert or participation with them who receive actual notice of this Injunction immediately and unconditionally releasing the plaintiffs and the certified class of SORTS residents from being held in custody of the DMH at the SORTS facilities with no further obligation or duties to SORTS, the DMH, and the statutory scheme that was used to imprison the plaintiffs and the other class members, both residents and detainees;

(i) Awarding plaintiffs and their counsel all attorney's fees, expenses, and costs herein; and

(j) Award such other and further relief the Court deems appropriate.

COUNT IV – Deprivation of Rights Guaranteed by the United States Constitution and Title II of the Americans with Disabilities Act and Prayer for Injunctive and Declaratory Relief

203. Plaintiffs incorporate by reference all allegations contained in Paragraphs 1 through 132.

204. This Count is brought pursuant to Title II of the Americans with Disabilities Act (the "ADA") as an alternative claim to Counts I, II, and III of this Complaint against the DMH and the Defendants. The ADA prohibits discrimination in all "services, programs, or activities of a public entity," including a Public Entity. 42 U.S.C. §12132.

205. A "Public Entity" as defined by the ADA and case law is a very broad definition and includes "any State or local government and any department, agency, special purpose district, or other instrumentality of a State or States or local government." *Armstrong v. Wilson*, 124 F.3d 1019, 1023 (9th Cir. 1997). This "include[s] every possible agency of state or local government." *Id.* Hence the ADA applies to state prisons, See *Pennsylvania Dep't of Corr. V. Yeskey*, 524 U.S. 206, 209 (1998) and local law enforcement agencies, see *Gorman v. Bartch*, 152 F.3d 907, 912-13 (8th Cir. 1998). Quite simply, the ADA's broad language brings with its scope "'anything a public entity does.'" *Pennsylvania Dep't of Corr. v. Yeskey*, 118 F.3d 169, 171 & n.5 (3d Cir. 1997) *aff'd* 524 U.S. 206 (1998). This includes programs or services provided at jails, prison, and any other "'custodial or correctional institution,'" as well as mental health services and other activities or services undertaken by government. Even convicts do not park their rights against discrimination at the prison gates, much less the Plaintiffs and other residents of SORTS, whom the DMH and the Defendants contend are civil committees and not prisoners.

206. That said, Plaintiffs do not concede their primary claim and argument in this case that SORTS is a prison disguised as a mental health facility. However, if the Court finds SORTS to truly be a mental health facility, then, alternatively, Plaintiffs and the residents of SORTS are victims of discrimination because of their alleged disability in that, *inter alia*, SORTS is understaffed and underfunded in comparison to other DMH programs. Moreover, the Plaintiffs and the other residents are illegally segregated from other patients and residents treated at DMH facilities, who are treated in a different setting and with different resources that have resulted in far greater releases from confinement than SORTS residents. SORTS residents are held in a maximum security environment instead of in the Least Restrictive Alternative even though, by

the DMH's own statistics, fully fifty per cent of the SORTS residents present "no apparent risk." The practices of the DMH and the Defendants are also thus in violation of the ADA's integration mandate, which requires that the "services, programs, or activities of a public entity" be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. §325.130(d).

207. Under the ADA, the Plaintiffs and the other residents of the SORTS are thus "qualified individuals," entitled to be protected from discrimination because of the DMH has branded them as having a "mental abnormality," which the DMH and the Defendants have conceded is a "disability" under the ADA.

208. Based on Title II and its integration mandate, the United States Supreme Court held that the "unjustified isolation" of persons with disabilities by State and local governments constitutes discrimination under Title II. *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999). Accordingly, the civil rights of the Plaintiffs and the rest of the SORTS residents have been violated by unnecessary segregation, maybe with only eight possible exceptions (the residents in the Annex), out of 190+ residents in maximum security at the SORTS Farmington and Fulton facilities. Missouri's statutory scheme as previously described herein is in violation of the ADA, a federal law that, under the Supremacy Clause of the United States Constitution, preempts state law, including the SVP statutes cited in earlier passages of this Complaint.

Jurisdiction and Venue

209. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§1331 and 1345 (2000).

210. Venue in the Eastern District of Missouri is proper pursuant to 28 U.S.C. §1391 (2000).

The Defendants

211. The Defendants, as senior management of the DMH, operate and manage, both strategically and day to day, SORTS, and as such have responsibility for the services, treatment programs, procedures, care, rules, regulations, and daily operations provided to the Plaintiffs and the other residents at SORTS.

212. At all times pertinent herein, the Defendants acted in concert with each other, aided and abetted each other in the commission of the acts and conduct giving rise to the claims asserted in Count IV and each was an agent of the other, so that the actions of any one Defendant created vicarious liability for the other Defendants.

The ADA

213. The ADA establishes a broad mandate, contrary to the practices and operations of the DMH and the Defendants and Missouri statutory law, that the Plaintiffs and the other residents of SORTS have the right to live integrated lives, not be segregated, be in custody of the Least Restrictive Alternative, have an equal opportunity for release as other DMH programs and facilities, and have equal monies and resources expended for their care and treatment consistent with monies and resources expended for other patients and residents of DMH programs and facilities. *See, e.g.*, 42 U.S.C. §§12101(a)(2), (b)(1)-(2). Title II is part of the ADA's "clear and comprehensive national mandate" to end the segregation of persons with disabilities in virtually all aspects of American life, including employment, public accommodations, and transportation. See id. §12101. It is the State's obligation (in this instance the DMH and the Defendants) to fulfill this mandate on behalf of its citizens, whether they receive services during the day or in residential settings at night, and regardless of the severity of their disabilities. The Supreme Court recognized in *Olmstead* that "social contacts, work options, economic independence, . . . and cultural enrichment" are among the "everyday life activities" severely diminished by unnecessary segregation. *Olmstead*, 527 U.S. at 600-01. Yet with SORTS, "one size fits all,"

and different privileges, housing conditions, and treatment programs are largely immaterial and a sham because SORTS is a prison disguised as a mental health facility and the goal is confinement, not treatment and release.

The ADA as Applied to SORTS – a Dismal Failure to Comply

214. Many of the SORTS residents have been relegated to the SORTS segregated program for as long as a decade and a half. Fully fifty per cent of the residents, as previously alleged, present "No Apparent Risk," yet they are held in maximum security, segregated from all other patients and residents in the Missouri Department of Mental Health.

215. The DMH and the Defendants have failed to offer SORTS residents the critical transition, vocational, and employment services necessary to make work and participation in post-secondary integrated employment and day settings a reality. The DMH and the Defendants purport to offer transition through a conditional release program, but that is both a failure and an artifice. The DMH and the Defendants, as well as Missouri statutory law, have created so many impossible and burdensome conditions that the conditions literally swallow any benefits of release. Three individuals have supposedly been conditionally released. But each returns nightly to the maximum security confinement of SORTS behind the two rows of razor wire, instead of the Least Restrictive Alternative and the ADA's integration mandate.

216. The civil rights of people who can and want to receive employment services in the community are violated when they are unnecessarily segregated at SORTS. Likewise, the civil rights of people who can and want to receive day services in the community are violated when they are unnecessarily segregated in facility-based programs. Moreover, as in the context of residential service settings, administering and funding day activity services, including employment services, in integrated settings is not only practicable but has been shown to lower costs over the longer term, and does not fundamentally alter state service systems. To the extent

the DMH and the Defendants argue that they must follow Missouri law and the SVP statutes in particular, the answer to that contention is obvious – the Constitution and federal law trump state law and the DMH and the Defendants know that they cannot hide behind state law requirements that violate the constitution and federal law. One of the problems with the management of SORTS is that the DMH General Counsel fails to understand or declines to recognize this elementary legal position. In some ways, the argument could be made with reason and good cause that the DMH General Counsel should be named as a Defendant in this case because she is arguably as complicit as lay management in the operation and management of SORTS and knows or should know SORTS' evident shortcomings.

217. The DMH and the Defendants have placed the Plaintiffs and the other SORTS residents at serious risk of unnecessary segregation because of the lack of integrated transition services, integrated employment opportunities, and appropriate referrals to prepare residents for transition into work in integrated settings. The one time Director of Behavioral Services at SORTS, Dr. Jon Rosenboom, described the implications and risk of unnecessary segregation SORTS residents in this email in this way:

> "From a natural progression in the treatment of our more advanced residents, some increased responsibility and personal freedom is crucial. We now have 4-6 residents within 1-2 years of a recommendation to CO for partial conditional release [interesting that Dr. Rosenboom cannot use the word 'release' or 'conditional release' without modifying the word or phrase with 'partial.'] After over 7 years of these individual's treatment and progress, they continue to be supervised 24/7, have no personal monies on their person, cannot buy a soda or candy bar from vending machines that they pass 10 times a day, and have now lost a good deal of the benefits of personalization of their room through the life safety interpretations/restrictions associated with TJC accreditation. **They are becoming more institutionalized and the potential that their work in treatment will bring fruit is subject to fading."** (Emphasis added).

In addition, Mary Weiler, then SORTS Director of Social Services, in a plea for help to other officials operating SORTS programs in other states wrote in an email:

> "We are moving toward conditional release of several residents. All of these men have been out of mainstream society (jail, prison, SVP residential treatment) for at least 20 years. I would appreciate references to articles or other resources that would be helpful in teaching reintegration skills to these men (i.e. imagine the changes in telephonic communication over 20 years!). Thank you."

218. As a result and as acknowledged with great clarity in the foregoing Rosenboom/Weiler emails, to the extent the DMH and the Defendants have provided employment, vocational, and reintegration skills to SORTS residents it has been counterproductive because it has not been provided in the most integrated setting appropriate to the needs of the residents, in violation of the ADA. Instead, the DMH and the Defendants plan, structure, and administer their system of providing employment, vocational, and day services in a manner that delivers such services primarily in segregated and facility-based day programs, rather than in integrated employment and day settings. Sheltered and facility-based day programs segregate the SORTS resident from community and provide little or no opportunity to interact with person without disabilities, other than paid staff, who now are on notice by the filing of this Complaint that they may be participating in and actively involved in a program that violates the law, ethical medical practices, and their duties and obligations to their patients as licensed health care providers.

219. SORTS' residents tend to remain in facility-based day activity service programs for years at a time, and the DMH and the Defendants offer very few services and supports to assist the residents to transition back to integrated employment and day settings from segregated employment and day settings. All they get are endless, useless, hopeless, mind numbing group therapy sessions, with repetitive, make work assignments that do not advance treatment or bring about a realistic opportunity to be cured of their alleged disability, a program that is remarkably segregated, different for no useful reason or rationale related to care and treatment and runs counter to a goal of release to the community, all at the same time being severely underfunded,.

220. In Olmstead, the Supreme Court recognized the harm caused by unnecessary segregation: "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id*. At 601.

221. *See also Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013) ("In sum, individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II. . . claims because they face a risk of institutionalization.") (emphasis added); *M.R. v. Dreyfus*, 697 F.3d 706, 734 (9th Cir. 2012) ("An ADA plaintiff need not show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate[;] [r]ather, a plaintiff need only show that the challenged state action creates a serious risk of institutionalization."

222. Title II of the ADA states as follows: "no qualified individual with a disability, by reason of such disability, shall be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id.* §12132. As Congress found, "[I]ntegration is fundamental to the purposes of the ADA. Provision of segregated accommodations and services relegate persons with disabilities to second-class citizen status." *See* H.R. Rep. No. 101-485(III), at 56 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 479; *see also* 28 C.F.R. pt. 35, app. B at 673 (same); *Helen L. v. DiDario*, 46 F.3d 325, 335 (3d Cr. 1995) ("The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them.").

Summary of Additional Facts Specific to the Claim Under Count IV

223. In their own words as described in more detail elsewhere in this Complaint and presented here in summary form, the following candid, inner DMH communications illustrate

and prove that the DMH and the Defendants operate and manage an institution that violates the ADA because the treatment is substandard, is not meaningful, other DMH programs receive more resources and money, better staffing, have the true intent to treat a disability, do not engage in impermissible segregation, utilize the principle of the Least Restrictive Alternative, are committed to community based programs, have genuine release protocols, greater release rates, and do not discriminate and have differing standards for release within the same or similar patient base as SORTS:

> That Director Schafer has stated that "No one has ever graduated from [SORTS] and somewhere down the line, we have to do that or our treatment processes become a sham."
>
> That Director Schafer has stated that "The 'end game' related to MOSOTC is to[a]void building new facilities for Sexual Predators as long as possible. New tougher sentencing laws will ultimately reduce the number of referrals to DMH, but this impact will not be felt until at least 10 years from now."
>
> That, from time to time, Alan Blake, the former COO of SORTS, has offered these opinions and facts about SORTS:
>
> "Unfortunately DMH is not will to applying [sic] the values it espouses or things would be different."
>
> "The state keeps trying to get by on the cheap."
>
> "We are [a] disaster waiting to happen."
>
> "I fear [we] are going to have some major care failure that will contribute to my early retirement."
>
> "We are also now vulnerable to claims that we offer inferior treatment in that we are not staffed at a similar rate to other areas of the facility and thereby are providing inadequate treatment."
>
> "I have a worried sense that the budget is being driven by Steve and the money people, not by policy and need."
>
> "I continue to be concerned that this ongoing minimal funding keeps us on the edge of adequate and inadequate, and in a federal court's view, even our adequate may be inadequate enough for an adverse ruling."

> "As it is I am starting to have problems keeping management staff from getting discouraged and giving up. They are worn out, frustrated distressed and wearing out."
>
> "We are the DMH redheaded stepchild and they don't care if we fail."
>
> "We have been getting farther and farther behind. That is why I initiated the behavioral health structure in order to reduce the impact of the inadequate funding of this facility for YEARS, and find a way to operate for less."
>
> "If we are to seek accreditation with current staffing levels and patterns, we will need to significantly reduce treatment to assure that assessments documentation and treatment plans are in place."
>
> "All this opens us to a federal lawsuit for providing substandard care. A successful lawsuit in this area will cost the state millions."
>
> "However, this again places the Department at risk of legal action regarding substandard care."
>
> "The facility will take on the effect of a prison and be in violation of Supreme Court rulings. The residents will likely initiate legal action for which the department and state will have difficulty mounting a defense."
>
> "We are so far from JCAHO [accreditation] that I cannot conceive of it. For lawsuits, we have had over 50 filed – mostly [but not all] frivolous."
>
> "We have been trying to find how to make a $600,000 core reduction and the ramifications."
>
> "[If that happens] most nursing and medical staff will leave, and most professional staff will follow. At that point we become a prison."

Or Jon Rosenboom's observation:

> "Finally, I am often struck by the unsettling conclusion that direct patient care is one of the last priorities when stacked against all of the other expectations."

Or Dr. Joseph Park's insights:

> "Psychiatric inpatient facilities are backing up, admitting far more commitments than discharges. This, in turn, clogs acute care facilities, which must hold patients longer who are awaiting admission into state long-term psychiatric care. This system "constipation" forces state facilities to operate beyond 100% of capacity for long periods of tie, exhausting staff, causing staff overtime and high turnover rates, and

> inevitably increasing the risk of staff injuries and patient abuse and neglect."

Or Dr. Jay Englehart, the Medical Director of the SMMHC (which includes SORTS) warning about a DMH "Central Office" directed effort to try to overcome the shortage of physicians and save money by the hiring of Psychiatric APN's noting that this is…

> "…the model which the prisons are moving toward, but I really do not want have [sic] a standard of care or staffing which is equal to that of the prisons. I hope we are better than that."

Or the candid admission as far back as 2002 by Ann Dirks-Linhorst that:

> "I know that yesterday you indicated that you all had inherited a 'bad' program."

Or the unknown SORTS employee, who acknowledged that SORTS had no release/integration program in place, nor did it account for the need to have LRA's.

Class Action

224. This case is brought on behalf of a class that consists of all persons who have been, are, or will be confined in the custody of SORTS or have been, are, or will be detained pursuant to consideration by the State as to whether a petition for civil commitment will be filed or if filed then required to wait, in a maximum security, segregated jail, for a civil commitment trial.

225. The class is so numerous that joinder of all members is impracticable. The population presently in the custody of SORTS apparently exceeds 200 individuals and is constantly growing larger as new persons are detained before trial and civilly committed. The class of those detained at any particular stage of the civil commitment process as set forth in the Missouri SVP statutes exceeds 50 in number.

226. There are questions of law and fact common to the members of the class, and these questions predominate over those affecting only individual class members. The predominate common questions are: (1) whether the DMH and the Defendants or those acting under their control or direction discriminate against the Plaintiffs and the other members of the proposed class on the basis of their alleged disability in violation of the ADA; and (2) whether the DMH and the Defendants have violated the due process rights of the Plaintiffs and the proposed members of the class in violation of the Fourteenth Amendment to the United States Constitution.

227. Plaintiffs' claims are typical of the claims of the class members. All are based on the same factual and legal theories in that they have all suffered as a result of the practices in violation of the ADA and the United States Constitution as alleged in this Count of the Complaint.

228. Plaintiffs will fairly and adequately represent the members of the class. They have no interests antagonistic to the class, and they are represented by counsel, who are competent and experienced in complex civil litigation.

229. A class action is superior for the fair and efficient adjudication of this matter, in that the DMH and the Defendants, by creating and maintaining the practices alleged in this Count of the Complaint, have acted on grounds generally applicable to the class, and, as a result, declaratory and injunctive relief with respect to the entire class is appropriate.

General Allegations

230. The DMH and the Defendants are obligated to operate SORTS in a manner that does not infringe upon the federal rights, as protected by the Fourteenth Amendment to the Constitution of the United States and by other federal law, of individuals residing at SORTS.

231. The DMH and the Defendants are obligated to provide treatment, supports, and services to individuals residing at SORTS consistent with the ADA and implementing regulations. 42 U.S.C. §§12101-12213; 28 C.F.R. pt. 35 (2006).

232. At all relevant times, Defendants have acted or failed to act, as alleged herein, under color of state law.

233. Defendants have failed and are continuing to fail to provide the Plaintiffs and the other SORTS residents with that level of treatment, habilitation and training, including behavioral and related training programs, required by the ADA, necessary to protect the residents' liberty interests and to ensure their safety and freedom from undue or unreasonable restraint.

234. Defendants have failed and are continuing to fail to ensure that restraints are administered to residents by appropriately qualified professionals in keeping with accepted professional standards, and are not used as punishment, in lieu of treatment, or for the convenience of staff. Defendants have failed and are continuing to fail to supervise adequately residents in restraints to protect them from harm, including the worsening of their mental health as a result of the violations of the ADA and practices contrary to the constitution.

235. SORTS's treatment, support, and services substantially depart from generally accepted professional standards of care, thereby exposing individuals residing at SORTS to significant risk and, in some cases, to actual harm, including emotional and psychiatric damage.

236. SORTS's treatment, support, and services substantially depart from generally accepted professional standards of care in the following specific respects, among others:

(a) the provision of adequate psychological and behavioral services;

(b) the provision of adequate medical, neurological, and nursing services;

(c) the provision of adequate psychiatric services;

(d) the provision of adequate habilitation and therapy services, including physical therapy, occupational therapy, speech and language therapy, and other forms of therapy, physical management, nutritional services and related services; and

(e) the provision of adequate protections from harm.

(f) the failure to provide necessary monetary and nonmonetary resources consistent with the requirements of the ADA and the constitution.

(g) the failure to provide necessary monetary and nonmonetary resources equal to that provided to other DMH programs and facilities.

(h) the failure to provide the Least Restrictive Alternative.

(i) the segregation of the Plaintiffs and other SORTS residents from the community and other DMH patients and residents, who receive better care and treatment and are more likely to be released.

Violations of the Due Process Protections of the Fourteenth Amendment to the United States Constitution

237. The egregious and flagrant acts and omissions alleged in this Count of the Complaint constitute a pattern or practice that violated the federal rights, as protected by the Fourteenth Amendment to the Constitution of the United States and by other federal law, of individuals residing at SORTS.

238. Unless enjoined by this Court, Defendants will continue to engage in the egregious and flagrant acts and omissions set forth in Count IV that deprive the SORTS's residents of rights, privileges, or immunities secured or protected by the Constitution of the United States and federal law, and will cause irreparable harm to these residents.

Violations of the Americans with Disabilities Act

239. The egregious and flagrant acts and omissions alleged in this Count of the Complaint violate the ADA and implementing regulations. 42 U.S.C. §§1211101-12213, 28 C.F.R. pt. 35.

240. Unless enjoined by this Court, Defendants will continue to engage in the egregious and flagrant acts and omissions set forth in this Count of the Complaint that deprive the residents of SORTS of rights, privileges, or immunities secured or protected by federal law, and will cause irreparable harm to these residents.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request this Court to enter its decree and judgment, findings of fact and conclusions of law against the Defendants and those acting in concert in favor of the Plaintiffs and the class on Count IV of the Fifth Amended Complaint, which result in the following remedies and relief by way of a permanent injunction and declaratory relief:

(i) Permanently enjoining Defendants, their officers, agents, employees, subordinates, successors in office, and all those acting in concert or participation with them from continuing the acts, omissions, and practices set forth in Count IV, and that this Court require Defendants to take such actions as will ensure lawful conditions of institutionalization are afforded to residents of SORTS, including the provision of adequate treatment in the most least restrictive setting appropriate to their individualized needs;

(ii) Declaring that the acts, omissions, and practices set forth in Count IV constitute a pattern or practice of resistance to SORTS residents' rights, privileges, or immunities secured or protected by the Constitution or laws of the United States, and that those acts, omissions, and practices violate the Constitution and laws of the United States, including the Americans With Disabilities Act; and

(iii) Granting such other and further equitable relief as the Court may deem just and proper, including an award of attorney's fees and costs.

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ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of February, 2014, I electronically filed the foregoing with the Clerk of the Court using the ECF system, which sent electronic notification of the filing on the same day to all counsel of record.

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/s/Eric M. Selig

SORTS Census, Bed Space and Funded Bed Projections – December 2009

- **In FY'09, the in-house census exceeded funded beds.** The reduction in funded beds from FY08 to FY09 assumed a rapid placement of in-house detainees in contract detention centers, but placement was delayed by court action and need for statutory change. This has since been obtained and all but 2 detainees have been placed. However, the delay coincided with an unprecedented and unpredicted increase in the number of new SVP commitments to SORTS. This increase in commitments was fueled, in part, by the detainees placed in contract detention centers demonstrating an increased willingness to stipulate to SVP commitments to SORTS. The lack of available beds in FY09 was exacerbated by the reduction in the number of beds on the Hoctor wards to 16 residents per ward to accommodate The Joint Commission standards.
- **A new ward was funded for a partial year (7 months) in the FY'10 regular budgeting process.** This ward increased SORTS' on paper budged census, but because of the aforementioned census pressures, these beds were occupied by individuals already committed to SORTS and no new capacity was created. This only real change was the placement of PRN staff into regular merit system position codes. At this point, the SORTS complex has only one remaining vacant16- bed Hoctor ward available for funding in FY 11 to accommodate additional SVP commitments during the Fiscal Year. Presuming historical admission rates, it will be necessary to open the last ward as early as July, 2010, prior to the receipt of any appropriation. In the interim SORS will support the ward by hiring PRN staff and use of overtime. On a practical basis, it would be prudent for the Department to secure funding to open the last Hoctor ward as early in FY11 as possible, preferably July 1, 2010. Although the historical practice has been to appropriate sufficient dollars to allow for a ward to be opened in December, this results in overcrowding, eventually requiring that the ward be opened in advance of the appropriation. Although that has not been significantly problematic prior to efforts to obtain accreditation, in the current environment overcrowding results in practices that are violations of accreditation and life / safety standards, thereby placing accreditation efforts at risk. In addition, an unfunded ward lacks the staff needed to provide treatment, housekeeping, clerical and support services are not available, placing an additional burden on existing staff, thereby diluting services for several months. This is all the more problematic as allegations of overcrowding and inadequate services are the subject of conditions of confinement lawsuits by residents.
- **At the current rate of admissions the SORTS wards inside the secure perimeter will be full before the beginning of FY12.** Some relief will be provided should the state proceed with planned Capital Improvement projects involving the renovation of the Hoctor first floor central hallway (adding 14 beds) and the construction of an eight step down transition beds under a separate roof. However, this is not likely to be completed before FY12 and will not resolve all bed space needs during FY12 and beyond. Moreover, the conversion of the Hoctor first floor central hallway will result in the loss of significant office space for professional staff, requiring 2 to 3 individuals to share the residual office space.
- **The rate of growth may be counteracted by resident conditional releases or discharge because of severe, debilitating, chronic medical conditions.** However, the rate of discharges is not anticipated to approach the rate of admissions for many years.

EXHIBIT 1

Enke, Teri

From: Vincenz, Felix
Sent: Monday, June 22, 2009 3:26 PM
To: Reitz, Robert
Subject: State Bond Initiative and New CI Opportunities - Original Instructions
Attachments: RE: MSOTC and Aged/Infirm; FW: letter; FSH Size

Follow Up Flag: Follow up
Flag Status: Flagged

I think it does make sense, but include it as an option.

From: Reitz, Robert
Sent: Monday, June 22, 2009 2:28 PM
To: Vincenz, Felix
Subject: RE: State Bond Initiative and New CI Opportunities

Working on it, but we potentially have two plans:

1) FTE reductions only – Security, dietary, etc
2) FTE reductions and privatization of perimeter security, dietary, housekeeping, etc.

With fringe in FY10 being as high as it is, does it make sense for us to include a plan for privatization of most non-essential services? Ken thinks there's more than $1M in potential savings if we do.

From: Vincenz, Felix
Sent: Monday, June 22, 2009 2:13 PM
To: Reitz, Robert
Subject: FW: State Bond Initiative and New CI Opportunities

Remember – I'm needing something on this by the end of the week.

From: Vincenz, Felix
Sent: Wednesday, June 17, 2009 6:15 PM
To: Reitz, Robert; Martin, Marty A.; Adams, Karen; Blake, Alan; Gowdy, Rick; Rosenboom, Jonathan
Cc: Carson, Rebecca
Subject: State Bond Initiative and New CI Opportunities

Karen/Alan/Jon - Here is the information of which I spoke with Karen and Alan. Just to be clear – this replaces the concept of the 16 bed community option that was attached.

Bob/Marty – Fulton is very much back on the table. However, I need you, Ken and Marty to come up with some projections about how a new Fulton could realize some savings, both in E&E costs, support staff, and potentially, even in some direct care staff. I know Ken and I used to discuss how new air exchange standards zeroed out fuel and utility savings, and how any savings we realized in support staff and wards that allowed for more efficient staffing patters would need to be plowed into enrichment of the existing clinical staff. However, we need to either make that case or demonstrate some savings. At the very least, we need to demonstrate how more efficient ward designs will enable us to save staffing costs associated with watching restrooms and hallways, and even more importantly, in reduced overtime costs. Get on this and give me something within the next 7 to 10 days.

From: Schafer, Keith
Sent: Wednesday, June 17, 2009 2:58 PM

EXHIBIT 2

To: Schaeperkoetter, Jeff
Cc: Harris, Jeff; Miller, Mayme; Luebbering, Linda; DMH.CO Exec Team/Assistants
Subject: Bond Initiative

Jeff, Linda, Jeff and Mayme, the Governor's Bond strategy is exciting and exceptionally important to DMH. I can immediately think of three key projects that could make a major difference in our ability to provide good, cost effective services:

Building a new Fulton State Hospital, including a new SW Minimum Security Forensic Facility and a new wing at NWPRC (St Joseph) to reduce Fulton overcrowding: As you know, Design and Construction already has the cost analysis for a new Fulton State Hospital campus. You and we have also done some analysis on the associated Southwest forensic minimum security facility and an additional wing to the Northwest psychiatric rehabilitation center to house individuals now stuck on the Fulton State Hospital Campus. In addition to relieving overcrowding at Fulton and cutting down on staff injuries and the $3 million we are spending annually in overtime there, the new Southwest and Northwest facilities will create 200 good new full time state jobs at a net cost of only $3 million in total GR, or about $15,000 per job (including fringe). The rest of the cost of those jobs will be covered through federal reimbursements.

MOSOTC: We are looking down the barrel of a mandatory $72 million construction project to add necessary space to the Missouri Sexual Offender Treatment Program in Farmington to handle the 160 person increase in DOC referrals we will experience over the next ten years. As you know, we are maxed out on space at the current MOSOTC facility. Since there is no enthusiasm for an outpatient model like that operated in Texas, we must now plan for the construction of this facility as soon as possible. We would like to build 140 or so beds built within the razor-wire complex where the current MOSOTC facilities sit. We would also like to think about five or six cluster group homes on the SE Missouri Mental Health Center campus that would allow us to move elderly and medically frail MOSOTC patients to a different level of care. We could carefully staff these homes with a high level of security aides to make sure there is no risk to the community from the elderly and medically fragile MOSOTC patients living in the group homes. For example, we just had an 82 year-old MOSOTC patient die in June from his medical condition. We also need a place where MOSOTC "graduates" can go and live and work. We could reserve a bedroom in each of these group homes for that purpose, hiring the graduates as DMH peer specialists. If they live and work there successfully for a number of years, then we could step them up to probationary outpatient placement. No one has ever graduated from MOSOTC and somewhere down the line, we have to do that or our treatment processes become a sham. The group home cluster is a new concept that we have not previously discussed with your staff or the Governor's Budget Office.

Nevada Habilitation Center: Now that Bellefontaine has been taken care of, the most pressing facility problem on the DD Habilitation Center side is Nevada Habilitation Center. As you know, it is an old, high-cost campus that does not have group homes like the other habilitation centers. We will be thinking about how we could most effectively replace that campus through construction that would eventually facilitate us converting the cost of that program to the Home and Community-based Waiver, as was just done in the 2010 budget for Marshall and DDTC. We might actually want to build clusters of group home facilities in Nevada and surrounding cities that total the same number of beds now on that single campus.

I know other DMH projects will emerge, but I wanted to give you a heads up to those that most quickly come to mind. We will ask for a meeting with you and your staff in the near future to discuss these further.

Keith Schafer, Ed.D.
Director
Department of Mental Health
1706 East Elm, Jefferson City, MO 65102
Phone: 573-751-4970 or 573-751-3070
email: keith.schafer@dmh.mo.gov

Gowdy, Rick

From: Schafer, Keith
Sent: Monday, March 24, 2008 9:55 AM
To: McGinty, Brent; Parks, Joe; Gowdy, Rick; Bax, Bob; Heckemeyer, Jan
Subject: MOSOTC update
Attachments: DMH Budget Discussion Notes for Senator Nodler 09.doc

I plan to give this to Jim Lembke and Gary Nodler, plus a few other people on the Senate Budget Committee. What do you think?

EXHIBIT 3

DMH Budget Discussion Notes for Senator Nodler
and Other Key Senate Budget Committee Members

Missouri Sexual Offender Treatment Center Budget Items (MOSOTC): DMH has both a 6 month cost to continue item for 17 beds partially funded in '08 budget and a new decision item for 17 additional beds.

Budget Issue Background: DMH is proposing to contract with at least 2 modern county jails for a cluster of cells in each jail for "detainees" referred by DOC through Attorney General's Office. These detainees await adjudication by local courts to determine if they should be civilly committed to DMH for inpatient treatment for sexual predatory behaviors. Over 50 detainees now await adjudication. Time from referral from DOC to adjudication for commitment averages 22 months and has gone as long as 5 years. Current detainees at MOSOTC generally refuse treatment on advice of their defense attorneys and are angry at having completed DOC sentence and now being further detained by DMH. Staff and client injuries generally occur on detainee units.

By the end of FY 2009, MOSOTC buildings will be full and cannot house additional referrals. DMH must either build a new facility within the razor wire confinement area, or implement the jail strategy for detainees. State statute allows jail detentions. Two other states with similar statutes already do this (Kansas and S. Carolina). The Attorney General's office is concerned about increased risk of lawsuits but will support the DMH policy decision.

DMH moved a significant portion of the MOSOTC budget into the "Professional Services" line in FY 2009 to accommodate contract swill local jails. Representative Lembke, not knowing about our plans for jail detention, (DMH had failed to brief him on this) cut significant amounts of money from the Professional Services line for other initiatives. This would preclude our ability to place detainees in jails awaiting adjudication for commitment. Keith Schafer has since briefed Representative Lembke and indicated we would try to protect funding in MOSOTC core and new decision item lines to allow the change. Representative Lembke has indicated this would be consistent with his goals to assure that minimal funding be spent on sexual predators within the parameters of the state's obligation to provide treatment allowing involuntary commitment.

The "end game" related to MOSOTC is as follows:

1. Avoid building new facilities for Sexual Predators as long as possible. New tougher sentencing laws will ultimately reduce the number of referrals to DMH, but this impact will not be felt until at least 10 years from now.
2. Hold Detainees in County jails. This will cost about $70 per day versus the $200 a day at MOSOTC.
3. Reduce staff and client injuries at MOSOTC.
4. In FY 2010, try to move aging MOSOTC committees to other specialized treatment settings.
5. Use any savings to strengthen MOSOTC treatment to get it JACHO accredited. Once accredited, DMH may be able to bill for federal DISH reimbursement for accredited MOSOTC beds. This could be worth up to $5.0 million to the state's General Fund, greatly offsetting current per-day expenditures at the facility. This is a complicated process that will require DMH to figure out how to create room under its current DISH cap over the next three years.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

WADE TUPRIN,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case no. 06CV0761-W-GAF-P
	)	
STATE OF MISSOURI, et al.,	)	
	)	
Respondents.	)	

Response to Order to Show Cause

This Court should deny Turpin's petition for habeas relief because Turpin defaulted on all of his claims for relief and cannot overcome his defaults. The Circuit Court of Cass County found Turpin to be a sexually violent predator and civilly committed him to the Missouri Department of Mental Health. Turpin is currently imprisoned in the Missouri Sex Offender Treatment Center in Farmington. The proper respondent in this case is Alan Blake, the center's chief operating officer. Rule 2(a), Rules Governing §2254 Cases in the United States District Courts. Respondent prays, as an initial matter, that this Court dismiss the State of Missouri and the Missouri Attorney General as respondent and substitute Blake as a party respondent.

Turpin raises twelve claims in his petition:

1. The judge in the civil commitment proceeding was biased because he also heard other prior cases involving Turpin.

EXHIBIT 3A

Chief Operating Officer
Missouri Sexual Offender Treatment Center
1016 West Columbia Street
Farmington, Missouri 63640
573-218-7079
alan.blake@dmh.mo.gov

From: Reynolds, James
Sent: Wednesday, February 07, 2007 9:38 AM
To: Blake, Alan
Subject: RE: Psychiatrist Available -- Contact Jeremy Alexander

Alan, that is one of the most depressing emails I've seen in a while. I must bow to your place of honor as the most sucky system right now. I have often felt we at Northwest did more, with less, at least doctor wise than anywhere else. That was hands down true when Woodson was burdening us as well as the main building. At least MSOTC in the old days didn't have to worry about accreditation. But now, it seems you guys have definitely passed us.

In Colorado, and this is easy to research, the major players are all still there, in 1997-1999, the state hospital was woefully understaffed. Then 5 suicides happened in 18 months. I was fortunately not tainted by any, and left in April 99, but over the next three years they had a major class action Federal lawsuit that was finally settled. The legislature then and only then passed legislation increasing line staff on forensics (330 beds) by 64 new FTE's, and ordering the physician FTE's increased immediately from I think 7 ward doctors to 13. Of course, even then I think the other nonforensic divisions were left out, causing considerable friction among employees. But you can only imagine the heartache suffered by the providers who *were* unfortunate enough to be holding the bag when those bad things occurred, that of course were only in part their fault, if at all.

From: Blake, Alan
Sent: Wednesday, February 07, 2007 9:28 AM
To: Reynolds, James
Subject: RE: Psychiatrist Available -- Contact Jeremy Alexander

I am glad to commiserate. You are preaching to the choir. There is no room for a reasonable judgment in good faith that does not turn out, or the best service with the resources available not being enough.

The state keeps trying to get by on the cheap. Major corrective change (and not done very well) when a crisis, tragedy, or major public embarrassment occurs. This is no way to manage a system. Our facility has passed NWPRC in census, and we have half the infrastructure and support. We are a disaster waiting to happen. We have older residents with major physical issues. We have a good full time general physician (by luck only), but we do not have the capacity to operate a skilled nursing facility or hospital wing. Conditional release of sex offenders, much less sexually violent predators, to a skilled nursing setting has recently been a state controversy. I fear are going to have some major care failure that will contribute to my early retirement. (And that is beyond the thug element we are getting from the prison system – I worry about serious assault of residents or employees by one of these fellows that spent years in administrative segregation or supermax in DOC due to assaults and in one case, an in-DOC murder.)

EXHIBIT 4

yes on these guys, and if they go out and don't get in trouble no one cares. But if they go out and re-offend, I'm responsible." Needless to say, we didn't invite him back, but it does get you to thinking.

Sorry for long-windedness.

Jim

From: Blake, Alan
Sent: Wednesday, February 07, 2007 8:03 AM
To: Reynolds, James
Subject: RE: Psychiatrist Available -- Contact Jeremy Alexander

Given the staff challenges, I try to circulate such information, lest other facilities in need did not receive it. Something has to change for DMH to more easily recruit quality professionals in the future. The department is fortunate to have each one of us, but at time will come that it will be unlikely we may be able to recruit qualified colleagues.

If we would have been allowed to bring David on board we would have snatched him up. We still speak in him in glowing terms. All of us seem to have had a very positive experience with him. Unfortunately DMH is not willing to applying the values it espouses or things would be different.

Alan Blake, MS, LP
Chief Operating Officer
Missouri Sexual Offender Treatment Center
1016 West Columbia Street
Farmington, Missouri 63640
573-218-7079
alan.blake@dmh.mo.gov

From: Reynolds, James
Sent: Tuesday, February 06, 2007 4:24 PM
To: Blake, Alan
Subject: FW: Psychiatrist Available -- Contact Jeremy Alexander

Obviously Alan, as a UT Memphis grad this doctor by definition is a quality prospect. And he/she trained in literally God's country, eastern Tennessee, making for an even more desirable acquisition. Unfortunately for them, fortunately for me, I have no acute need right now. But I very much appreciate you thinking of us. Please feel free to forward any such notices, and I will do the same if you are looking.

P.S. I remain so grateful to you for Dr. Sternberg. He came from this same outfit. I literally think I would not be here right now had he not come along to help me through my critical staffing shortage. I hope he is now in turn

Gowdy, Rick

From: Enke, Teri
Sent: Tuesday, August 18, 2009 11:05 AM
To: Gowdy, Rick
Cc: Hartman, Lana
Subject: FW: New Decision Item Justification for SMMHC/SORTS and TJC
Attachments: FW: SMMHC - SORTS FY11 Decision Items - side discussion; FY11SORTS Positions New DI FTE Justification.xlsx

Importance: High

Rick - here are back-up e-mails for the 2:00 meeting today. (Karen, Alan and Julie have already received.)

From: Vincenz, Felix
Sent: Monday, August 10, 2009 2:01 PM
To: Blake, Alan; Adams, Karen; Inman, Julie
Cc: Reeves, Steve; Parks, Joe
Subject: FW: New Decision Item Justification for SMMHC/SORTS and TJC
Importance: High

Per Joe, the increase from $830K to $1.5M is based on 2 facts:

1) The historical ward request never factored in the increased staffing need for TJC – Joe buys this, but Keith does not, because we claimed that our conversion plan post detainees retained sufficient staff to get TJC accreditation – he'd buy a modest increase to 890K, but nothing beyond this.
2) The need to have their ward staffing be equivalent to that of SMMHC – Joe doesn't buy this

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From: Blake, Alan
Sent: Friday, August 07, 2009 4:40 PM
To: Reeves, Steve; Inman, Julie; Adams, Karen
Cc: Parks, Joe; Vincenz, Felix; Schollmeyer, Vicki; Bross, Brad
Subject: RE: New Decision Item Justification

For many years we have been operating based on a decision that we could not ask for the numbers needed. We keep slowly pulling resources from APS and the region. At some point we need to compensate or stop pulling lest we begin to create more visible problems for the other side of our (now) house. We are also now vulnerable to claims that we offer inferior treatment in that we are not staffed at a similar rate to other areas of the facility and thereby are providing inadequate treatment. The next lawsuit discovery may well ask from the whole facility and the disparities will be evident to a good attorney. We need to do TJC level assessment and treatment planning. That takes clinical staff time we have been pushing to be providing treatment. We can pull them from treatment, but then we have a present lawsuit that expects our treatment rate to remain high, and should it not be, our AGs have suggested we may have an adverse ruling. We need adequate staff to run this facility adequately and safely.

From: Reeves, Steve **Sent:** Friday, August 07, 2009 4:08 PM

To: Inman, Julie; Adams, Karen; Blake, Alan
Cc: Parks, Joe; Vincenz, Felix; Schollmeyer, Vicki; Bross, Brad
Subject: FW: New Decision Item Justification for SMMHC/SORTS and TJC
Importance: High

Hi Julie,

EXHIBIT 5

Questions for DMH after book review:

What is the 5% inflationary rate for the pharmacy contract based on? *This is written into the original contract with our pharmacy provider.*

Is the 5% annual increase written into the contract? *Yes*

These are people/services not medications, correct? *Yes*

Why is Northwest PRC pharmacy so much higher than the other facilities? *There were some staffing changes to the core pharmacy service (not the Advanced Practice portion) at NMPRC. Please see line item 007, third renewal period in the amendment to contract C307128001 (attachment #1). We have also included the complete contract history in regard to NMPRC (attachment #2).*

MHD estimates the increase in pregnant women being 6.53%, where does the 11.58% come from? Was it just preliminary information? David

Book 1, p 94, Are all of these part of the current contract agreements? Could any of these go to GR without jeopardizing the relationship? *Yes, these payments are covering actual contract provisions such as food service or emergency room services. Therefore, diverting these funds would result in an actual cut to facility budgets.*

Book 1 p 257, is this new federal grant funding? How do we get cash to support this reallocation? *Funding for the Prevention State Incentive grant has expired, so we are requesting this authority be moved back to ADA Federal Block Grant. This individual was moved to the prevention grant on a time-limited basis, and the funding needs to follow her back to ADA block grant funding. Block Grant cash not used while position was funded with Prevention State Incentive grant were used as one-time funds for prevention programming.*

Book 1, p 272 & 273, are we currently doing the detox beds at Truman? *Yes, those started on June 15, 2009. We contacted OA B&P on this issue prior to approving.*

The federal $ reallocation from adult community to the CPS facility support, how is that being earned, what does it support now? *Funding comes mainly from Medicare Part D and CPS operated DD waiver beds. These funds may or may not be available year to year, but DMH was proposing using these funds if available to reduce the likelihood of a GR supplemental request.*

What is the difference in FY10's ndi and FY11's ndi for the MSOTC expansion 7 months funding? FY10=830,124 & 17.4 FTE/ FY11=1,040,088 & 20.10 FTE.

[redacted]

[redacted]

For many years SORTS has been operating based on a decision that we could not ask for the numbers needed. We keep slowly pulling resources from APS and the region. At some point we need to compensate or stop pulling lest we begin to create more visible problems for the other side of our (now) house. We are also now vulnerable to claims that we offer inferior treatment in that we are not staffed at a similar rate to other areas of the facility and thereby are providing inadequate treatment. The next lawsuit discovery may well ask from the whole facility and the disparities will be evident to a good attorney. We need to do TJC level assessment and treatment planning. That takes clinical staff time we have been pushing to be providing treatment. We can pull them from treatment, but then we have a present lawsuit that expects our treatment rate to remain high, and should it not be; our AGs have suggested we may have an adverse ruling. We need adequate staff to run this facility adequately and safely.

How much net funding did DMH actually get from the DD certification fee? How much for the .5% COLA and how much for the 125 individuals off of the waitlist? Where is the fed draw down on the DD certification fee being spent? *DD has not collected any certification fees in FY 2010. The certification fee for FY 2010 will be collected in April/May. The total proceeds collected cannot exceed the current cost of DMH staff performing Certification/Licensure visits. Payroll, fringe and EE costs for Certification/Licensure staff in FY 2010 are projected to be $1.5 million. The .5% COLA was approximately $1.0 million. The remaining certification fee proceeds is planned to support 50% of the Prevention Waiver state share. Local Senate Bill 40 Boards will pay the other 50% of the state share costs.*

Transformation ends 9/29/2010? Do we have inflated authority for FY11? *The Transformation Grant will expire in FY 2011. In addition, there will most likely be some carry-over of grant funds. Therefore, we won't have to reduce this appropriation until FY 2012.*

Book 1, p 217, How will the ICF/MR switch to group homes affect the UPL? Will we still earn as much? *Yes. The funding we receive in our FED fund to support community programs were replaced by GR in the FY 2010 transition changes. Going forward, we will continue to analyze the impact of UPL; however, we do expect to support the GR portion of UPL through FY 2011.*

Gowdy, Rick

From: Blake, Alan
Sent: Thursday, August 06, 2009 12:16 PM
To: Vincenz, Felix
Subject: FW: SMMHC - SORTS FY11 Decision Items - side discussion

I ramble again and take advantage of you.

I have a worried sense that the budget is being driven by Steve and the money people, not by policy folks and need. Note that from my estimate, the initiative to have SA in treatment team meetings is essentially not funded, nor is having a career path for SAs. We need at least 3 more SAs, and we don't have enough clinical or support staff to fill the coverage gap (in part because of recruitment and in part because of the need to keep treatment rates up to demonstrate our commitment to the courts to provide care at a constitutionally acceptable level). Please do not let them take out the MHM 1, as we need another unit manager to keep up with all that is going on. I am forgoing a UPS for a LPC (or when we get there, LCSW if one miraculously appears on the doorstep and wants to be a team leader / UPS). My fear is that we can get neither, but I am trying to move toward a reorganization that had clinical team leaders.

Also, this 7 months funding is getting behind the curve in terms that we seem to run out of funded space before the next ward is funded. Even with the detainees gone, I estimate we will be over census before the ward is funded.

I know this is a very difficult budget year, but even when it was not, there was very little catch up. I continue to be concerned that this ongoing minimal funding keeps us on the edge of adequate and inadequate, and in a federal court's view, even our adequate may be inadequate enough for a seriously adverse ruling.

Constitutionality of SVP Laws....

I don't think I sent you an article my counterpart in New Hampshire forwarded regarding the SVP laws. There is a lot of information about the litigation in Washington and how that state got into trouble.

Other headaches, a lawsuit that is requiring more discovery. Fortunately no pro bono attorney, but the learning from other lawsuits on the part of some of the residents is advancing rapidly so that we have to take time to respond. I have to complete some interrogatories and it will take awhile. This one may not make it to court, but the legal questions raised could keep it alive for a bit.

Alan Blake, MS, LP

Chief Operating Officer
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NOTE NEW FACILITY NAME

Our Values: RESPECT, EXCELLENCE, COMPETENCE, EMPOWERMENT, SAFETY, COMMUNICATION - R-E-C-E-S-C

EXHIBIT 6

If we go by hospital standards we need to have nurses on wards. To cover seclusion and restraint, we need adequate medical staff to provide coverage to meet standards.

If we reduce treatment to 1 ½ per week, we can greatly reduce needing to hire more psychologists and social workers. If we went with a psychologist per ward and they were ½ time team leaders / ward administrators, we could eliminate UPSs – if we can get / keep truly qualified psychologists for the SVP population.

From: Vincenz, Felix
Sent: Monday, July 07, 2008 12:08 PM
To: Vincenz, Felix
Subject: FW: MSOTC FY10 New Decision Items
Importance: High

From: Vincenz, Felix
Sent: Monday, June 30, 2008 8:51 PM
To: Blake, Alan
Subject: FW: MSOTC FY10 New Decision Items
Importance: High

With the lawsuit(s), census, pressures associated with the detainee moves, and anticipatory stress associated with JCAHO/CMS accreditation/certification, I can well appreciate that your staff feel beleaguered and besieged. However, let me assure both you and them how much we appreciate the extraordinary efforts that have been expended, on behalf of your consumers, their families, and the public's trust. You have all done an extraordinary job, and have developed a program that is the source of considerable pleasure and pride that are shared by Rick, Joe, Keith and myself. Please, please convey that to all involved. It is a message I hope to reinforce when Becki and I come and meet with you and your executive team.

Now, having said that, I'm not even sure I follow the request that was submitted, Alan. Back when we were doing the calculation regarding the detainee moves and the impact of converting SA staff positions associated with the detainee wards to professional staff necessary to meet JCAHO certification, we had all agreed that what we were requesting was going to get us there. Asking for additional FTE in today's fiscal environment is a virtual non-starter. However, I agree that we need to carefully monitor your census. If commitments accelerate like we fear, we will need to do something , first as a supplemental item, then as a cost to continue.

Feel free to give me a call at home (I'm off this week) and discuss this further. Also, I assume that this was twixt you and me, so I didn't copy Karen. However, do feel free to cut and paste whatever sections of my reply you'd like her to see.

From: Blake, Alan
Sent: Monday, June 30, 2008 12:56 PM
To: Vincenz, Felix
Subject: RE: MSOTC FY10 New Decision Items

I must protest. I fully believe we will be over census and unable to meet JCAHO standards if we keep doing this 5 month delay. We are at census currently. If we move 3 wards out, we might get by with it in 09, but we are averaging 20 referrals yearly for the past 3 years, and we anticipate a greater number of detainees will stipulate to get out of jail and back to MSOTC.

As it is I am starting to have problems keeping management staff from getting discouraged and giving up. They are worn out, frustrated distressed and wearing out. (I try to have them take off to make up for all the extra hours because of the signs of burn out, but then they get further behind and adds to their sense of failure.) Because of the risk level and lack of experienced staff, we are considering changing our schedules so a senior manager is on duty evenings and maybe nights. However, if we do that, it is not possible to be in one's office as it is necessary to be on the wards problems solving almost constantly, so again, another way resulting in getting further behind. Having reasonable resources is all they want. The comment at our risk management meeting was, "We are the DMH redheaded step child and they don't care if we fail." In arguing against that view, the reply is that what "they" do to let us do our job is what tells not what is said. There is a lot of unhappiness here.

From: Inman, Julie
Sent: Monday, June 30, 2008 1:20 PM
To: Reeves, Steve

EXHIBIT 7

This is confusing. There appears to be some overlap. I think these are the positions included in Julie's email.

We have 1.20 Staff Physician Specialist (psychiatrist) in our current budget. We hoped for another psychiatrist to provide adequate coverage regarding seclusion / restraint, monthly notes, annual assessments, etc.

We are seeking enough nurses to move toward covering all of our wards to allow a RN on every shift, every day. (25.5 for 5 wards or 30.6 for 6 wards – assuming all the detainees left – now we are essentially up to 6 wards and anticipate need the 7th ward for new committed this year - 35.7 RN IIIs). The current budget has 25.5 FTE. (We are also converting 5 of these to RN IVs so we can provide for RN house supervision on evenings, nights and weekends.)

We want an additional general physician due to the many medical coverage issues, as well as to back up when a physician leaves.

We need more clerks to handle the increased volume of medical record documentation.

I want a 3rd Unit Manager as there is so much going on that the two we have cannot keep up, despite their best efforts and extra hours. The unit managers will be responsible to see that standards are maintained. As it is, the two unit managers spend 75% of their time putting out fires, and have limited time to monitor and take corrective action to meet standards, do performs, supervise, train, oversee unit programming, etc.

From: Vincenz, Felix
Sent: Tuesday, August 19, 2008 1:53 PM
To: Blake, Alan
Subject: FW: MSOTC FY10 New Decision Item Request - Discussion with Alan
Importance: High

I'm doing a critical issues paper for MSOTC – I need additional information as to the 11.6 FTEs you thought were needed to get JCAHO accreditation (see Julie's e-mail below). I want to verify that these are above and beyond the 11 FTE in the attachment immediately below, which included meeting both behavioral health and hospital standards when we first talked about the grand plan. If above and beyond, I will need to know: (a) what types of FTE and; (b) the numbers you already have in those same classifications, which I will then inflate with the numbers in the attachment immediately below to determine if I agree with you J

From: Blake, Alan
Sent: Tuesday, July 01, 2008 10:25 AM
To: Vincenz, Felix
Subject: RE: MSOTC FY10 New Decision Items

You are right. It is a huge request. It is unreasonable because prior (to your present position) requests were unreasonably low and inadequate.

It is the request to do it right (or at least closer). We have been getting farther and farther behind. That is why I initiated the behavioral health structure in order to reduce the impact of the inadequate funding of this facility for YEARS, and find a way to operate for less. That is why we cost $200 - $220 per day per consumer when the other long term facilities cost much more.

Some of our assumption was that Behavioral Health Standards would be applied back when. We did not assume providing 8 hours per resident per week of SVP specific treatment. Now Hospital Standards are necessary. That adds need for persons to do the additional thing required by JCAHO / CMS (and in a somewhat short period). If we are to seek accreditation with current staffing levels and patterns, we will need to significantly reduce treatment to assure that assessments, documentation and treatment plans are in place. We have greatly streamlined to produce maximum efficiency. The rate of treatment is much greater than most other DMH facilities (and remember, for this suit, psycho-social, education, substance abuse, and almost everything else we do that is therapeutic from your view, does not count per the view presented by the AG.)

We do ITPs every six months. We are proud that our residents participate (if willing), know what goals on their ITP, and are in the discussion as to whether they do or do not meet the goals at the end of each semester. Given the long term nature of the population, every three months is not especially helpful. We have a medical care section for each resident with ongoing medical issues, and it is updated as needed. We are working on a short term mechanism for short term issues. All these we are trying to better integrate. I will be sad to end up doing what the other facilities do, as I think we are doing better for the residents than I've seen in other places.

We do a Comprehensive Social History on the front end, but no annual social histories – we let the annual assessment of mental status cover for all the annual assessments. The annual assessment includes any new social history information, there is a med / psych update included (usually by our very competent advanced practice nurse). Currently these are done by psychologists and more senior social workers. We do minimal documentation for physicals, etc, and will not meet standards without someone to be assessing and writing those reports.

Blake, Alan

From: Blake, Alan
Sent: Friday, April 06, 2007 10:10 AM
To: Inman, Julie
Subject: FW: Ramifications of core cuts for MSOTC

Alan Blake, MS, LP
Chief Operating Officer
Missouri Sexual Offender Treatment Center
1016 West Columbia Street
Farmington, Missouri 63640
573-218-7079
alan.blake@dmh.mo.gov

From: Vincenz, Felix
Sent: Friday, April 06, 2007 8:39 AM
To: Blake, Alan
Subject: RE: Ramifications of core cuts for MSOTC

The senate was much more understanding and kept the budget item open for further discussion in reconciliation committee with the house. Continue to stay tuned....

From: Vincenz, Felix
Sent: Wednesday, April 04, 2007 6:07 PM
To: Blake, Alan
Subject: RE: Ramifications of core cuts for MSOTC

We're trying to work on something. Stay tuned....

From: Blake, Alan
Sent: Wednesday, April 04, 2007 11:49 AM
To: Gowdy, Rick; Vincenz, Felix

EXHIBIT 8

4:05CV2022 In Camera-6607

6/8/2007

SORTS 0002153

Cc: Bax, Bob; Henry, Patty
Subject: Ramifications of core cuts

In further follow-up to discussions regarding the impact of the House core cut to MSOTC, I offer these thoughts:

Out of the $1.3 E&E not tied to personnel benefits, the roughly $600,000 cut is almost half of the E&E available. There are four major spending items greater than $100,000 in the FY 07 allocation: Medications ($362,850), food / dietary supplies ($268,507), supplies ($162,300) and professional services (contract lab, medical services and other professional services - $ 432,612).

With medication, if we go to a fail first system of going back to the older drugs, there is some savings in the sho run as noted below, but potential major losses and expense in the long run. The savings might amount to $95,000, if our census does not increase (and it is increasing). Expense will increase as Dr. Englehart will withdraw services from the facility due to ethical concerns, and we will not have a means to offer psychiatric services as the ANP will no longer be allowed to practice without a psychiatrist sponsor. Being unable to offer psychiatric services opens us to a lawsuit for substandard care, as well as we will have several persons in psychiatric crisis and by law unable to refer to a DMH facility. (We may be able to refer to a community facility - the nearest being Crystal City or Saint Louis, if accepted - for acute care, but we will have a revolving door, and greatly increased expense for hospitalization in a private setting plus DMH staff required to provide 24 / 7 supervision.) All this opens us to a federal lawsuit for providing substandard care. A successful lawsuit in this area will cost the state millions.

Food costs can not be reduced, and are likely to increase due to census increases and inflation.

Professional services may only be reduced by ending a variety of medical and dental services. We are actually over budget at of February ($178,227). We have an individual scheduled for cancer treatments, two scheduled for joint replacement, have changes not received for an individual sent to the ER with a heart attack, then to a medical center for three days in intensive cardiac care (unfortunately he died). Given the time these bills are submitted and paid, some or all may not be process until next fiscal year. We receive reduced cost due to an innovative contract with an insurance company initiated by Dr. Englehart (a significant savings per year). Based on past history we may anticipate several major surgeries in the next year. We will not be able to cover the cost of these surgeries for the E & E appropriation and provide other necessary . operations expenses. We may cap what we will provide, and only allow life saving procedures. In that scenario, we do not fund joint replacement, some cardiac procedures must be managed by medication (by which time we have now cut back on), not provide dentures, hearing aides, etc. However, this again places the Department at risk of legal action regarding substandard care.

Trimming all other areas will not provide any substantial gain, and will reducing the ability of the facility to provide normal and necessary services.

Bottom line is that if the core cut stands, any areas for cut back will substantially impair the operation of the facility. As this occurs, it may realistically be expected that most professional employees will begin to seek employment elsewhere due to ethical and safety issues. The facility will take on the effect of a prison and be in violation of Supreme Court rulings. The residents will likely initiate legal action for which the department and state will have difficulty mounting a defense.

From: McCarver, Mike
Sent: Monday, April 02, 2007 10:48 AM
To: Blake, Alan
Cc: Englehart, Jay; Inman, Julie
Subject: RE: Legislative Inquiry

Below is the rough estimate of the savings per month if all the MSOTC patients were switched over to Haloperidol (20mg average dose per day). Haloperidol is an older Antipsychotic medication.

Blake, Alan

From: Blake, Alan
Sent: Thursday, November 15, 2007 2:29 PM
To: Turner, Marilyn
Subject: RE: largest hospital for sexually violent predators in turmoil

It is very short sighted, very expensive, and there is little effort to identify potential offenders and seek to intervene before there are offenses.

I will say that we are making progress with some of our fellows. Others...

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-----Original Message-----
From: Turner, Marilyn
Sent: Thursday, November 15, 2007 2:28 PM
To: Blake, Alan
Subject: RE: largest hospital for sexually violent predators in turmoil

The whole mess is a bad situation all around. Not that I have a lot of sympathy for sex offenders, but I think the net has been cast way too wide, and, US Supreme Court notwithstanding, I think that locking people up after they've served their sentences is just wrong. If we want to keep them out of circulation, pass the laws that will keep them in prison. It's more honest.
And as you point out, the community doesn't want them and can successfully keep them out. Seems shortsighted to me. I'd rather know that they lived down the block instead of knowing that they were under some bridge somewhere.
Once again, my opinions are not mainstream.
M.

-----Original Message-----
From: Blake, Alan
Sent: Thursday, November 15, 2007 2:21 PM
To: Turner, Marilyn
Subject: RE: largest hospital for sexually violent predators in turmoil

I met some of the folks from California at a conference in San Diego a couple of weeks ago. This is relatively accurate. The really sad part about the ones released by the court, two of them have not been able to find placement after over a year. The court finally insisted they be released, and consequently, they are homeless.

Alan Blake, MS, LP
Chief Operating Officer
Missouri Sexual Offender Treatment Center
1016 West Columbia Street
Farmington, Missouri 63640

EXHIBIT 9

Blake, Alan

From: Blake, Alan
Sent: Wednesday, February 07, 2007 10:05 AM
To: Reynolds, James
Subject: RE: Psychiatrist Available -- Contact Jeremy Alexander

We are so far from JCAHO that I can not conceive of it. The Colorado situation is unnerving

For lawsuits, we have had over 50 filed – mostly frivolous. One has made it into federal court. 5 or 6 are still pending. All relate to conditions of confinement. I periodically am best friends with a new assistant attorney general. Dr. Gowdy insists my last name is Vs.

Felix passed the below email from the superintendent at Larned State Hospital in Kansas on to Rick and me - The KC Star had a couple of article on it that you may have read:

From: Mark Schutter [mailto:MES0309@lsh.ks.gov]
Sent: Tuesday, February 06, 2007 8:56 AM
To: Joann O'Connor; Vincenz, Felix; Jeff Buttler; Bill Gibson; SCOTT VINIARD; Helen stevens; Cynthia Kelley; Robert Lee; Dave Hartford
Cc: Michelle Robinson; Barbara Mongeau; Pam Melton
Subject: SVPSs and Kansas

Secondly, you may have heard that LSH is getting shot at in the media. It is a long story which I can complete if you care to give me a call at 620-285-4360. To give you a quick sketch, residents of our Sexually Violent Predator program were able to call and write to CMS, portraying themselves as seriously abused psychiatric patients. This resulted in the Kansas Department of Health and Environment coming out to do a survey under CMS contract, which turned up housekeeping and water temp issues, and one patient choking death a few months ago which occurred despite a special dysphagia diet and etc precautions. We submitted requests for corrections to the facts alleged and language used, all of which were rejected. No patients from our regular psychiatric or forensic programs lodged any complaints.

The KDHE then sent the preliminary report to one of the sex predators, who began contacting the media and this resulted in quite a free for all. The SVPs are continuing to contact everyone and anyone with complaints, but legislators and the public are beginning to catch on to who they are dealing with. Last Friday three SVP's ,managed to call in to a Ks. Public Television show in which legislators took phone calls from the public on the air - and made more allegations. Quite a deal!

The Plan of Correction for issues that required attention has been accepted and is reaching full implementation. KDHE will come back and resurvey within the near future. We continue to remain in good standing with CMS. The vast majority of the standards cited were KDHE, not CMS. Call with questions if hearing more about our experience can be of some help to you in warding off similar issues.

I love my job!!!

Mark

Alan Blake, MS, LP

EXHIBIT 10

4:05CV2022 In Camera-7300

6/26/2007

SORTS 0001285

Estimated savings per month if Haloperidol was used in place of the Atypical Antipsychotic agents: $8,716.27 per month

Estimated costs of discontinuing all the MSOTC PRN medications except for some pain meds: $100-200 per month

As Dr. Englehart mentioned in his e-mail the newer generation Atypical agents have many advantages over the older agents in regard to the side effect protocol. Unfortunately they are very expensive.. JCAHO considers these newer agents the DRUGS OF CHOICE FOR TREATMENT OF PSYCHOTIC PATIENTS.

From: Blake, Alan
Sent: Monday, April 02, 2007 10:22 AM
To: Gowdy, Rick
Cc: Vincenz, Felix
Subject: Core Reduction MSOTC

We have been trying to find how to make a $600,000 core reduction and the ramifications. In E & E it is not there. Our total allocated E & E is $1,378,426, not including staff benefits. The only places to reduce are in medical and pharmacy by putting a cap on services, and by going to a fail first system with medications. Medical / Dental as of February is up to $500,000. If we don't have cancer treatments, joint surgery, cardiac by-pass and stents, gall bladder and other similar interventions, even that will not make it up. (and we will be subject to a difficult to defend lawsuit). If we would do any thing in this manner, most nursing and medical staff will leave, and most professional staff will follow. At that point we become a prison.

If it comes out of staff, we have major service reductions, thereby slowing any progress toward discharge, and security issues will increase as well in that we will have an increased number of residents with time on their hands.

From: Blake, Alan
Sent: Monday, April 02, 2007 9:28 AM
To: McCarver, Mike
Cc: Englehart, Jay; Inman, Julie
Subject: Legislative Inquiry
Importance: High

To respond to a legislative inquiry, we need an estimate of costs savings if all MSOTC residents on 2nd generation psychotropic medications are changed back to the earlier psychotropic medications. (perhaps a month estimate?). Additionally, if all PRN medications were discontinued (except Tylenol / ibuprophen and similar OTC pain relievers) what might the cost reduction per month be?

Gowdy, Rick

From: Gowdy, Rick
Sent: Friday, October 10, 2008 1:52 PM
To: Blake, Alan
Cc: Shine, Liz; Vincenz, Felix
Subject: RE: SVP Release DOR

10-10-08.

Dr. Vincenz and I reviewed your proposal and have some questions and suggestions. Since we already have a call scheduled for next week we can discuss this with you then.

Also, I met last week with Scott Johnston of P&P; initially to discuss making sure both P&P and MSOTC are aware of those residents who have ongoing P&P responsibilities, but we also discussed the need to begin to consider supervision of residents on release. It will be essential that P&P is closely involved with your staff in the release process since they will providing monitoring. Remember, with the passage of the lifetime supervision legislation, at some point in the future most MSOTC residents will have an ongoing responsibility to P&P as the result of both their criminal commitment and their civil commitment. We can discuss your working with the local P&P staffs on Thur as well.

Whatever Mr. Burdick's arguments may be, you haven't referred anyone for release because you haven't determined anyone to yet be clinically appropriate. Clearly some of your residents are moving forward in treatment; treatment with this group of sex offenders is difficult and public safety requires a careful, deliberative process.

RNG.

Confidentiality Statement:

From: Blake, Alan
Sent: Friday, October 10, 2008 11:00 AM
To: Gowdy, Rick
Cc: Shine, Liz; Vincenz, Felix; Rosenboom, Jonathan; Meade, Linda; Weiler, Mary; Light, Sheila; Hartman, Lana
Subject: SVP Release DOR

I am nagging you about the SVP DOR and getting it in place. We have a challenge from Tim Burdick regarding the constitutionality of the release process and our lack of movement thereof. I have asked Sheila to fax a copy to you.

Not having a procedure in place strengthens his argument, in addition to not having given agreement to any petition. Some of our inaction at this level is because we don't have a procedure, although we are getting ready to look at three residents for a conditional release path. (It would be helpful to have a step down unit in the fence and a cottage outside, but we don't have the funds for the step down unit any more, and SMMHC tells me they have full cottages.)

EXHIBIT 12

deficiencies resulting in abuse and neglect in Missouri's DMH's service system, including:

- DMH's inability to recruit, train and retain direct care and key clinical staff in both CPS and MRDD facilities. Examples: Marshall Habilitation Center routinely operates with at least 60 direct care staffing vacancies, exhausting available staff through mandatory overtime. The annual turnover rate for psychiatrists and nurses at CPS facilities exceeds 30%. These phenomena are occurring in many other DMH facilities.

- A similar crisis is occurring in DMH contracted community provider agencies, whose starting pay for direct care staff is between $7-8 per hour for direct care staff. (By contrast, DMH pays $10 per hour and still cannot recruit enough direct care staff.)

- MRDD has statewide inconsistencies in eligibility determination, service planning, waiting list criteria, case management and treatment services.

- CPS housing services are inadequate, relying heavily on large, under-funded residential care facilities.

- Hundreds of individuals who are seriously mentally ill or alcohol and/or drug dependent are also chronically homeless.

- MRDD central administration does not have the clinical leadership necessary to assure high quality care in its state operated and community placement programs forcing MRDD to hire expensive consultant companies to perform basic clinical quality control functions.

3. **Need for Better Mental Health and Medical Service Interface**

According to recent research involving eight states, including Missouri, persons with serious mental illnesses (SMI), on average, will die 25 years earlier than the average American. The majority will die from the same diseases that will also kill most of the rest of us, including complications from diabetes, cardiovascular diseases, COPD, etc. But DMH consumers will die much earlier; many of the reasons are obvious, including poverty, poor nutrition, lack of exercise, and the side effects of powerful psychotropic medications. Frequently, they will die earlier because of uncoordinated medical care. As Dr. Joe Parks, DMH Medical Director, likes to say, "We probably can't get too excited about eliminating psychiatric symptoms or improving a patient's behavioral functioning by a few points if s/he going to die on us at age 50 from a medical disease we could have treated!" DMH can no longer be content to focus solely on a psychiatric illness without attending to the individual's broader physical health needs. This is equally true of the consumers in ADA and MRDD.

4. **Inability of DMH Facilities Efforts to Move Residents to Community Placement:**

- Seven of ten residents in state psychiatric facilities are "forensic" patients, either determined incompetent to stand trial for a committed crime, determined not guilty by reason of insanity, or deemed a sexual predator in need of treatment after lengthy stays in a Missouri Corrections facility. Once DMH has treated these patients and deems them ready to leave an institutional facility, their right to community placement is at the committing court's or local prosecutor's discretion. Judges are reluctant to release such patients. As a result, DMH

psychiatric inpatient facilities are backing up, admitting far more commitments than discharges. This, in turn, clogs acute care facilities, which must hold patients longer who are awaiting admission into state long-term psychiatric care. This system "constipation" forces state facilities to operate beyond 100% of capacity for long periods of time, exhausting staff, causing staff overtime and high turnover rates, and inevitably increasing the risk of staff injuries and patient abuse and neglect.

- A similar problem is now increasingly occurring in state-operated MRDD habilitation centers from forensic referrals, the admission of a younger population with borderline intellectual functioning and severe behaviors or sexual deviancy, and refusal of guardians to allow community placement.

5. Need to Link Critical Mental Health Services to other Human Service Programs

- Approximately 9,700 children are in Children's Division custody. Over 35% been placed in custody because of substance abuse (2,900) or alcohol abuse (850) by the parent(s), and some for both. Most children removed believed that they did something wrong that cause their separation from family. All need mental health screening and counseling, while their parents need comprehensive assessment and intensive substance abuse treatment.

- Despite tragedies such as those at Columbine High School and other schools across America, only nine Missouri school districts have qualified mental health professionals serving in a formal school-based mental health program. Seven additional Missouri school districts have written grants for school based mental health services.

- Over 15% of all incarcerated inmates in Missouri Corrections facilities have a diagnosed serious mental illness such as schizophrenia, bi-polar disorder, or major depression, not counting persons with substance abuse problems; 75% of these individuals will re-offend and return to Corrections within five years of release. DMH does not yet have coordinated discharge planning and community treatment services available to these individuals.

- Over 75% of incarcerated inmates have substance abuse problems. One in four known substance abusers that do not get treatment will return to prison within the first year of release, while those who get treatment in prison with continuing care in the community return at a rate of less than 5%.

- One in every 13 admissions to Missouri hospitals are alcohol or other drug related, and over half of those were admitted through emergency rooms. Furthermore, about 22% of psychiatric acute care admissions are persons with substance use disorders. Missouri has only three modified medical detoxification centers that are capable of providing alternatives to hospitalization.

- Over 50% of all incarcerated individuals in the Kansas City Municipal Jail have a serious mental illness, a phenomenon increasingly typical in local jails. Many are homeless. DMH does not provide treatment services, discharge planning, housing supports, or community treatment for these individuals.

- The Department of Health and Senior Services has noted increasing numbers of eldercare hotline referrals associated with mental disorders or substance abuse problems. DMH and DHSS do not yet have mechanisms to coordinate services needed by these referrals.

6. **Special Populations With Unmet Mental Health Needs:** The Mental Health Commission, MH Transformation Groups and the DMH Leadership Team have identified four underserved populations with significant unmet mental health needs:

- ***Missouri Elders*** with mental health problems like depression, dementia, and substance abuse, which often exacerbate with age, personal loss and complicated medical conditions. Missouri elders comprise 13.5% (800,000) of the state's population and will grow to 20% by 2030.

- ***Deaf or Severely Hearing Impaired Children and Adults*** with mental health disorders. 2% of Missourian's are culturally deaf; 1,700 deaf adults have severe mental illness; 500-1,000 deaf children have severe emotional disturbances. DMH has not adequately addressed mental health needs of people who are deaf/severely hearing-impaired.

- ***Missouri Military Personnel Involved in the Iraq and Afghanistan War:*** According to information from a study of 205,097 veterans undertaken by the VA and Duke University, 35.7% (73,157) of veterans reported mental health issues. For the 22,000 Missouri troops deployed to Iraq and Afghanistan, this would equate to 7,900 troops who would need mental health services upon de-activation. The Veterans Administration and state mental health agencies have not yet developed interface mechanisms to assure coordination of federal and state services.

- ***Non-English-speaking Immigrants and Evolving Ethnic Communities:*** Missouri has experienced in-migration of new ethnic populations, including Hispanics, Bosnians/ Croatians/Serbians, Vietnamese, Arabic, etc. DMH must develop appropriate interpreter services, train clinicians for cultural awareness and recruit mental health professionals and natural support agencies and individuals from ethnic population ranks.

7. **DMH Statutory Mandate to Prevent Mental Disorders, Developmental Disabilities and Other Alcohol and Drug Abuse in Missouri**

Missouri DMH is not adequately addressing one of its three statutory missions, that of preventing mental disorders, developmental disabilities and substance abuse (Chapter 630.020 RSMO). There is a perception that prevention is vague and unaccountable, but there examples of specific, measurable prevention objectives that can achieve good outcomes.

- Some developmental disabilities (i.e., fetal alcohol syndrome, spina bifida) can be prevented in children through good prenatal care during pregnancy and by increasing the awareness of the importance of not smoking or using alcohol and other drugs during pregnancy.

- Research shows that children of alcoholic parents are far more likely to become involved in alcohol and drug abuse. We may be able prevent cross-generational substance abuse through preventive education and support for the children of substance abusers.

- Funding and strategies to retain and support direct care staff, both in community residential settings and in state-operated facility programs;
- Funding/strategies to retain and support key clinical positions in community and DMH facility programs, including psychiatrists, psychologists, therapists and nurses;
- Offender reentry programs for co-occurring MI/SA inmates leaving Corrections;
- Specialized services for individuals who are deaf and severely hearing impaired;
- Mental health services for children and their families involved in abuse and neglect situations;
- Creation of a DMH training academy of the scope and quality similar to the academies at the Department of Corrections and the Highway Patrol;
- Funding to support direct care staff training costs for the College of Direct Support program.
- Specialized treatment and housing supports for homeless, mentally ill and substance abusing individuals who are "frequent flyers" e.g. who repeatedly frequent emergency rooms and psychiatric inpatient programs;
- Funding to provide services to eligible persons with developmental disabilities on the MRDD waiting list, and individuals with mental health problems who are newly Medicaid eligible;
- Funding to provide more alcohol and drug treatment on demand;
- Funding to promote accreditation of MRDD, CPS and ADA community providers and MRDD state-operated habilitation centers;
- Funding for specialized mental health eldercare services;
- Funding to promote employment opportunities for DMH consumers;
- Funding for the prevention of mental diseases, DD and substance abuse; and
- Funding to increase public understanding and attitudes about persons with mental disorders, developmental disabilities and alcohol and drug abuse.

DMH EXECUTIVE TEAM SFY 2009 "PROGRAM REDIRECT" PRIORITIES

In addition to seeking new funding for DMH priorities, the Executive Team is committed to redirecting funding in existing programs when appropriate. DMH is considering redirect initiatives in the following programs:

The Missouri Sexual Offender Treatment Program (MOSOTC): MOSOTC provides treatment for sexual predators that have completed their sentences in the Missouri Department of Corrections and are still deemed a risk to society. Two categories of individuals are housed at MOSOTC. The first are detainees awaiting a court decision regarding whether they should be committed to DMH for treatment of their sexually deviant behaviors. The second are individuals for whom court commitments have already been issued. DMH is considering paying county jails to house detainees awaiting court commitment proceedings. For committed individuals who are elderly or medically fragile, but not yet determined appropriate for community placement, DMH is considering creating a special treatment unit at the state-operated Southeast Missouri Mental Health Center (formerly called Farmington State Hospital) for more appropriate treatment.

Conversion of State Operated Acute Psychiatric Centers to Local Community Control: Missouri operates acute psychiatric inpatient beds at Western Missouri Mental Health Center, Metropolitan Psychiatric Center, Southeast Missouri Mental Health Center, and Mid-Missouri Mental Health Center. All these programs are federally designated as *"Institutions for Mental*

[redacted]

From: Englehart, Jay
Sent: Monday, October 29, 2012 12:25 PM
To: Wilson, Roy; Young-Walker, Laine
Subject: RE: Psychiatric Staffing at DMH Facilities - concerns about APRNs

I was warned of this slow creep away from physicians when I was the first to hire an ANP back in 2003 I think. I know this is the model which the prisons are moving toward, but I really do not want have a standard of care or staffing which is equal to that of the prisons. I hope we stay better than that.

Jay Englehart, MD
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Farmington, MO 63640
Office Phone: 573-218-6708
New Email: jay.englehart@dmh.mo.gov

-----Original Message-----
From: Wilson, Roy
Sent: Monday, October 29, 2012 11:03 AM
To: Young-Walker, Laine
Cc: Englehart, Jay
Subject: FW: Psychiatric Staffing at DMH Facilities - concerns about APRNs

Laine this is a very import issue that should be on this month's agenda. While I believe in the rational use of APRNs, this was originally and remains primarily an issue of Psychiatrists' retention!
Roy

-----Original Message-----
From: Vincenz, Felix
Sent: Thursday, October 25, 2012 8:47 AM
To: Wilson, Roy
Subject: FW: Psychiatric Staffing at DMH Facilities - concerns about APRNs

fyi

-----Original Message-----
From: Vincenz, Felix
Sent: Thursday, October 25, 2012 8:03 AM
To: Parks, Joe

EXHIBIT 14

Subject: FW: Psychiatric Staffing at DMH Facilities - concerns about APRNs

FYI

-----Original Message-----
From: Reitz, Robert
Sent: Wednesday, October 24, 2012 12:34 PM
To: Martin - Forman, Marty A.; Vincenz, Felix; Javois, Laurent; Young-Walker, Laine
Cc: Ring, Melissa
Subject: FW: Psychiatric Staffing at DMH Facilities - concerns about APRNs

Here are the concerns raised about using APRN's by Dr. Englehart that were mentioned on today's call.

Laine, was wondering if this needs to be another agenda item for next month's medical director meeting?

-----Original Message-----
From: Englehart, Jay
Sent: Thursday, October 18, 2012 11:06 PM
To: Reitz, Robert; Ring, Melissa
Cc: Inman, Julie
Subject: RE: Psychiatric Staffing at DMH Facilities

This all makes me incredibly nervous, and will have far-reaching consequences for our facilities. My concerns are:
1. In order to do this right, the physician supervising the NP needs to have time to do so, and therefore a reduced patient load themselves. This severely cuts into the cost savings realized, especially if we are paying the going rate for NP's.
2. It is difficult for an NP to take on as large a load as a physician unless the level of supervision is high, without compromising patient care some.
3. It is difficult already to recruit psychiatrists who want to work in our institutional setting. We are reducing the pool of candidates substantially by essentially cutting out those who are unwilling to supervise an NP, and any increased salary will be unlikely to offset those reduced numbers with interest, at least at the levels which could be afforded (probably an increase in the $20K range).
4. All of our facilities, from what I can tell, are moving toward an older, psychiatrically and medically sicker population, with multiple problems. This is especially true in the SORTS units. NP training gives them the ability to deal with relatively simple cases, but does not provide the kind of background to oversee complicated cases, of which there will be progressively more, not less. Some of our specialized units staffed for higher medical acuity can help with this, but in more complicated cases, direct psychiatrist involvement will be needed more often as time goes on. This seems to be working against the goal of providing improved overall, person-centered care for the whole range of medical and psychiatric illnesses as we are doing on the outpatient side with our Health Care Homes.

I recognize the budgetary constraints we are living under, and the desire to give the most efficient cost-effective care we can, but we may need to figure out the best way to deploy these second level practitioners to find a better balance between quality and cost than what I see using my current model of having an NP serve in a physician's stead as a team leader, with supervision occurring outside of team meetings, and usually through record review, rather than in direct observation.

Jay

From: Reitz, Robert
Sent: Thursday, October 18, 2012 11:34 AM
To: Ring, Melissa
Cc: Inman, Julie; Englehart, Jay

Subject: RE: Psychiatric Staffing at DMH Facilities

The PAB recommendation this year was to increase the Health Care Practitioner classification by two ranges, which fell short of our request, but would result in a top end of around $88K if I recall. I've alerted Mark, Joe and James that if we went down this road, we would need to consider using 1%unclassified positions, which would be a departmental priority. We also have discussed recommending to the PAB that the Health Care Practitioner merit position move to unclassified status entirely like we have done with psychiatrists so we don't have to use our 1% positions.

From: Ring, Melissa
Sent: Thursday, October 18, 2012 11:24 AM
To: Reitz, Robert
Cc: Inman, Julie; Englehart, Jay
Subject: RE: Psychiatric Staffing at DMH Facilities

What is being done with regard to Nurse Practitioner salaries, my understanding is that is a problem.

Melissa Ring, Ph.D., MHA
Chief Operating Officer
Southeast MO Mental Health Center;

Phone: (573) 218-6704
Fax: (573) 218-6703

From: Reitz, Robert
Sent: Thursday, October 18, 2012 11:17 AM
To: DMH.CO CPS COO's / Admin Assts; DMH.CO CPS Medical Directors
Cc: Stringer, Mark; Parks, Joe
Subject: RE: Psychiatric Staffing at DMH Facilities

Just so folks know, there are 56 Adult Psych/MH, 22 Child-Adolescent Psych/MH Nurse Practitioners, 36 Family Psych/MH Nurse Practitioners, and 2 Psych/MH Nurse Practitioners licensed by the MO Board of Nursing. I did not check to see if these numbers are mutually exclusive. If anyone is interested, I'd be willing to send a letter to some or all regarding opportunities with DMH. Let me know if you're interested.

From: Parks, Joe
Sent: Thursday, October 18, 2012 10:39 AM
To: DMH.CO CPS COO's / Admin Assts; DMH.CO CPS Medical Directors
Cc: Stringer, Mark; Reitz, Robert
Subject: Psychiatric Staffing at DMH Facilities

In view of our increasing difficulty recruiting and retaining psychiatrists to assure adequate staffing at our inpatient facilities DMH director Keith Shafer will consider and authorize raises for psychiatric staff on an individual facility by facility basis under the following methodology. Facilities with psychiatric vacancies may hire a Psychiatric APN and use the net funding difference between the APN salary and the funding from the psychiatric vacancy to provide raises for other psychiatric staff at the facility. Facilities wishing to proceed in this manner should provide a specific proposal showing all current salaries and funded vacant positions currently and what the revised salaries the new APN and psychiatric staff would be following hiring of an APN. Proposals should be forwarded to myself and Mark Stringer, we will review and forward them to Keith who will then obtain final authorization from OA budget office.

Unknown

To: Bellew-Smith, Marty
Cc: Blake, Alan
Subject: RE: Confidential- Please Do Not Forward

I do not believe that this is an issue of forgetting. I am painfully aware of my timeline deficiencies. For me it is an issue of putting out the fire that is burning closest to me.

Despite the fact that we have had several terse communications from clerks and courts, the fact of the matter is that most of the jurisdictions have NOT complained when the report was overdue, some even months overdue. From a pure Skinnerian point of view what does this teach me about this deadline?

However, internal deadlines typically have more immediate and personally unpleasant consequences for impending or missed deadlines, like the Clinical Leads sending out reminder e-mails or the public embarrassment of being unprepared for an ITP or presentation, or just letting down a fellow clinician in our mutual struggle to provide treatment.

Finally, I am often struck by the unsettling conclusion that direct patient care is one of the last priorities when stacked against all of the other expectations for ITPs, ward management duties, court reports, admission mental health assessments, committee work, recruitment, supervision for licensure, new employee training, staff development, personal development, co-signing progress notes, responding to resident grievances, attending required meetings, reviewing and answering the 100+ e-mail messages received per day, training for the new levels system, etc.

As a former Assistant Superintendent and Deputy Division Director, I am well aware of the management maxim of assigning work and letting people "figure out their way to meet their priorities." Early on, Greg Dale, a big proponent of the Theory X view of employees coached me that employees are cry babies that will complain about any workload. He had also promulgated the opinion that people should work all hours until the job is done, and the administrator has no real obligation to know their supervisees' workload. I accepted that maxim, acted on it in my life, and now one failed marriage later, I disagree.

I can't believe that I am saying this, but everything cannot be a priority at the same time, across all time. As a manager, my responsibility is to know the workload capacity of my human resources and to not over tax that capacity, willingly or carelessly. Crises occur and Herculean efforts are sometimes needed to keep the organization afloat, like stopping all work to write ITPs prior to a survey or getting caught up on duty to warn notifications or having a work stoppage to get late court reports caught up. However, I cannot routinely assign additional duties or inject chaos into the work lives of my employees and expect them to figure it out on their own. I had to recall, that my experience of the organization as an administrator was much different than that of the line clinician. Except for meetings, my work was project oriented. I could carve 4-8 hours, or 2-3 days out of my schedule to respond to the knee-jerk reaction or question of the day from a legislator. That is what administrators do. One day per month at DOC was MoSOP grievance day. I carved the whole day out to sit and read and respond to inmate MoSOP grievances that had reached my level of review. And when I didn't have someone above me doing that to me, I was busy thinking knee jerk things to have my clinicians do on the spur of the moment.

JON

1

EXHIBIT 15

4:05CV2022 In Camera-6553
SORTS 0002100

Jonathan D. Rosenboom, Psy.D., LP/CPHSP

Missouri Sexual Offender Treatment Center

From: Bellew-Smith, Marty
Sent: Tuesday, August 02, 2005 2:55 PM
To: Blake, Alan; Swift, Brenda; Rosenboom, Jonathan; Meade, Linda; Wolf, Deanna; Phillips, Yvette
Subject: RE:

We need to do something so that people are not forgetting to write their court reports. Liz sounded less than happy.

From: Blake, Alan
Sent: Tuesday, August 02, 2005 2:39 PM
To: Bellew-Smith, Marty; Swift, Brenda; Rosenboom, Jonathan; Meade, Linda; Wolf, Deanna; Phillips, Yvette
Subject: RE:

It is. Brenda needs access to calendars.

From: Bellew-Smith, Marty
Sent: Tuesday, August 02, 2005 2:00 PM
To: Swift, Brenda; Rosenboom, Jonathan; Meade, Linda; Wolf, Deanna; Phillips, Yvette
Cc: Blake, Alan
Subject:

Brenda,

Is there a way to put an automatic pop up reminder of each court report and it's due date on the computers of individuals assigned to do a court report. For example, I'm currently working on Wilkinson (who is due 8/21). But, would it be possible for a reminder to pop up on my screen on 8/8/05 telling me that the report is due in on 8/21 and I'm going to be in hot water if I don't have it in.

I know this is a lot of work for you and don't do it yet, but would it be possible?

Gowdy, Rick

From: Parks, Joe
Sent: Sunday, February 01, 2009 2:29 PM
To: Vincenz, Felix; Reeves, Steve
Cc: Rehak, Tom; Gowdy, Rick
Subject: RE: House Hearing Follow-Up questions - RICK

No – they want the cost for doing SVP on the Texas model vs. keeping SVP commitees in jail or prison. They didn't seem able to hear our explanation that keeping SVP commitees indefinitely in a jail/prison environment (cells) would lead to constitutional challenges.

From: Vincenz, Felix
Sent: Sunday, February 01, 2009 2:14 PM
To: Reeves, Steve; Parks, Joe
Cc: Rehak, Tom; Gowdy, Rick
Subject: FW: House Hearing Follow-Up questions - RICK

I don't have any context for this question. Joe – are they talking broadly about what it costs to provide services on average to someone on an outpatient basis vs. the average cost for someone in jail?

From: Rehak, Tom
Sent: Friday, January 30, 2009 8:50 AM
To: Gowdy, Rick; Reeves, Steve
Cc: Vincenz, Felix
Subject: RE: House Hearing Follow-Up questions - RICK

Me too

From: Gowdy, Rick
Sent: Friday, January 30, 2009 8:50 AM
To: Reeves, Steve
Cc: Rehak, Tom; Vincenz, Felix
Subject: RE: House Hearing Follow-Up questions

I need more context to even begin to think about this—I am not sure what that means savings in outpt vs jail or outpt vs prison. Can you or Felix provide some context as to what population this question referenced? The simplest answer would be to find the avg cost of the typical outpt consumer vs about $50 per day for a jail.

From: Reeves, Steve
Sent: Thursday, January 29, 2009 3:26 PM
To: Lyle, John K. (Ken); Bross, Brad; Vincenz, Felix; Rehak, Tom; Gowdy, Rick; Parks, Joe
Subject: FW: House Hearing Follow-Up questions

Since each of you has specific knowledge to the questions being asked below, I would appreciate your response to the questions asked in House Hearing this week. Please provide your response to me by COB Monday, Feb 2. Thanks

---

From: McGinty, Brent
Sent: Thursday, January 29, 2009 1:58 PM
To: DMH.CO Exec Team/Assistants; Epple, Laurie; Reeves, Steve; Grosvenor, Jeff
Cc: Schmidt, Pam; Snider, David; Schollmeyer, Vicki; Hennier, Gale
Subject: House Hearing Follow-Up questions

EXHIBIT 16

We have discussed and will be working on the communication strategy over the next week or so.

From: Vincenz, Felix
Sent: Saturday, March 05, 2011 11:14 AM

...s of Conditional Release, and

...ation regarding the conditional
...since these WILL be in the

Subject: Meetings with Sen. Engler and Rep. Tilley - Conveyance of Property; Rumors of Conditional Release

FYI – looks like Julie and Alan did a nice job, but note Engler's concerns regarding SORTS, rumors of release, Lembke's stance, and the budget

From: Inman, Julie

...eet with them
...individually.

...d:
...perty transfer of the
...n't get a word in on
... and he would make
sure we get something to help with this. I don't know what that means but didn't ask as he moved on to discussing SORTS. The land transfer is very important to him. He did state that it will likely take 5 years or more before they can put in the outer road since there is no funding.

...that they normally worked for release conditions within that county. We expressed to Senator Engler that we will keep his office informed once we have viable candidates for release and the Director will be giving approval for the resident to petition for conditional release.

From: Vincenz, Felix
Sent: Saturday, March 05,

FYI – looks like Julie and Alan did a nice job, but note Engler's concerns regarding SORTS, rumors of release, Lembke's stance, and the budget

From: Inman, Julie
Sent: Friday, March 04, 2011 03:52 PM
To: Bax, Bob; Vincenz, Felix
Subject: FW: Meetings with Sen. Engler and Rep. Tilley

Alan and I met with Senator Kevin Engler and Rep. Steve Tilley yesterday.

EXHIBIT 17

- Senator Lembke – Sen. Engler talked about his concerns with Senator Lembke and the fact that Sen. Lembke "hates" SORTS. He says he has his hands full trying to defend the program. He stressed the importance of not having these rumors going on during this.
- He also asked how things were going since the Acute care closures. I told him we haven't been hearing much lately, we know ERs have seen some increases but it has not been what was expected in most areas within our region. He said that when he spoke with the hospital administrators within the Farmington area that they stated that it was a non- event.

Alan and I met with Rep. Steve Tilley later in the day. Following are the items discussed:

- Property – I told Rep. Tilley that I understood the need for the outer road and that the land would likely be transferred but that I wanted to pass along our concerns not only with the trail that we use but with the natural barrier this creates for us between the facility and the highway. He stated that once the road goes into place that he would get funds for some type of fencing to go in as a barrier.

- Senator Lembke – Sen. Engler talked about his concerns with Senator Lembke and the fact that Sen. Lembke "hates" SORTS. He says he has his hands full trying to defend the program. He stressed the importance of not having these rumors going on during this.

forward copies of those to you also.
Julie

Julie A. Inman
Regional Executive Officer

- SORTS – Rep. Tilley hasn't been hearing concerns from folks the way that Senator Engler has. Alan again talked about the process and that we would be sure to include him, Senator Engler, and others in the conversation when approval for a person to petition the court is to be given by the Director and before any court hearings.

in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited by federal or state law. If you have received this communication in error, please notify me immediately by telephone at (573)218-6701, and destroy all copies of this communication and any attachments

Enke, Teri

From: Blake, Alan
Sent: Wednesday, June 17, 2009 2:21 PM
To: Vincenz, Felix; Gowdy, Rick
Cc: Rosenboom, Jonathan; Enke, Teri; Hartman, Lana; Light, Sheila
Subject: RE: MSOTC and Aged/Infirm

I have Thursday morning and Friday except 10-11, and then I am gone for 2 weeks. To move this forward, Jon can push this forward in my absence.

Alan Blake, MS, LP

Chief Operating Officer
Missouri Sexual Offender Treatment Center
1016 West Columbia Street
Farmington, Missouri 63640
573-218-7079
alan.blake@dmh.mo.gov

From: Vincenz, Felix
Sent: Wednesday, June 17, 2009 1:57 PM
To: Gowdy, Rick; Blake, Alan
Cc: Parks, Joe
Subject: MSOTC and Aged/Infirm

Keith spoke with me yesterday afternoon about the possibility of selecting some 16 aged/infirm consumers from SORTS and developing a community alternative, demonstrating that as a strategy for saving about 36% of the costs of a ward and reduce expansion costs for another ward, and buying us a little breathing space in terms of census. Set up a meeting for the three of us to discuss this.

EXHIBIT 18

Enke, Teri

From: Vincenz, Felix
Sent: Monday, September 14, 2009 1:20 PM
To: Vincenz, Felix
Subject: SNF Candidates

From: Vincenz, Felix
Sent: Thursday, September 10, 2009 11:10 AM
To: Reeves, Steve; Parks, Joe
Subject: SNF Candidates

My note: Actually, Alan has now clarified that through the whole facility, we have 27 folks who are presumed to meet LoC option in the DA124 process

---

From: Blake, Alan
Sent: Thursday, September 10, 2009 11:05 AM
To: Vincenz, Felix
Cc: Inman, Julie; Adams, Karen
Subject: FW: SNF, not good news

Per staff on Hoctor it appears we only have 6 qualifying for SNF on Hoctor 1 per the criteria. I just asked if there are any others in the facility, and hope they may find some more.

From: Johns, Kelly
Sent: Thursday, September 10, 2009 11:02 AM
To: Blake, Alan
Subject:

At this time SNF candidates include: 6 men.
Schottel
Bonine
Coffman
Wheeler
Arthur
Woods

Enke, Teri

From: Reeves, Steve
Sent: Thursday, September 10, 2009 11:18 AM
To: Parks, Joe; Vincenz, Felix
Subject: Budget Numbers
Attachments: RequestedInfoSORTS090909.xlsx

Importance: High

I added the cost of the GPS tracking system and 2 FTE Forensic Case Monitors. This brings the total savings down to $98K. I don't think this is going to be worth the headache. See attached below

---

From: Vincenz, Felix
Sent: Thursday, September 10, 2009 10:26 AM
To: Reeves, Steve; Parks, Joe
Subject: FW: Requested SORTS Information
Importance: High

Well, the E&E costs cut the projected savings in half, with some unknowns associated with the GPS system. However, this does not include potential offsets due to charging the consumers "rent" and expecting them to cover some portion of their outside services.

From: Inman, Julie
Sent: Thursday, September 10, 2009 10:14 AM
To: Vincenz, Felix
Cc: Adams, Karen; Blake, Alan
Subject: Requested SORTS Information
Importance: High

Felix,
The attached document contains one tab that shows the cost of one Hoctor ward and a tab which shows the estimated cost of 16 residents in a group home setting.

As I'm sure you are aware, the numbers for the group home setting are our best guesstimates based upon the limited information available. It is really unknown at this time where many of the expenses (food, drugs, etc) would be purchased from and therefore the cost of these items are unknown. Also, there are no expenses shown regarding the cost of GPS tracking devices. This expense needs to be researched further.
Please let me know if you have questions or need further information. I am going into a meeting now, however if you email me I can answer questions from email or step out to call if needed.
Julie

Julie A. Inman
Chief Financial Officer
CPS - Southeast Region
(573)218-6789
julie.inman@dmh.mo.gov

SMMHC - SEXUAL OFFENDER REHABILITATION AND TREATMENT SERVICES
ESTIMATED COST OF ONE HOCTOR WARD
09/09/2009

Costs of 16 Bed Hoctor Ward

Typical Hoctor Ward

Personal Services

	FTE	Dollars
Office Support Asst (keybrd)	1.00	$24,810
Custodial Worker	1.00	$21,266
Security Aide I	14.00	$466,186
Security Aide II	3.00	$105,948
Registered Nurse III	5.00	$264,308
Registered Nurse IV	0.25	$14,172
Activity Aide II	1.00	$25,195
Psychologist 1	1.00	$61,620
Unit Program Supervisor	1.00	$45,652
Clinical Social Work Specialist	1.00	$46,842
Mental Health Mgr 1 (Unit Mgr)	0.25	$15,279
Total Personal Service	28.50	$1,091,278
Fringe Rate		57.71%
Fringe Amount		$629,777
Total PS with Fringe		**$1,721,055**

Expense and Equipment

	$ Estimates	
Food/Dietary	$35,566	
Drugs	$32,293	
Other Supplies	$18,728	
Lab	$1,077	
Medical/Dental	$47,302	
Other Services	$39,559	
Other Expenses	$12,000	
Total E&E		**$186,525**
Total PS, Fringe, and E&E		**$1,907,580**
Cost of SLPRC Group Setting		**$1,809,354**

CPS Southeast Region, 7/28/2011

Enke, Teri

From: Vincenz, Felix
Sent: Friday, March 05, 2010 7:24 PM
To: Vincenz, Felix
Subject: Aging and SORTS
Attachments: FW: SORTS Aging Stats

Importance: High

From: Blake, Alan
Sent: Friday, March 05, 2010 1:33 PM
To: Gowdy, Rick; Light, Sheila
Cc: Vincenz, Felix
Subject: RE: URGENT Info for 2:30 Meeting

9 definitely medical fragile – needing ongoing nursing / physician attention. Note that some of these persons, if in the community, still need to be in a locked or controlled nursing care facility, even though they have limited physical ability to move about. There is the next level of aging and medically needy; I estimate maybe another 9-12, but would not currently qualify for SNF settings.

As of today we 16 persons 65 or older, with 6 more becoming 65 this year.

As an aside, we are estimating 1/3 of our folks are DD or have cognitive impairments. Many of these might fit in group home settings.

From: Gowdy, Rick
Sent: Friday, March 05, 2010 12:02 PM
To: Gowdy, Rick; Blake, Alan; Light, Sheila
Cc: Vincenz, Felix
Subject: RE: URGENT Info for 2:30 Meeting

Just to be clear, I think given the short time we are just looking for answers to the 2 questions below, not to have the documents updated today. I only sent the documents FYI.

From: Gowdy, Rick
Sent: Friday, March 05, 2010 11:35 AM
To: Blake, Alan; Light, Sheila
Cc: Vincenz, Felix
Subject: URGENT Info for 2:30 Meeting
Importance: High

See below and see attached.

From: Welch, Cathy
Sent: Friday, March 05, 2010 11:30 AM
To: Gowdy, Rick; Vincenz, Felix
Subject: Info for 2:30 Meeting
Importance: High

For the meeting at 2:30, Keith wants you to bring along the following info related to **SORTS:**

1) How many residents are over the age of 65

2) How many are considered medically fragile.

Thanks.

Cathy Welch
Director's Office
Department of Mental Health
1706 East Elm, Jefferson City, MO 65102
Phone: 573-751-4970 or 573-751-3070
Fax: 573-526-7926
E-mail: cathy.welch@dmh.mo.gov

From: Vincenz, Felix
Sent: Thursday, September 10, 2009 10:26 AM
To: Reeves, Steve; Parks, Joe
Subject: FW: Requested SORTS Information
Importance: High

Well, the E&E costs cut the projected savings in half, with some unknowns associated with the GPS system. However, this does not include potential offsets due to charging the consumers "rent" and expecting them to cover some portion of their outside services.

From: Inman, Julie
Sent: Thursday, September 10, 2009 10:14 AM
To: Vincenz, Felix
Cc: Adams, Karen; Blake, Alan
Subject: Requested SORTS Information
Importance: High

Felix,
The attached document contains one tab that shows the cost of one Hoctor ward and a tab which shows the estimated cost of 16 residents in a group home setting.
<< File: RequestedInfoSORTS090909.xlsx >>
As I'm sure you are aware, the numbers for the group home setting are our best guesstimates based upon the limited information available. It is really unknown at this time where many of the expenses (food, drugs, etc) would be purchased from and therefore the cost of these items are unknown. Also, there are no expenses shown regarding the cost of GPS tracking devices. This expense needs to be researched further.
Please let me know if you have questions or need further information. I am going into a meeting now, however if you email me I can answer questions from email or step out to call if needed.
Julie

Julie A. Inman
Chief Financial Officer
CPS - Southeast Region
(573)218-6789
julie.inman@dmh.mo.gov

Enke, Teri

From: Vincenz, Felix
Sent: Thursday, September 10, 2009 11:03 AM
To: Reeves, Steve; Parks, Joe
Subject: Candidates for the 16 availabile, SNF option on SORTS campus problematic

---

From: Blake, Alan
Sent: Thursday, September 10, 2009 10:58 AM
To: Vincenz, Felix; Adams, Karen
Cc: Inman, Julie
Subject: RE: SORTS/SLPRC Option for Core Cut Scenario - SNF Criteria

I am told we will have the SNF number in about 45 minutes, and a list of names shortly after, as staff are reviewing with the idea we are estimating on having a nursing unit internally at the SNF level in a new building.

I don't know that we have the physical space or utility connections to double the transition unit.

We will still want a transition place internal to the facility to prepare for any less secure setting.

Currently we believe we can find 16 that could be place in the SLPRC option. We have a pool of 24 from which we can get the 16. The top 5 could go today to the SLPRC setting (and pass then neighbor test easily), if we had the court orders and conditions to go to SLPRC. The rest may need greater support / treatment, but don't represent a risk to the community in terms of compliance and appreciation of their situation. The setting would likely enhance their treatment and provide motivation. A few would be best engaged in the work program at SLPRC, and the focus would be on learning to live in a supported setting. (A couple of them would make better employees at SLPRC than SLPRC has currently. Certainly they would be good peer counselors.)

Name	DOB	Age	DOA	Location
Donaldson, Timothy	[redacted]964	45	02/07/2000	Blair 2 / 211 / A
Williams, Donald	[redacted]1963	45	01/04/2002	Blair 2 / 210 / B
Lewis, James	[redacted]1959	50	06/19/2000	Blair 2 / 212 / B
Seidt, David	[redacted]1954	54	12/19/2003	Blair 2 / 203 / B
Smith, Kenneth	[redacted]1952	57	05/04/2000	Blair 2 / 205 / B
Allison, Michael	[redacted]1968	41	08/14/2004	Blair 3 / 314 / B
Evans, George	[redacted]1960	49	10/02/2004	Blair 2 / 207 / A
Scates, Clifford	[redacted]958	50	10/16/2000	Blair 2 / 201 / A
Shafer, Jamin	[redacted]1970	39	05/23/1999	Blair 3 / 313 / A
Haenchen, Kevin	[redacted]1967	41	04/27/1999	Blair 3 / 306 / B
Fennewald, James	[redacted]964	45	02/07/2006	Blair 2 / 209 / A
Bowles, Paul	[redacted]1962	47	09/25/2008	Blair 3 / 313 / B
Degeare, Steven	[redacted]1961	48	01/08/2003	Hoctor 1 / 168A / C
Vanzant, Ricky	[redacted]959	49	12/19/2001	Hoctor 4 / 218 / C
Norton, Michael	[redacted]1957	52	05/17/2001	Blair 2 / 206 / B
Martineau, Lou	[redacted]956	52	06/16/2005	Blair 2 / 205 / A
Spencer, Nelvin	[redacted]957	52	01/19/2001	Blair 3 / 310 / B
Hodges, Gary	[redacted]1957	52	08/03/2005	Blair 3 / 304 / B

[redacted] wrote:

---- Original Message ----
From: [redacted]
To: [redacted]
Sent: Tuesday, October 31, 2006 5:09 PM
Subject: Re: Dakota

Hi [redacted]

I am so sorry to hear about Dakota. I will pray for her recovery, I can clearly understand your concern over her immune system. I think I shared with you that I lost one of my german shepherds to cancer of the spleen. Chemo wasn't an option for her, but they thought they could get it with surgery. DW

I don't know if you were aware, but [redacted] owned a pet store for 13 years and dealt with a lot of animals and of course animal owners. He is personally aware of 6 dogs that went through chemotherapy for cancer and survived. He said if they catch it early they usually have a much better success rate than they do with people. Some of the medication they are giving Dakota may be causing her increased appetite but that will be in her best interest. You were right I do care and please keep me informed as to how she is doing. What type of cancer is it? Knowing how you are with your animals I am sure it was caught early. [redacted]

.....It's a cancer developed from her own mast cells. I was in the back yard one Sunday planting bulbs. She was sticking her nose into the process (normal for her). I looked at her and thought I saw a lump. I felt and indeed it was what seemed to be a small lump. I called the next day. Got her in on Tuesday. They did a biopsy and surgery on Wednesday. Between Sunday and surgery, she developed a second one. It turns out the first one only looked small. It was under her passenger side arm. She had her blood tests this morning, but I won't know until tomorrow whether they can give her the next treatment. [redacted]

IT is horrible to feel so helpless and want so bad to make things better. I am assuming the doctors feel very optimistic about her prognosis. [redacted]

I am glad you love your job. To me it sounds like a dream job. As for me, well I struggled with whether or not to leave MSOTC, but I think it is going to get worst before it gets better. They stopped almost all treatment. The only thing continuing was process groups and we were told they could be interfered with if they felt it was needed. I expressed my concern that the legislation that allowed us to exist was based on treatment being provided, but they hope to be able to increase treatment before that is caught by the wrong people. I have to admit that I miss the work there, I really used to love my job and look forward to going into work. Towards the end it was not very enjoyable. Working with the residents was great, but the politics and games going on were ridiculous. I was willing to try to avoid it and ignore it as long as I was able to continue treatment with the guys, but when that was being stopped and it was impossible to avoid the games it just wasn't worth it. The sad part is when I spoke with you and was hired I had every intention of staying there otherwise I would never have bought my house. I really enjoy working with that population. It really is getting bad at MSOTC. [redacted]

.....I'm hearing the same thing from everybody that contacts me. I wish I could do something to help them. But, all I can do is pray. I feel so incredibly sad. I worked so incredibly hard to develop that program, but I could see it being destroyed. I just could not tolerate watching it any longer. I feel so sad for the residents. [redacted]

EXHIBIT 19

I agree, I feel very sad for the residents as well. I have to believe that someone or some state office will intervene and get things back on track, because MSOTC's existence is necessary for the safety of society. What was difficult for me was that I saw progress in several of the residents and one or two I fear or going to end up backsliding bad. The only two therapists who rarely if ever cancelled their groups were myself and [redacted]. Without mentioning names one of the others only met twice during a whole trimester and another cancelled between 60 -70% of their groups. The guys were upset by it.
[redacted]

I would like to keep in touch. For now if you want to reach me use my home email or call me at one of the following numbers: hm: [redacted]. I will be in touch soon or contact me as you receive more news on Dakota. Thanks for letting me know about her and hang in there.
[redacted]

.....I will let you know how she's doing as I find out. If I become a pest about it just tell me you need a break. You know how I get about my animals. They really are a part of my family and I can bore normal people to death with their exploits and difficulties. [redacted]

I am sure that I am as bad if not worse than you when it comes to animals. I am hoping depending on what my near future holds for me to possibly get a German Shepherd puppy this coming spring. If I do I will try if I can figure out how to do it to send pictures to you. I just figured out how to change the font size and color on this message. Slowly I will become more and more computer literate. <G>
[redacted]

Please feel free to contact me any time you wish. You have the email now and my cell is [redacted] I work at home many days writing. I love writing in my flannel PJ's. Two and sometimes 3 days a week I am out doing evaluations or court work. October has been a busy month. I was hired to do three each month. In October I did ten. There was just an absolute onslaught during the month. Three is the normal load. There literally was not time to go to the bathroom duirng October. I just absolutely love the work. I look forward to getting up every morning. The work is challenging and stimulating. The work is honorable. And, I have been so incredibly surprised by the amount of work I can complete when I'm not harrassed or impeded by politics, game playing, socializing, and all that smooshing in offices all day long. I never cease to be amazed at the amount of time people can fritter away each day. [redacted]

You are right to go from 3 to 10 for the month is a major jump. To be free of politics and game playing is something I strive to be one of these days. I tried to call your cell and left a message. Hope to talk with you soon. Again, I will never be bored by the exploits of your animals and they are members of our families. In my heart I feel that only people who feel that way really should have them. [redacted]

.....Please keep in touch if you wish.

[redacted]

[redacted]

[redacted] wrote:
I don't need anything. I tried to get in touch with you by email because I wanted to tell you that my big wolf dog was diagnosed with cancer. I was relatively sure you would care. I had the tumors removed and she has started chemo--weekly for 8 weeks and then every other week for the next 8 weeks. I'm scared about the chemo and her immune system, but there was little choice. Either I gave up and she died very quickly or I tried and maybe just maybe they will be able to save her life. She goes in for blood tests every Tuesday morning and if she passes her blood tests then she can have her chemo on Thursday. She had her first chemo last Thursday and appears to be doing OK.

She's absolutely ravenous and has tripled her intake of food since the surgery. I've just been feeding her all she wants because I figure with the chemo that she's going to need the best nutrition she can get. She's eating five 22 ounce cans of Pedigree beef or chicken chunks a day and free feeding on Benefial Dry Food. She's not gaining weight. She never had much of an appetite previously and given the tendency of large dogs to get hip problems as they age I'd been pleased that she stayed naturally slim. I figure with the chemo and cancer she is going to need all the good nutrition she can get.

I was puzzled when I contacted you and you didn't respond. Then, I remembered you computer gremlins. I just figured your computer at work was doing what your computer does. I get lots and lots and lots of emails and phone calls from nursing staff, security aids and support staff. The only people I don't hear from are professional staff. I assume that is a function of the fear that has gripped MSOTC. I keep getting these emails and phone calls from very diverse staff telling me that it is REALLY bad. One of them told me that you had resigned. I was shocked. So, I contacted [redacted] and asked him to please get in touch with you. I figured if you had managed to escape that you had a right to make your own decisions now. I hope things are going well for you.

I absolutely love my job. I recently told my sister that I hope and pray that I will be able to stay healthy enough to work until I'm 70, 75 or 80. I had no idea life could be like this. I am so incredibly grateful to be allowed to have this job and do this work.

If you want, please stay in touch.

[redacted]

Gowdy, Rick

From: Dirks-Linhorst, Ann
Sent: Wednesday, February 06, 2002 1:04 PM
To: Bellew-Smith, Marty
Cc: Gowdy, Rick; Johnson, Victoria
Subject: RE:

I hate to say that we have trod this ground before, but we have trod this ground before. Lauretta and I had already worked on a policy that did restrict visitors to immediate family children, etc - no cousins, nephews, etc., etc. We did not restrict to only those over 18 - even in mind of the clinical areas. There were determinations made regarding potential therapeutic value or lack thereof. The old policy that we had operated under was SVPTP policy 5.340. There was even an application form for juvenile visitors. You may want to review it for a starting point.

I know that yesterday you indicated that you all had inherited a "bad" program, but there was a lot of work that had been done on policies, and a lot of discussion on those topics in the first year. I understand if you want to change decisions that had already been made, but you may want to at least review prior documents from that first year as a starting point.

—Original Message—
From: Bellew-Smith, Marty
Sent: Wednesday, February 06, 2002 12:44 PM
To: Dirks-Linhorst, Ann
Cc: Gowdy, Rick; Johnson, Victoria
Subject:

Ann,

Joe Mangini asked me to get in touch with you.

Joe, Harold, Vickie and I are trying to get the Visitor's Policy/Visiting Security Policy finalized.

I have very strong clinical concerns about the impact of bringing children into a prison setting where they may be further victimized or in any way damaged through exposure to or contact with sex offenders, other criminals or the environment. I do not believe this is a place for children. In my opinion, these children have already been damaged enough and don't need us to be allowing any more damage.

Currently, children visit in a dining room up at FCC. So, they may be exposed to other sex offenders and their families. Depending on staffing, there may have been times when children have been exposed to some of our residents (family and friends) even if they did not have children visiting.

I am aware that individuals have a right to visit their families.

First, may we restrict visits to individuals who are over age 18?

Second, if we must allow children to visit, may we restrict visiting of children under the age of 18 to non-victims who are either the son or daughter (biological or legally adopted) of the resident.
Are we required to allow nieces, nephews, cousins, grandchildren, step children, the neighbor children.

EXHIBIT 20

SUBJECT	DISCUSSION	DECISIONS/ ACTIONS
	Submitted request to have family send in Playboy magazines so he can masturbate to appropriate fantasies.	Will be discussed by team and incorporated into treatment plan.
HH – Level 4 2/9/01	No discussion. Remains on TWR.	
TI – Level 1 4/18/01	Does not participate in any form of treatment.	
JJ – Level 3 4/16/01	Involved in altercation with others on 5/16/01. Received order from Public Defender Nancy McKerrow. MO Court of Appeals reversed commitment.	Received 30 days TWR for assault. Moved to detainee side of ward.
EK – Level 2 4/2/01	Doing okay.	
CO – Level 2 4/26/01	Committed rule violation when he was in another resident's room playing a board game. This set off altercation for which others received TWR.	
WS – Level 4 12/13/00	Doing okay.	
JS – Level 3 12/18/00	Requested level 4.	Denied—does not do homework or apply principles.
DS—Level 3 8/1/00	No discussion.	
ET—Level 4 10/13/00	Involved in altercation with others.	Level 4 suspended 30 days and TWR 30 days.
	NEW BUSINESS	
PHLEBOTOMIST SERVICES	Need to contact MARMC to see if we can contract to provide services.	K. Short contact MARMC
PERSONNEL ISSUES/ KEY CONTROL	SVP was not budgeted adequately. Some CTC positions will be moved to this program. SVP will take responsibility for staffing key control.	Identify staff and cross train.
MATTRESSES	Hospital bed was delivered to SP1. Mattress was taken off regular bed for use on hospital bed.	Order three mattresses for each of the hospital beds.
DIETARY ISSUES	Plastic knives are not provided in the dining room.	V. Johnson request and set up system to count.

Recorded by: Sheila Light
Sheila Light

Reviewed by: V. Johnson, RN
Victoria Johnson, RN IV

4:05CV2022 In Camera-5644

EXHIBIT 21

5-26-09.

What are the rules across the fence for FCC? Can an FCC inmate be unescorted, for what length of time and what are the procedures? Clearly MSOTC is a treatment facility and our procedures might end up being completely different, but I would like to know what the FCC procedure is before a final decision is made. Also, the comments by Mr. Jordon are well taken and should be discussed.

RNG.

Confidentiality Statement:

From: Vincenz, Felix
Sent: Friday, May 22, 2009 4:43 PM
To: Rosenboom, Jonathan; Adams, Karen; Blake, Alan; Gowdy, Rick
Subject: FW: Variation for check in for residents

I'm OK with this as well.

From: Adams, Karen
Sent: Friday, May 22, 2009 3:43 PM
To: Blake, Alan; Vincenz, Felix; Gowdy, Rick
Cc: Amsden, Nancy; Bender, Kristina; Jordan, Scott; Rosenboom, Jonathan; Wills, Bob
Subject: RE: Variation for check in for residents

Sounds like a reasonable step to me. Not only for the residents involved, but for others seeing the progression and encouraging them toward more freedom as well. I think with the limitations you have described below, I am ok with it.

From: Rosenboom, Jonathan
Sent: Friday, May 22, 2009 3:39 PM
To: Blake, Alan; Adams, Karen; Vincenz, Felix; Gowdy, Rick
Cc: Amsden, Nancy; Bender, Kristina; Jordan, Scott; Wills, Bob
Subject: RE: Variation for check in for residents

From a natural progression in the treatment of our more advanced residents, some increased responsibility and personal freedom is crucial. We now have 4-6 residents within 1-2 years of a recommendation to CO for partial conditional release. After over 7 years of these individual's treatment and progress, they continue to be supervised 24/7, have no personal monies on their person, cannot buy a soda or candy bar from vending machines that they pass 10 times a day, and have now lost a good deal of the benefits of personalization of their room through the life safety interpretations/restrictions associated with TJC accreditation. They are becoming more institutionalized and the potential that their work in treatment will bring fruit is subject to fading.

From: Blake, Alan
Sent: Friday, May 22, 2009 2:58 PM
To: Vincenz, Felix
Cc: Gowdy, Rick
Subject: RE: Variation for check in for residents

EXHIBIT 22

----- Original Message -----
From: "Weiler, Mary" <Mary.Weiler@DMH.MO.GOV>
To: [redacted]
Sent: Monday, September 29, 2008 6:33 AM
Subject: community reintegration

Dear List,

We are moving toward conditional release of several residents. All of these men have been out of mainstream society (jail, prison, SVP residential treatment) for at least 20 years. I would appreciate references to articles or other resources that would be helpful in teaching reintegration skills to these men (i.e. imagine the changes in telephonic communication over 20 years!). Thank you.

Mary T. Weiler, MSW, LCSW,

Director of Social Work , Missouri Sexual Offender Treatment Center

1016 W. Columbia Street, Farmington, MO 63640

Telephone (573)218-5043

Fax (573)218-7053

E-mail: mary.weiler@dmh.mo.gov

EXHIBIT 23

[redacted]

From: Moll, Linda
Sent: Friday, January 11, 2013 11:06 AM
To: Anderson, William
Cc: Arnett, Justin; Ring, Melissa; Carich, Mark
Subject: SOS Training Presentation
Attachments: Program training slides 2 days FARMINGTON.pptx

Attached please find the slides I used when training staff on the SOS program. These are adapted from the slides Jill used in her 2 ½ day training with us before we kicked off the program here – as you can tell, I have attributed the presentation to her and added my name only for the elements specific to Farmington. I asked her permission to use her slides and presentation.

The beginning of the presentation covers some basic data about sex offenders, which both she and I have used with new employees. For experienced SORTS employees, I skipped ahead to the information about the SOS program philosophy, basis, etc.

Per my conversations with Emily Davis and Suzan Campanelli, as well as Dr. Hayreh and Genie Bonte, I was more than willing to present on the SOS program philosophy, basis, etc., but would need to turn it over to someone from the current team for details about the current workings of the program. But I'm willing to help in whatever way you need -

Linda Moll, Ph.D.,
Adult Psychiatric Services Director of Treatment Services
SMMHC Director of Psychology
1010 W. Columbia Street
Farmington, MO 63640
Phone: (573) 218-6827
FAX: (573) 218-5072
Linda.Moll@dmh.mo.gov

EXHIBIT 24

FARMINGTON SOS

PATIENT HANDBOOK

Program Overview

The Sex Offender Rehabilitation and Treatment Services (SORTS) unit at Farmington State Hospital is a program for clients who have been civilly committed under Missouri State Statute 632.480 as Sexually Violent Predators. Clients who reside in the SORTS unit are those with serious histories of violent sexual offending and corresponding mental illnesses (i.e., paraphilias) that increase the likelihood of their criminal sexual behavior. In addition to sex offender treatment, SORTS clients represent a broad range of psychosocial treatment needs, including mental illness, personality psychopathology, trauma, geriatric and medical concerns, intellectual and developmental disabilities, isolation from family members and other supports, substance abuse, and lengthy histories of incarceration and hospitalization.

Safe Offender Strategies is a treatment approach for sexual offenders developed by Jill Stinson, PhD, and Judith Becker, PhD. This approach emphasizes the role of self-regulation and self-regulatory deficits in the development of problematic or illegal sexual behavior. As a treatment, Safe Offender Strategies is a skills-based intervention that facilitates self-monitoring and self-management for sex offending clients in long-term or residential settings. Treatment providers work collaboratively with clients to individualize treatment planning and measure progress in multiple domains of functioning.

Here, Safe Offender Strategies has been expanded and developed as a program, with standards, treatment opportunities, and responses to client behavior that are consistent with the goals and philosophy of the original treatment approach. This program manual contains a description of the philosophy and rationale for treatment, basic assumptions about SORTS clients, stages of commitment and measuring treatment progress, client privileges and responsibilities, consequences, and available treatment programming. An overarching goal is to balance community safety needs with the treatment and support needs of high-risk sexual offenders.

HOCTOR 2/SOS PROGRAM MISSION

Using the SOS program philosophy, Hoctor 2 seeks to provide progressive therapeutic measures to meet our patients' needs - "meeting patients where they are in treatment using a validating and therapeutic approach to bridge the gap to recovery".

Program Philosophy and Rationale for Treatment

Traditional sex offender treatment programs have utilized harsh, punitive, and confrontational approaches for dealing with sex offending behavior. Clients have been assigned treatment goals and coached in techniques to help them avoid potential risks, like contact with potential victims (e.g., women, children), sexual urges, or dysregulated emotional, cognitive, and interpersonal states. Sex offending clients have not consistently benefitted from such approaches, which often have had difficulty with client compliance and lasting treatment effects. Therefore, Safe Offender Strategies represents a departure from these approaches.

Safe Offender Strategies (SOS) is based on the fundamental premise that people with deficits in self-regulatory functioning will sometimes engage in maladaptive behaviors in order to regulate themselves. These behaviors are maladaptive because they are harmful to themselves or others. This sometimes includes sexual behaviors, depending on the person's history, beliefs and cognitive worldview, individual personality traits, opportunity, and reinforcement history. Not all persons with self-regulatory problems become sexual offenders, but some do. These persons will continually struggle with effectively and safely managing their sexual urges emotions, beliefs and expectations, and interactions with other people. These are the clients for whom Safe Offender Strategies was developed.

Individuals with histories of sex offending behavior presumably demonstrate difficulties with self-regulation in several domains. These difficulties arise when the individual experiences dyresgulation (briefly defined as distress or discomfort) and is unable to tolerate or manage it in an effective way. Signs of *emotional dysregulation* may include intense anger, loneliness, depression, mania, or panic. Indicators of *cognitive dysregulation* include blame, judgment, rationalization, racing thoughts, problem-solving deficits, or delusional beliefs. *Interpersonal dysregulation* can include arguing, lying, manipulating, or isolating oneself from others. Finally, *behavioral dysregulation* is more observable and is often related to maladaptive behavior, such as impulsivity, substance abuse, and aggression. Clients in sex offender treatment often display unique combinations of dysregulation and self-regulatory deficits, thereby creating the need for individualized treatment interventions.

In treatment, clients need to learn a combination of strategies for risk management and adaptive self-regulation. This is broadly accomplished

through self-monitoring, skills training, support, and fostering a sense of self-efficacy and commitment to change. The treatment process begins with assessing client readiness and engagement and ends with client self-management and consistent use of adaptive regulatory strategies to cope with dysregulation in the moment. Along the way, clients develop their own individualized plan for coping with their dysregulation and their sexual urges. Diverse programming opportunities help them develop functional and adaptive skills, supportive and healthy relationships with others, and future goals that enhance their lives.

Clients in the SORTS unit are long-term, high-risk sexual offenders. They often have lengthy histories of problematic sexual behaviors, unhealthy relationships with others, and other difficulties with mental illness, substance abuse, and incarceration and hospitalization. The SOS program assumes that clients will need long-term care and treatment to address the complexity of their behavioral problems and self-regulatory deficits. Treatment programming is designed to address these needs gradually and comprehensively, with ample opportunity for clients to practice newly learned skills and abilities in their current milieu on a daily basis.

Treatment providers and staff members for the SOS program work collaboratively with clients to develop treatment goals that are most relevant to them, that reflect their current commitment to treatment and treatment needs, and that will ultimately help them move toward more effective self-management. It is understood that each client's attainable level of self-management varies dependent on health factors, adaptive functioning level, available social support in other settings, and risk of future sexual offending. Treatment providers work with each client where he (or she) is at and acknowledge the difficulty of making widespread and lasting change in so many areas of the client's life. Strategies for effectively working with clients to enhance self-monitoring and self-management include validation, behavioral chain analysis, and skills building. Other therapeutic principles that are central to the SOS program include Motivational Interviewing and restorative justice.

Clients involved in the SOS program are expected to make progress at their own pace and with their own (reasonable) goals. Stages of client progress and corresponding programmatic privileges and restrictions are based on the client's level of commitment to change and active participation in treatment efforts. As clients become more committed, more self-aware of their treatment

needs, and more skilled at self-management, they will be given greater opportunity to exercise newly learned adaptive strategies in their daily environment. Problems with behavior, treatment engagement, and interactions with staff and peers are somewhat expected, given the complexity of their needs and the long-term nature of program intervention. This is not to say that such acts are passively condoned – there are consequences for clients when they exhibit maladaptive strategies or behaviors. Many of these are dealt with in treatment and within the context of their relationships with staff and other clients so that they may serve as learning opportunities for the future.

The most important thing to know about SOS is the concept of ***dysregulation.*** Dysregulation is just what it sounds like – a state of feeling somehow, out of balance ("Things are not okay") to the point of intense discomfort or distress, to the point where the person can't take it anymore. **Everyone** experiences dysregulation of some kind, at some point in their life, and pretty much everyone, at some point in their life, deals with it in a way that isn't particularly effective or doesn't have a great outcome.

There are four types of dysregulation discussed in the SOS program:

Emotional Dysregulation	**Cognitive Dysregulation**	**Interpersonal Dysregulation**	**Behavioral Dysregulation**
Anger	Blame	Arguing	Impulsivity
Loneliness	Judgment	Lying	Substance abuse
Depression	Rationalization	Manipulating	Aggression
Mania	Racing thoughts	Isolating	Sexual offending
Panic	Delusions	Making threats	Suicidal behavior
	Problem solving deficits		

[redacted]

From: Labundy, Jim
Sent: Thursday, November 15, 2012 7:41 AM
To: Adams, Maria; Bender-Crice, Kristina; Bonte, Eugenie; Bress-Scroggins, Jean; Carich, Mark; Chamberlain, Christopher; Chilton, Vickie; Edgar, Evelyn; Fenwick, Sandy; Hayreh, Davinder; Labundy, Jim; Sanchez, Andrew
Subject: Emailing: Fulton tripLatest1
Attachments: Fulton tripLatest1.doc

The message is ready to be sent with the following file or link attachments:

Fulton tripLatest1

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

EXHIBIT 25

Fulton trip, November 2012:

Our trip to Fulton was quite educational, and well worth the time and expense. We were able to participate in all of the groups and activities that were unavailable prior, and were able to see the entire core process of SOS. We were also able to have adequate time with the director and unit managers, to ask individual clinical and process questions, and to ask about the things we observed. Our observations seem to fall into two categories:

1. Ambience/Atmosphere:
   There was a distinct ambience notable upon entry to the wards. Fulton is fortunate to have bright white open cheery wards, very spacious with wide hallways, and large, white, open rooms with many Windows. This afforded sunlight to wash throughout, adding to the ambience. The hillside visible through the windows was of green countryside, adding to a peaceful view. Staff and residents are on a first name basis, and that seem to add to a more pro-social atmosphere for all. The language of staff and resident was one of the DBT – origin, speaking of skills used, skills that could be used, and no talk of thinking errors, or other CBT carryovers from other programs. There was not a sense of policing the residents, but one of interacting and attempting to help them find the skills needed for whatever was currently operative. The staff and the residents were interacting as one large treatment team, or treatment community, and we could detect no "us – versus – them" attitudes on either part. The residents report" staff talks to us, like people, and treat us like human beings." They have simplified a lot of interactive strategies, for example TV scheduling: whoever is in the TV room at the time of choices to be made will determine the program for that time; only stage for and above can vote on what is watched, but all may view it. Restorative Justice was a simple process we could readily begin. They allow for directly addressing an individual

culprit for whatever transgression has occurred, and not punishing the whole group. These two arenas alone have solved a lot of staff/resident discord. Their belief is that people who are scheduled for group should be responsible to go to group. Being a long-term treatment program, eventually the lack of responsibility is contained within the staging levels. Incentives truly meaningful. It was no surprise that their use of the work program has been phenomenal. Level III can begin working with a lower number of hours, and more hours are appropriated as staging levels increase. It is fairly simplistic to achieve a level V, but they have never moved anyone to level VI at this point. That seems to be where "the rubber hits the road". That incentive, working, has an overriding impact, a positive one, in all of their programming.

Ironically, we visited the work program to see how it operates and ask questions, and their whole program could fit in our Hoctor 6 day hall! Space is not the issue, as I was led to believe.

Another small area that was quite impressive was there use of first names for staff and residents; it altered the negative history from prior treatment and/or incarceration. Many of those simple little characteristics in their programming added up to a huge difference in ambience, all in a positive direction.

2. Clinical:

We felt validated regarding the clinical formats we are working towards, and have actually been developing from our own treatment histories and backgrounds. We have to be careful to not fall back into the CBT/correctional format, as my history for example, was MoSOP-based in Corrections, then repeated here, but my years of outpatient treatment before that allowed me the latitude of including systems theory and Bowenian family systems theory, expanding the therapeutic process a great deal. I saw this influence with Jill's writing, as the

systemic overtones of her formatting the groups for specific interaction soon became evident.
What we are doing now approximates that more than the correctional models still using CBT as a format. Our current approach to chaining, self-regulation, self-monitoring, and the SOS groups, are falling close to where Jill wanted to go with SOS. Some tweaking will still be needed, but this may be the simpler areas to accomplish. They also see anger management as part of their core process program, and life skills, also. We'll be interested in tweaking some of the groups for the January semester.

Their staffing, of course, made us drool. There are two licensed clinicians in every group, minimally, more in many. Mike, the director of all programming, is a clinical social worker, and the two unit managers are also licensed clinicians, one a psychologist and one a clinical social worker. The third ward they are now in process of developing has another clinical social worker for its unit director. The SA's seem to run the Ward on day-to-day basis, with an SA-2 on days and evenings, with the nurse more in the background. Why this was so was not questioned, nor revealed, but their general over-all organizational chart would resemble ours in most ways visible--not surprising, as both are DMH inpatient programs, long-term. They have a psychiatrist who is part of the treatment team and was at the morning meetings that resemble ours at 8:30 AM. Ironically, one day it took 15 minutes and the other day at almost 30 minutes, that that was for doing all three wards! It may be a sign we all do talk too much!
They also have an internist, functioning much the same as our own.

In summary, the benefits our program can realize from what we and the other staff attending have learned can also be divided into two categories:

1. program specific/within Ward: some of the tweaks that appear needed can be handled by the staff assigned to the Ward, as it doesn't change any policies or procedures, so that mandates may be carried out in a true SOS - fashion. The whole staff need to get on board regarding respect and humankind's intrinsic nature of being. It would help for all staff and residents to change to a first name basis; patients report that this staff "listens to and talks with them, not AT them". Men can shake hands, as this is allowed.

2. Some changes may come with a consultation from administration. While everything we learned at Fulton is obviously approved by the Department of Mental Health, we need as a staff to get away from the attitude of "we can't do it here in Farmington because..." and move on to "how do we get this done here and in the near, near future?". After meeting with Mike and his staff, it appears that many of our problems stem from how far we were lead to vary from Jill's original program intension; seeing how the program works in action, and now having her book as a guide for action, limits could possibly be only those we do not see as opportunities.

What must be understood is that it is almost impossible to capture the true essence of what is different in the program's, in that it is primarily one of attitude, a true sense of community with staff and residents, and how the humanity of all is respected. The functional part of the programs roll out naturally from their basic assumptions about what truly enables transformative change.

[redacted]

From: Blake, Alan
Sent: Tuesday, June 12, 2012 7:41 PM
To: Carich, Mark
Subject: RE: How is the new job going?

Yiou can tell her I drank both of them.

You might see if the state will pay for a membership to Sex Offender Civil Commitment Network (SOCCPN). That is the organization for the state SVP programs. It is a great group of folks. I think you would find several things they do of considerable interest, especially regarding research and other aspects that would be very publishable. They have a website you can google. I suspect you already know a few members.

From: Carich, Mark
Sent: Tuesday, June 12, 2012 5:29 PM
To: Blake, Alan
Subject: Re: How is the new job going?

Glad I'm here. Sujatha. Says u owe her two bottles of wine. Mark

From: Blake, Alan
Sent: Tuesday, June 12, 2012 05:22 PM
To: Carich, Mark
Subject: How is the new job going?

Mark, I hope all is going well as you are settling in. I suspect there are probably things that have come up where you wonder "what was he thinking?" If I can be of any help or want my take on things, please feel free to call. 636-544-0174. Sheila knows where the bodies are buried. Take good care of her. She did a wonderful job of taking care of me. Bob Wills is also a wealth of good judgment and a good sounding board. There are a number of unique personalities there, but hard working and committed to good service. I am glad to know that a person with your knowledge and stature is there to take SORTS to the next level and that my friends and collegues are in good hands.

Alan Blake

EXHIBIT 26

[redacted]

From: Carich, Mark
Sent: Tuesday, July 16, 2013 10:50 AM
To: Hebert, Jannine M (DHS)
Subject: RE: [SOCCPN] request
Attachments: 0a EvaluatingTherapeuticChange-FULL-Final handout.ppt; 0a_Evaluating_Therapeutic_Change_Appendix_HDOUT1.ppt; MEANINGFUL RISK FACTORS 2011.doc; Dynamic Risk (Recovery) Factors.ppt; Risk_Assessment__Applications_to_Treatment11.ppt

It is the Schwartz series on corrections sex offender tx. 2008 edition might be vol. 6 don't remember-- it was on eval tx. progress based on our atsa presentation which are enclosed. The current goals grid is dysfunctional & is why we are developing something new. Once I locate it I will send it to you.

-----Original Message-----
From: Hebert, Jannine M (DHS)[redacted]
Sent: Tuesday, July 16, 2013 10:09 AM
To: Carich, Mark
Subject: RE: [SOCCPN] request

Thanks, Mark. Yes, I have volume III of the sexual predator in my office and the others are at home. I will look up 2008 edition. Would you be willing to share your grid with me? I won't plagiarize or disseminate it, I am trying to get a general perspective of the world out there. I appreciate it.

-----Original Message-----
From: Carich, Mark [mailto:Mark.Carich@dmh.mo.gov]
Sent: Tuesday, July 16, 2013 10:03 AM
To: Hebert, Jannine M (DHS)
Subject: RE: [SOCCPN] request

We published a chapter on this with B. Schwartz 2008 on this topic. Currently we are using a goal grid, however, we are changing it up. I have been studying these issues since 1989 or before & it is still a work in progress.

-----Original Message-----
From: [redacted]
Sent: Tuesday, July 16, 2013 9:14 AM
To: [redacted]
Subject: [SOCCPN] request

Hi All
I am looking for examples of how other sex offender civil commitment programs measure client treatment progress or change. If you could share any policies, internally developed tools or program descriptions that capture this it would be greatly appreciated. Is anyone using the VRS-SO or the SOCQ? Hope everyone is having a lovely summer! Thanks so much.

Jannine Hébert MA, LP
MSOP Executive Clinical Director
444 Lafayette Road North
St. Paul, MN 55155-0992

EXHIBIT 27

651.431.4377
651.207.3336 (BB)

Caution: This e-mail and attached documents, if any, may contain information that is protected by state or federal law. E-mail containing private or protected information should not be sent over a public (nonsecure) Internet unless it is encrypted pursuant to DHS standards. This e-mail should be forwarded only on a strictly need-to-know basis. If you are not the intended recipient, please: (1) notify the sender immediately, (2) do not forward the message, (3) do not print the message and (4) erase the message from your system.

A blank message to these addresses performs the following -
SOCCPN-on@mail-list.com gets you on the list.
SOCCPN-off@mail-list.com gets you off the list.
SOCCPN-switch@mail-list.com toggles you to/from the fancy digest version.
SOCCPN-vacation@mail-list.com toggles you to/from the vacation list.

To change your email address, send a message to SOCCPN-change@mail-list.com with your old address in the Subject: line

Post your message to the list by sending it to SOCCPN@mail-list.com.

To contact the list owner, send your message to SOCCPN-list-owner@mail-list.com.

mail-list.com 1302 Waugh Dr. #438 Houston, Texas 77019 USA

This message was sent to 97 subscribers.

To unsubscribe, switch to/from digest, get on/off vacation, or change your email address, click here.
<http://cgi.mail-list.com/u?ln=soccpn&nm=mark.carich%40dmh.mo.gov>

[redacted]

From: Bender-Crice, Kristina
Sent: Thursday, January 10, 2013 3:36 PM
To: Kempker, Ericia; Wiedau, Kelly
Subject: RE: one quick paragraph

That guy is a moron! I have officially given up on this guys ability to do ANYTHING!!

Krissy Bender M.S.
Unit Program Supervisor
SOUTHEAST MISSOURI MENTAL HEALTH CENTER
Sex Offender Rehabilitation and Treatment Services Division
1016 W. Columbia St
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573-218-5033 Fax
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American Counseling Association

MISSION: To improve mental health of those we serve with a com-mitment to excellence in all we do.
VISION: "Working together to be the premier provider of Hope, Rehabilitation, and Recov-ery to achieve fulfilling lives."

From: Kempker, Ericia
Sent: Thursday, January 10, 2013 10:09 AM
To: Wiedau, Kelly; Bender-Crice, Kristina
Subject: RE: one quick paragraph

How have you been? Talk to Krissy about Mark and his comments about me ☺ She'll know what I'm talking about.

Ericia L. Kempker, Psy.D.
Licensed Psychologist
SVP Evaluator/Certified Forensic Examiner

EXHIBIT 28

[redacted]

From: Englehart, Jay
Sent: Monday, August 12, 2013 2:25 PM
To: Ring, Melissa; Amsden, Nancy; Anderson, William; Arnett, Justin; Carich, Mark; Clopper, Terry; Fletcher, Kevin; Forsythe, Cindy; Hackathorn, Cynthia; Hayreh, Davinder; Jackson, Dean; Light, Sheila; Longworth, Damon; Ramesh, Sujatha; Russell, Richard; Semar, Janine; Stienkemeyer, Robert; Swift, Brenda (SORTS); Walton (Adams), Andrea; Wills, Bob
Subject: RE: violations procedure

I agree that we are boxed into a corner at times and that the use of violations is not always therapeutic and may at times not be fairly applied. However, there are a number of problems that were seen when the clinicians were involved in making a clinical decision to uphold a violation, and front line staff were given more discretion in deciding what was and what was not a violation. There have also been times both when staff did not tell patients about a violation, and therefore there were no consequences paired with receiving the violation, or when there was an automatic process (such as that used in prison) of appeal where any consequence is delayed by up to a week, which also does not optimize any possible behavioral effects of receiving the consequence. A warning system we had at one point did not work because the most difficult patients would space out their negative behaviors so that no staff member witnessed them more than once, and because we were not tracking warnings, there was no way for subsequent staff members to know that patient had already been warned multiple times.

For me, there are two goals of having a violation system: 1) Having a central place where all "at risk" behaviors can be accessed and assessed for current security risk purposes and for clinical needs assessment; 2) Having a more or less objective system which depends less on clinical acumen and/or countertransference factors than our other judgments;

This kind of "objective" system is especially needed in the type of population we have at SORTS and are increasingly getting at APS: a group where many either have antisocial traits or frank psychopathy or have long periods of institutionalization where they have developed strategies for getting what they feel they need.

So, the question becomes one of willful behavior vs. behavior which can respond to treatment, which is what I think Dr. Ring is getting at below. Unfortunately, we do not have a good, comprehensive risk assessment and needs analysis document on each patient which summarizes the goals of their treatment **and** their individual traits which lead to risk. The ITP does some of this, at least on the goals side, but we don't have an ongoing needs assessment which deals with highly individualized risk factors into which we can fit some of the states people are in when they commit a violation.

So, I would propose a slightly different approach . . . keep the violation system as it is, but change the risk level system so that it is not so dependent upon violations to assess risk. For instance, two recent moves from Blair as a result of intolerable violations were unnecessary in my view, not because the violations were not intolerable, but because the risks involved given their histories did not require that they be moved to a new environment that was marginally more secure. The violation required that particular consequence however, because we just count them. The violations were however, huge clinical issues, which would keep them from progressing toward discharge until addressed and new skills developed.

This is a very, very long response to a very brief suggestion, but the history of the system is important, as are the goals, so I thought I needed to talk about both. Sorry.

Jay Englehart, MD
Medical Director
Southeast Missouri Mental Health Center

EXHIBIT 29

1010 West Columbia Street
Farmington, MO 63640
Office Phone: 573-218-6708
New Email: jay.englehart@dmh.mo.gov

From: Ring, Melissa
Sent: Friday, August 09, 2013 11:51 AM
To: Amsden, Nancy; Anderson, William; Arnett, Justin; Carich, Mark; Clopper, Terry; Englehart, Jay; Fletcher, Kevin; Forsythe, Cindy; Hackathorn, Cynthia; Hayreh, Davinder; Jackson, Dean; Light, Sheila; Longworth, Damon; Ramesh, Sujatha; Russell, Richard; Semar, Janine; Stienkemeyer, Robert; Swift, Brenda (SORTS); Walton (Adams), Andrea; Wills, Bob
Subject: violations procedure

I have been studying this issue some in light of how we are sometimes "boxed in" by our violations procedures.
One thing I studied is the procedures used by Wisconsin- also attached- which puts the emphasis on the sanctions or what is done about the behavior (which would be a violation in our lingo)
In my brief dealings with contentious violations the issue is usually not whether the behavior occurred or not but what the sanction or consequence should be. BUT, the way we have written the policy, IF the behavior occurred the consequences are prescribed so about all you could do is say it happened, did not happen or happened by did not meet the definition (Whether or not to uphold, expunge or modify the violation)
In thinking about this (and having read the new DOR on the exceptions committee), I wonder whether the team review process could be addressing not whether it happened but what the consequence should be and the consequence would be determined in light of mitigating factors, whether the same behaviors have been problematic, and any repairs or processing accomplished. Perhaps there could be an upheld violation but a waiver.... Just an idea.

The language could be something along the lines of....
The patient's treatment team reviews all reported violations using a just culture assessment of whether the behavior was a mistake, drift from usual behaviors, or willful or reckless disregard of expectations. The team also considers the patients response to the behavior and past history of the same of similar problems. Staff members are not required to impose a consequence for all violations of rules. The staff member may inform the patient that his behavior violated unit rules and discuss the patient's behavior with him. Depending on the situation, staff may counsel the patient. Counseling is intended to help the patient identify the goal of his behavior, understand the impacts of that behavior, identify appropriate alternatives, evaluate the benefits of those alternatives, and challenge the patient to choose among them. Warnings are intended to help patients identify and modify their behavior so they avoid consequences. Consequences may involve restrictions of privileges or adjusting the patient's risk rating level.