MSOP

MINNESOTA SEX OFFENDER PROGRAM

ANNUAL PERFORMANCE REPORT 2010

January 2011
Minnesota Sex Offender Program
444 Lafayette Road North
Saint Paul, MN 55155-0992

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Executive Summary

M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for the Minnesota Sex Offender Program (MSOP) by January 15th of each year. The statute stipulates the report must include information on the following:

1. description of the program, including strategic mission, goals, objectives and outcomes;
2. program-wide per diem;
3. annual statistics; and
4. the sex offender program evaluation report required under section 246B.03.

MSOP is one program, operating across two campuses. Admissions and the majority of primary treatment occur in Moose Lake. After clients demonstrate meaningful change and progress through the first two phases of treatment, they are considered for transfer to the St. Peter campus. St. Peter campus has two missions; reintegration and programming for alternative clients. Clients in phase III are provided opportunities to achieve therapeutic privileges to demonstrate their abilities to use new coping skills and risk management techniques in settings with less structure. St. Peter also provides the Alternative Program for clients with impaired cognitive abilities due to developmental disabilities, head injury or trauma, and other neuropsychological insults. These clients do all of their programming on the St Peter campus.

In 2010 the Minnesota Sex Offender Program received $47.5 million to build critical infrastructure not funded when the first phase ("Phase I") of an expansion at its Moose Lake site was completed in 2009. This "Phase II" of the expansion will provide additional space to help ensure that MSOP's rapidly growing client population has adequate living and treatment space, while ensuring public safety in a fiscally responsible manner. These new structures are collectively known as "Complex One" with the older structure being referred to as the "Main Building."

Phase II will enable MSOP to meet the daily needs of existing clients and provide legally-required treatment in a clinically effective manner, as well as provide other essential support space needed to operate effectively. Construction will include the construction of treatment rooms that were not built when the Phase I living units were constructed, and add needed kitchen space. Phase II will eliminate the use of off-site rental space and on-site trailers, which is expensive and poses significant safety, security, licensing and logistical issues. Additional enhancements to ensure the security of the facility and public safety of the facility include providing a secure shipping/receiving area, creating a client intake area, and expanding and upgrading security systems. Security system upgrades include fencing, electronic surveillance, communications, security entrances, and emergency systems.

The secure design of Phase II will allow the same operational efficiencies as realized by Phase I, helping to keep future costs down. MSOP has reduced its daily per client cost ("per diem") from $368 in FY08 to $328 in FY10.

Another accomplishment involved expanding Community Preparation Services ("CPS") to a second residential unit. CPS is the final stage of MSOP before provisional discharge to the community. Halvorson House, a single family home on the St. Peter campus outside of the secure perimeter opened in 2009. In 2010, MSOP expanded the CPS program into Green Acres, a group-home-style residence on the St. Peter Campus, also outside the secure perimeter. As of January 2011, MSOP has three clients in the Halvorson House and three clients in the Green Acres. MSOP is anticipating several additional admissions into CPS this year, which is anticipated to fill the existing beds at both Halvorson House and Green Acres. As such, MSOP is in the process of expanding the Green Acres by 15 additional beds.

Section I
Program Overview, Strategic Mission, Goals, Objectives, and Outcomes

Description of the Program: The Minnesota Sex Offender Program provides comprehensive sex-offender-specific treatment to individuals ("clients") who have been civilly committed by the courts. MSOP operates treatment facilities in Moose Lake and Saint Peter. Clients are committed as Sexual Psychopathic Personalities ("SPP") or as Sexually Dangerous Persons ("SDP") or as both SPP and SDP, only after a court has concluded that the individual meets the legal criteria for commitment. Such commitments are for an indeterminate time and, in most cases, follow an individual's completion of a period of incarceration.[1]

With the exception of clients in the MSOP Alternative Program, clients begin treatment at the Moose Lake facility.[2] After successfully progressing through the majority of their treatment there, clients are transferred to the St. Peter facility to complete treatment and begin working toward reintegration. All clients participating in treatment develop skills through active participation in group therapy. Clients are provided opportunities to demonstrate meaningful change through their participation in rehabilitative services such as education classes, therapeutic recreational activities, and vocational work program assignments. MSOP staff observe and monitor clients in treatment groups as well as in all aspects of daily living to determine and provide feedback on how clients are applying new knowledge and prosocial skills.

Mission: MSOP's mission is to promote public safety by providing world class treatment and successful reintegration opportunities for civilly committed sexual abusers.

Priorities: MSOP executive leadership has established priorities geared toward clarifying the treatment model, fostering cohesiveness and consistency in staff implementation of programming, and identifying areas in which efficiencies could be increased. The following priorities serve as the foundation for MSOP strategic planning.

MSOP is committed to creating a safe and respectful environment for clients and staff. Respect is defined as transparent and proactive communication, accountability, and recognition of the individualized needs of clients. Inherent in respect is the belief that all people are capable of making meaningful change if they possess the motivation and tools to do so.

Staff Development Goal: Develop and maintain a confident, healthy, and professional team.

Therapeutic Environment Goal: Establish MSOP as a world class, research-based, treatment program that is client-focused and has a clear progression across the continuum of care.

Values Goal: Create a values-based environment. Those core values that underlie the treatment program include a change-is-possible orientation, credibility, research-based, effectiveness, authenticity and integrity, transparency, and efficiency.

Learning Organization Goal: Establish a dynamic culture of learning at all levels of our world-class organization, which recognizes the many faces of learning.

Responsibility to the Public Goal: Partner with community stakeholders to enhance, develop, and effectively manage a world-class sex offender treatment program.

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1 As discussed in section III MSOP provides staffing for sex-offender-specific treatment to Department of Corrections' inmates who are identified as likely to be referred for civil commitment upon their release from incarceration.

2 Clients with low cognitive skills are placed in the MSOP Alternative Program and complete all phases of their treatment at St. Peter.

Strategic goals & objectives:

Goal	2010 Outcomes
Increase external credibility of MSOP	• Tours: Judge Quam, Special Review Board members, Bureau of Prisons, Office of the Legislative Auditor • Meetings with Ombudsman office
Formalize and integrate clinical programming	• Developed Program Theory Manual • Established role of PPG and polygraphs in treatment progression • Introduction of Family Therapy component in St. Peter • Implemented computer-based clinical documentation system • Integrated rehabilitative services staff into clinical meetings, trainings, and report writing
Increase professionalism and clinical competency of MSOP staff	• Trainings: PCL-R, therapeutic communities, MNATSA, traumatic brain injury, strategies with resistant clients, behavioral therapies • Contracted with consulting neuropsychologist
Use of Green Acres as second CPS facility	• The MSOP project team completed the schematic design for a 15-bed expansion of CPS and worked out a fast track plan to complete the project by summer 2011. • Staff reviewed the design and determined furnishing and equipment needs and placement of telephones, security cameras, electrical outlets and data ports.
Community housing established for clients on PD	• Four providers responded to our Request for Proposals for community-based housing. Master contracts with two halfway house providers were prepared and will be sent to the new administration in January for approval.
Create and clarify benchmarks, process and policy related to reintegration process	• Finalized the Reintegration Roadmap summarizing the path, privilege attainment, and estimated timeline for moving through Phase III in the Alternative Program, Supervised Integration (MSI), and Community Preparation Services (CPS). • Secured approval for eight new and revised policies related to Reintegration. Another three CPS policies await Committee approval. Began drafting Provisional Discharge policies. • Legislative recommendations were submitted to the administration.
Create an extensive network of community partners and providers willing and able to house and/or serve	MSOP made formal presentations on our overall program and Reintegration to the:

sex offenders.	• Ramsey County Board of Commissioners • Hennepin County Board of Commissioners • Minnesota County Attorneys Association All were well received and feedback indicated that the information was useful. • Provided leadership to the Minnesota Sex Offender Reentry Project (MNSORP), which helped plan and deliver activities to help educate and engage community partners, including roundtable discussions on housing, employment and social supports, offender panel presentations, conference workshops and a day-long symposium on sex offender issues. • Attended monthly Transition Coalition meetings at the Department of Corrections ("DOC") to network with attendees. • Attended the two-day Minnesota County Associations conference. • Participated in The Second Chance Coalition's Housing Committee discussion with community landlords / housing providers.
Enhance and strengthen communication and mission of "one program, two sites."	Enhanced electronic communications during the last year. MSOP's staff communication tool was enhanced with all staff having access to specific communications for each facility, as well as all overall MSOP communications. In addition, executive staff from each facility participate in a morning meeting to address daily day-to-day program issues.
Develop and maintain relationships with local community leaders building communication, resources, and program support	Both facilities conducted quarterly stakeholder meetings with the key community leaders to discuss emerging issues and future facility plans. In addition, the facilities work closely with many regularity agencies (Department of Human Services Licensing Division for Rule 26, Department of Health for Supervised Living Facility ("SLF"), and the office of the Ombudsman for Mental Health and Developmental Disabilities, etc.).
Establish a MSOP security team and security enhancement plan	During the last year, MSOP established a cross-facility security team. The team includes the security leaders at both facilities, as well as an outside security consultant. The Team has visited both facilities to review the physical plant, policy adherence, and daily activities to enhance the safety and security of all MSOP. An action plan has been created and the team has made related staffing assignments. This group is also available to address any emerging safety and security issues.
Evaluate and identify future bed space options	MSOP updated the program client projections and

	compared them to the current bed space. The results indicated that MSOP will be out of bed space by the beginning of 2013. As a part of a legislative report mandated during the 2010 session, MSOP developed both short-term and long-term options to address MSOP's client growth beyond 2013. With additional funding for the legislature, MSOP has begun Phase II which constructs space for critical support functions (i.e. treatment space, kitchen and dining for the entire campus, class rooms, religious services, vocational programming, and warehouse). The projected Phase II completion date is May 2012.
Separation of vocational industries and increased vocational opportunities for clients	MSOP consolidated vocational work activities in the shop and on the units under one manager. This has increased the vocational work opportunities for clients as well as provided for better coordination of activities between clinical, recreation, and vocational program staffs. MSOP continues to work to separate the MSOP and MN Security Hospital vocational work activities on the St. Peter campus.
Complete Phase I improvements	MSOP completed finishing work on Phase I of the additional complex on the Moose Lake campus, which added 400 beds. This project included security upgrades and enhancements that integrated systems for the entire campus.
Increase compliance with Rule 26 and SLF licensing	MSOP continues to work with the MN Department of Health in developing a better match through waivers between MSOP and supervised living facility rules. The initial steps are underway in splitting MSOP from the rest of the St. Peter campus in the licensing rule. This allows for improved and more accurate waivers due to the unique programming needs of MSOP as compared to community supervised living facilities. A revised Rule 26 variance was negotiated to further clarify components of the original variance. The revised variance went into effect on December 7, 2010. This revised variance provides standards consistent with the current treatment structure of MSOP.
Establish accounts payable function	Completed.
Create electronic records for clients	The electronic client records project is underway. A contractor has been hired and the architectural model for the electronic client record has been approved by the agency. The architectural model is unique as it is a scalable model with the capability to expand record components instead of working with a finite number of applications within the record.

	Hand-in-hand with the development of the computer architecture for the record, existing paper records dating from the 1990s and earlier are being indexed and scanned for incorporation into the electronic record.
Obtain 100% compliance with MN Predatory Offender Registration (POR)	Over the last four years OSI has worked with the client population to achieve 91.3% compliance.
Development of legal network / comprehensive info on other civil commitment programs	In 2010, the MSOP legal department developed an electronic discussion list for other legal professionals working civil commitment programs across the country. Data yielded from surveys and requests from other programs has been centralized in an electronic workspace so it is readily accessible as needed for comparison and data requests.
Design and implement cohesive, concise, data-driven quarterly and annual report formats	Quarterly and annual statistics are now compiled from all primary areas / functions within MSOP. Reports are made available to the commissioner, staff, and other stakeholders. Goals and outcomes have become more quantifiable for more objective outcome assessment and trend analysis.
Analyze and prepare statutory language for independent and comprehensive statute for SDP / SPP civil commitments	In the 2010 session, MSOP was successful in moving most relevant statutory language to section .185 in M.S. 253B.

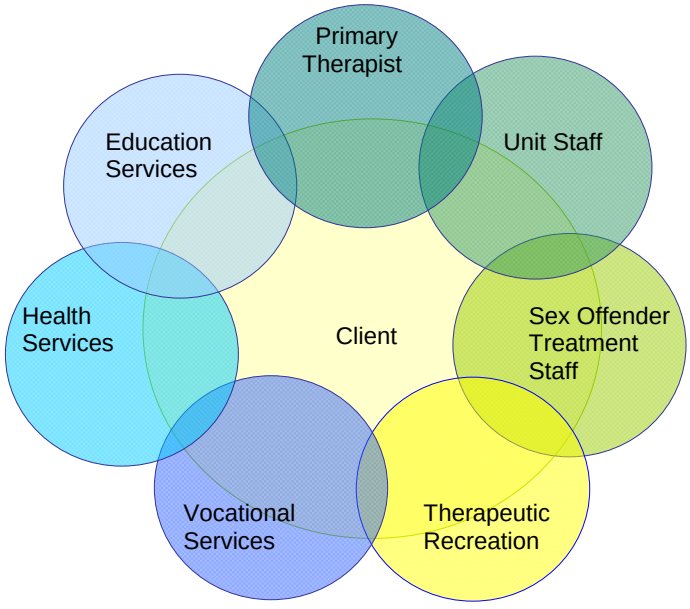
Section II
Treatment Model and Progression

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

Each client's treatment is guided by an individualized treatment plan that defines measurable goals. These goals are updated as the client progresses through treatment.

Clients progress through three phases of treatment. In the initial treatment phase, clients address treatment-interfering behaviors and attitudes. Following this preparation, clients in the intermediate treatment phase focus on their patterns of abuse and on identifying and resolving the underlying issues in their offenses. Clients in the final treatment phase focus on maintaining the changes they have made and demonstrating their ability to consistently implement those changes and manage their risk.

Comprehensive and Individualized Treatment
MSOP provides a comprehensive treatment program. Clients acquire skills through active participation in group therapy and are provided opportunities to demonstrate meaningful change through participation in rehabilitative services including education classes, therapeutic recreational activities and vocational work programs. Clients are observed and monitored not only in treatment groups, but in all aspects of daily living. This observation and monitoring is crucial for assessing clients' progress in making and maintaining meaningful personal change and in consistently applying treatment concepts, thereby decreasing their risk for re-offense



All clients follow Individualized Treatment Plans. The plan is developed with the client's multi-disciplinary team and is based on the results of a sexual offender assessment. The plan's goals are written to address the client's individual risk factors for recidivism and specific treatment need areas. Treatment progress is reviewed on a quarterly basis, and plans are modified as needed.

Treatment Design
MSOP clients who choose to engage in treatment participate in a sexual offender assessment that sets the foundation for their individualized treatment plan. Clients are then placed in programming based on their clinical profile. MSOP provides sex-offender-specific treatment to meet the needs of all clients. On average, clients participate in six to ten hours weekly of sex-offender-specific treatment with additional programming hours as warranted by individual need.

MSOP is one program at two facilities, one in Moose Lake and another in St. Peter. Each facility contributes to the mission of MSOP by specializing in different components of the treatment process.

The Moose Lake facility houses individuals who have been petitioned for civil commitment but not yet committed, clients who refuse to participate in sex-offender-specific treatment, and clients participating in initial and primary stages of treatment. Individuals who have successfully demonstrated meaningful change and have progressed through treatment are transferred to St. Peter to begin the reintegration process.

In addition to the components of reintegration, St. Peter is also the location of the Alternative Program for clients with compromised executive functioning and who therefore are not suited for conventional programming. These clients are in need of unique treatment approaches due to developmental disabilities, traumatic brain injuries, or severe learning disabilities.

MSOP Treatment Units:

Admissions (ADM): Clients newly admitted to MSOP and/or involved in the commitment proceedings but who have not been finally committed.

Alternative Program: Clients with compromised executive functioning. Alternative clients may have cognitive impairments, traumatic brain injuries and/or profound learning disabilities. It is unlikely that these clients would be successful in a conventional cognitive behavioral treatment program and therefore are in need of specialized programming.

Assisted Living Unit (ALU): Clients who are medically compromised to the extent of requiring specialized care

Behavior Therapy Unit (BTU): Clients who demonstrate behaviors that are disruptive to the general population and/or affect the safety of the facility: criminal behavior, repetitive restrictions to maintain safety, threatening behavior (i.e., assaults on staff/peers, thefts, predatory type behaviors, etc.) are treated on this unit with the goal of returning clients to their unitsonce the treatment-interfering behaviors have been resolved.

Conventional Programming Unit (CPU): Clients motivated to participate in sex-offender-specific treatment and are meeting behavioral expectations.

Corrective Thinking Unit (CTU): Clients who present with unique treatment needs including generally high levels of psychopathy and antisociality. Their traits often include: grandiosity, instrumental emotions, impulsivity, callousness, irresponsibility, conning and deception, belligerence, and lack of sustained effort in treatment.

Skill Building Unit (SBU): Clients with significant mental health diagnoses including Axis I diagnoses that do not meet the requirements for a transfer to the Minnesota Security Hospital and/or significant personality disorders that result in persistent emotional instability and/or potential self-harm.

Therapeutic Concepts Unit (TCU): Clients refusing to actively participate in sex-offender-specific treatment programming.

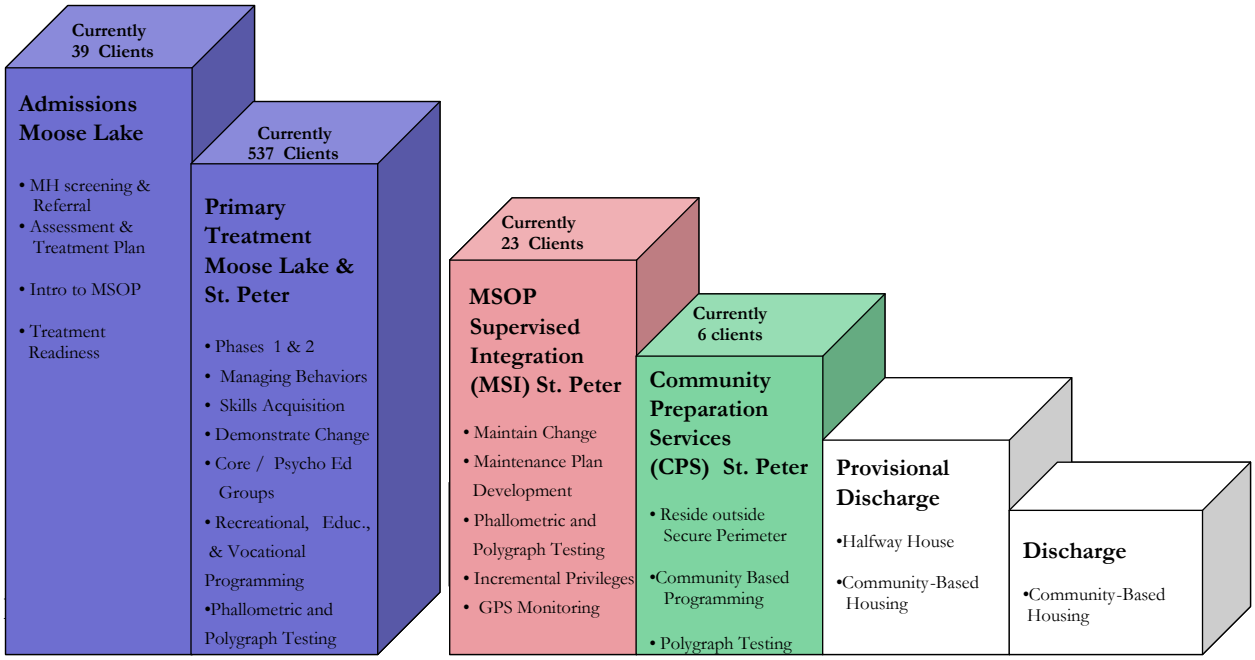
Young Adult Unit (YTU): Clients who are between the ages of 18 and 25 and do not meet criteria for the Alternative Program or CTU programming. Most of these men have not been incarcerated as an adult.

Treatment Progression

Clients progress through treatment by completing group module requirements, treatment assignments, risk management assessments, and by demonstrating they have changed their thinking and behaviors. Progress in treatment is assessed quarterly. Placement in treatment is determined by program matrix factors (See Appendix 1). These factors are reflective of the criminogenic needs of all sexual offenders. These treatment focused-areas are supported in the current professional literature and are indicators of risk for recidivism. At quarterly and annual reviews, clients conduct a self-assessment, and the results are compared to the assessment of their multi-disciplinary team. Individual treatment plans are modified accordingly.

Once clients have completed the majority of primary programming and have demonstrated meaningful change and successful risk management, they are assessed for and transferred to St. Peter to begin reintegration programming. This process consists of two program components: MSOP Supervised Integration ("MSI") and Community Preparation Services ("CPS").

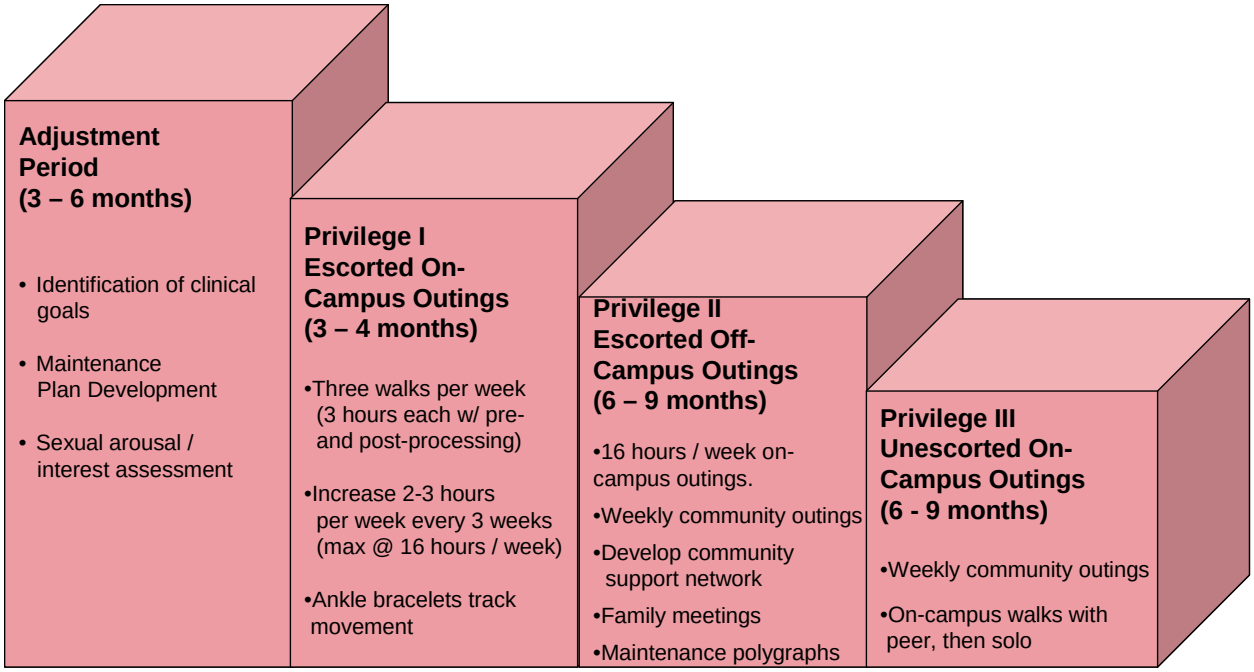
MSOP Treatment Progression Model



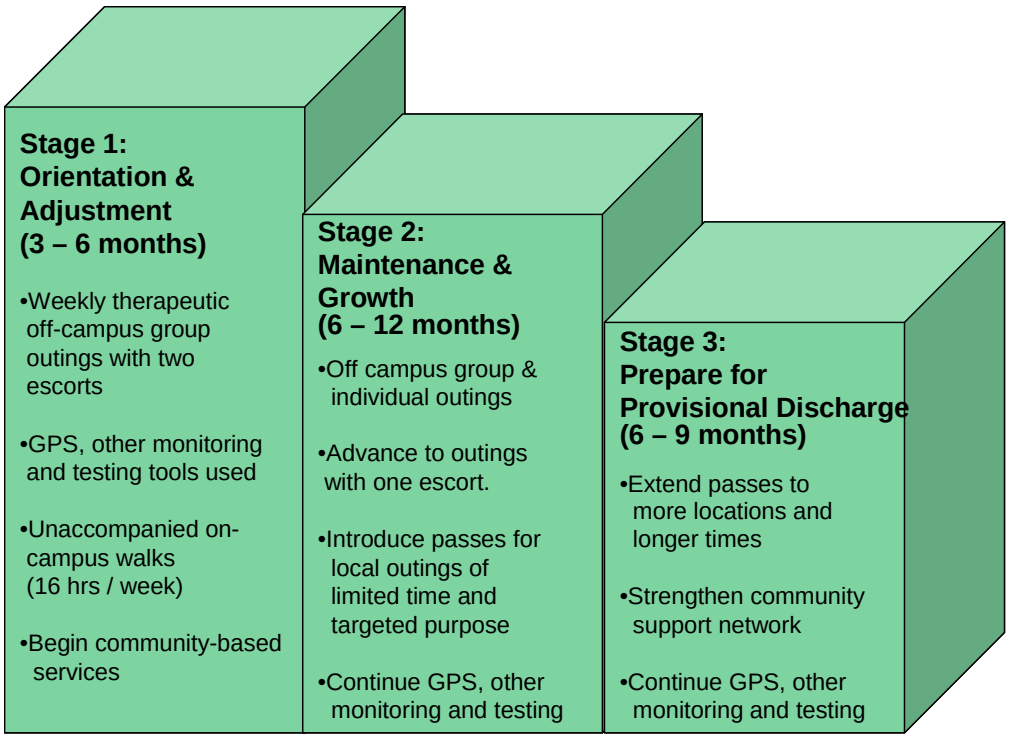
Reintegration is a transitional period designed to provide opportunities for clients to apply their acquired skills and to master increasing levels of privileges and responsibility while maintaining public safety. The focus of treatment during reintegration includes "decompression" from many years (often 15-20) of institutionalization. Clients are provided opportunities at a gradual pace to apply internalized treatment skills and behavioral changes.

MSOP Supervised Integration (MSI): Placement in this unit represents the beginning of the transitional phase of treatment at MSOP and focuses on solidifying skills for living safely in the community. After an adjustment period, clients are able to exercise progressively increased privileges: accompanied on-campus, accompanied off-campus, and unaccompanied on-campus liberties. All MSI clients with these privileges have Area Monitoring System (AMS) electronic monitoring bracelets.

Reintegration Progression Model



Community Preparation Services (CPS): After MSI clients have demonstrated consistent application of newly acquired skills and management of community environmental triggers, a client is generally considered ready for transfer to CPS, which can only occur via the judicial appeal panel process. CPS clients have both AMS and GPS monitoring. Initially, a CPS client is employed on campus and is allowed both campus and escorted community outings.



Section III
MSOP Department of Corrections Site

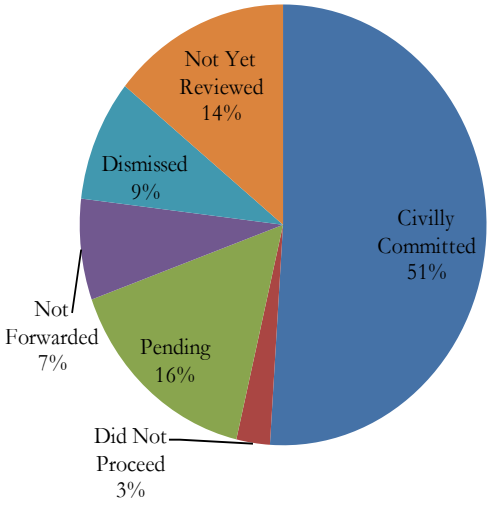
MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. This program provides sex offender treatment similar in scope and treatment design to the primary phase at the MSOP Moose Lake facility. Program participants are still serving their correctional sentences and have histories that indicate they are likely to be referred for civil commitment. Three outcomes may occur as the result of a client participating in this treatment prior to the end of their sentence in DOC:

1. The client is viewed as having made such significant progress toward management of risk factors that the county does not petition for their civil commitment.
2. The county still pursues civil commitment, but the court determines that the client has made sufficient progress so that civil commitment may not be necessary. For example, the judge may order treatment in a community-based setting.
3. The county pursues commitment, and the client is civilly committed to MSOP but is able to start at a later phase in treatment and/or move through MSOP more quickly based upon the clinical work the client has already completed in the MSOP DOC site with MSOP treatment staff.

There have been 251 men who have been admitted to the MSOP-DOC program since 2001. As of January 1, 2011, there are currently 50 in the program. Of the 195 men who have been discharged from the program:

- 97 (49.7%) are currently civilly committed (reside in the MSOP or DOC),
- 5 (2.6 %) were not forwarded for review (reside in the community or DOC),
- 30 (15.4%) forwarded for review, but the county did not petition for civil commitment
- (reside in the community or DOC),
- 14 (7.2%) petitioned for commitment but the petition was dismissed (reside in the community or DOC),
- 19 (9.7%) have petitions for commitment pending,
- 30 (15.4%) have not yet been reviewed for referral (reside in DOC not yet reviewed due to SRD date)

Disposition of MSOP DOC clients



Section IV

Minnesota Sex Offender Program
Fiscal Year 2010 Projected Per Diem

Direct Costs	Annual	Per Diem
Clinical	$ 8,355,800	$ 39.13
Health Care & Medical Services	5,718,700	26.78
Security	29,963,078	140.33
CPS & Community Preparation	1,036,789	4.86
Dietary	2,314,550	10.84
Physical Plant & Warehouse	6,045,918	28.31
Support Services	9,347,665	43.78
Vocational Program	2,060,500	9.65
Total Direct Costs	$ 64,843,000	$ 303.68
Additional Allocations		
Statewide Indirect[1]		$ -
DHS Indirect[2]		1.85
Building Depreciation		8.79
Bond Interest		13.03
Capital Asset Depreciation		0.69
Total Additional Allocations		$ 24.36
Total		$ 328.04
Average Daily Client Count (ADC)		585

[1] Minnesota Management & Budget charges for services such as central purchasing, payment processing, electronic fund transfers, and other services provided to all state agencies.

[2] Allocated cost of agency central functions such as, but not limited to: financial operations, budgeting, telecommunications and media services, occupancy, compliance and internal audit, legislative coordination, and licensing.

9/21/2009

MSOP Per Diem

While there are 21 other civil commitment programs (20 state programs and one federal program) in the country, there is no uniform method for calculating the per diem cost of program operations. A survey conducted by MSOP Financial Services revealed that most programs do not include all costs associated with operating and maintaining a program. MSOP uses a comprehensive per diem calculation that includes all direct and indirect costs, including costs incurred by the State for bonding and construction of physical facilities. This all-inclusive per diem for fiscal years 2010 and 2011 is $328. The marginal per diem, which is the estimated additional costs for each new admission into MSOP, is currently $144.

Section V

Annual Statistics

Current Program Statistics

Total MSOP Clients	**605**
Clients by Location	
Moose Lake	**459**
St. Peter	**146**
Clients by Age	
18-25	**26**
26-35	**139**
36-45	**136**
46-55	**156**
56-65	**106**
Over 65	**42**
Average Age	**46**
Youngest	**20**
Oldest	**89**
Race	
American Indian	**44**
Black/African American	**75**
Latino/Hispanic	**15**
White Caucasian	**463**
Other	**8**

Education	
0-8 Years	37
9-11 Years	109
12 Years	325
12+ Years	128
Unknown	6
Civilly Committed Offenders by County	
Hennepin	130
Ramsey	59
Olmsted	30
Anoka	25
Dakota	21
St. Louis	16
Other Counties	324
Metro Counties	261
Non-Metro Counties	344

Population Statistics

When civil commitment is pursued for an individual, upon expiration of a DOC sentence or a supervised release date, he or she is placed on a judicial hold while the petition is pending. Individuals on judicial holds have the option to remain in a DOC facility, be held in a county jail (210 days maximum), or be admitted to MSOP. As of 01.01.10, there were 29 individuals on hold status.

Clients on judicial hold status admitted to MSOP	13
Clients on judicial hold status in DOC / jails	16
Total on judicial hold status	**29**

Currently, the civil commitment process in Minnesota has two phases after a county attorney files petition for commitment. During an initial hearing, the court determines if the individual meets the statutory criteria for civil commitment. If this burden is met, the individual is initially committed and transferred to MSOP (if the client is not already admitted). Sixty days after this hearing, per statute, MSOP is required to submit a report to the committing court indicating whether or not the client's status remains the same. Specifically, does the client still meet the statutory criteria for civilly commitment? If the court determines there has not been significant change since the initial commitment, the client's indeterminate commitment is made final.

Clients who have been initially committed	17
Clients who have been finally committed	575
Total clients on civil commitment status	**605**

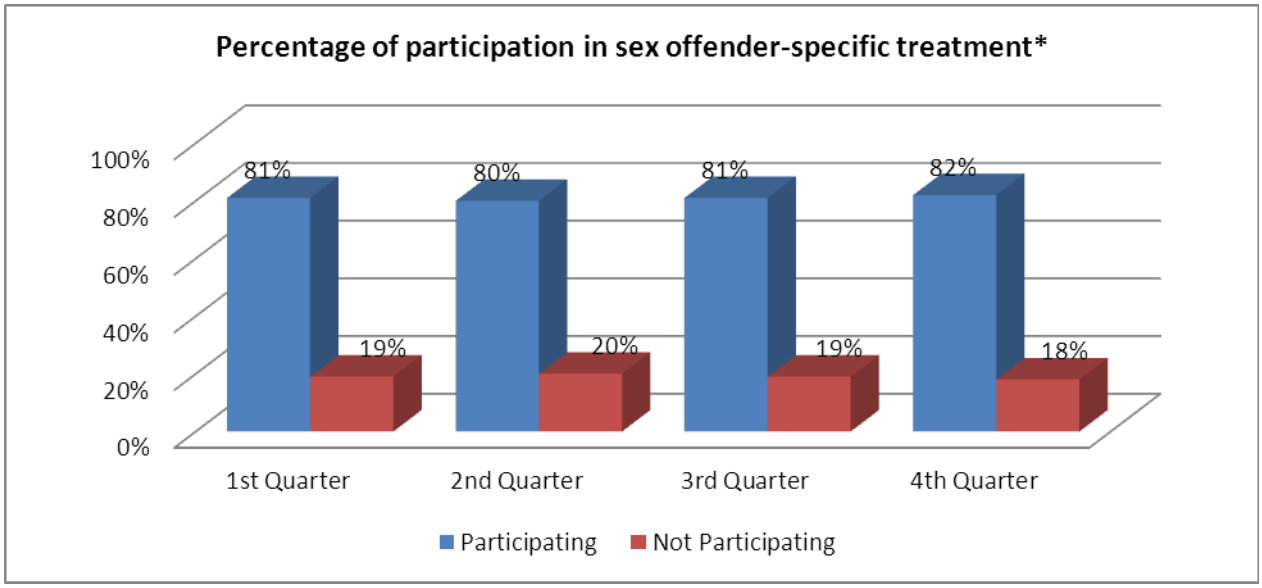
Many clients participating in treatment in MSOP remain under DOC commitment on supervised release status ("dually committed"). If these clients engage in actions or criminal behaviors which result in the DOC revoking their supervised release status or result in a new conviction, the clients are returned to DOC to serve a portion or all of their criminal sentences (21 clients in 2010). However, these clients still remain under civil commitment and will return to MSOP upon completion of the period of incarceration.

Clients who are under civil and DOC commitment in MSOP	224
Clients who are under civil commitment and in DOC	51
Total number of dually committed clients	**275**

Clinical Statistics

Treatment Participation

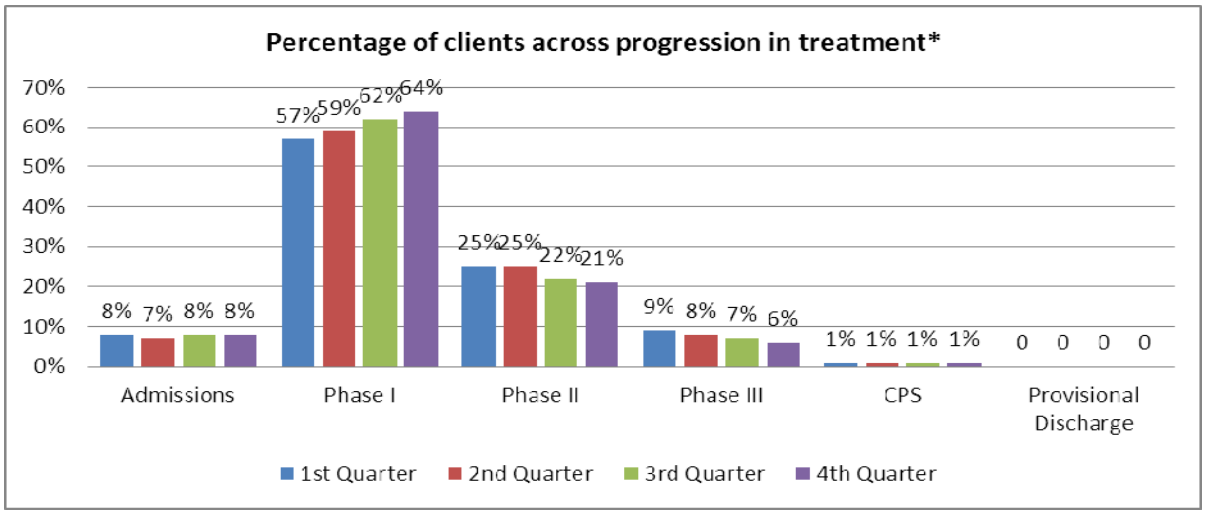
All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment, approximately 80% participate.



* This data does not include those clients who are on admission status or residing in DOC.

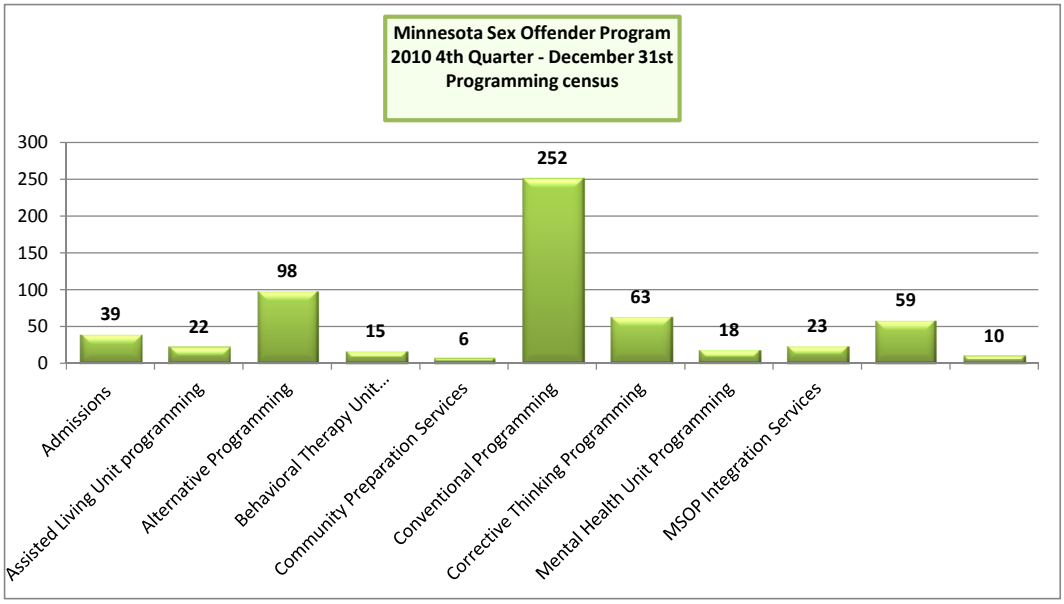
Once the civil commitment process is finalized, and an individual has participated in the sex offender evaluation process, he has the opportunity to participate in sex offender-specific treatment. The chart below represents the treatment progression of clients over the past calendar year.

Treatment Progression



* This data does not include those clients who are not participating in treatment.

As a result of initial and ongoing clinical assessments, clients are placed in treatment units appropriate to their individual treatment needs and abilities. The following chart illustrates the year-end distribution of clients across the treatment units. The MSOP population is diverse with 45% of the clients residing on units that provide specialty programming while 39% reside on units providing Conventional Treatment. The remaining 16% of the population resides on programming units that do not provide sex-offender specific treatment (ADM and TCU).



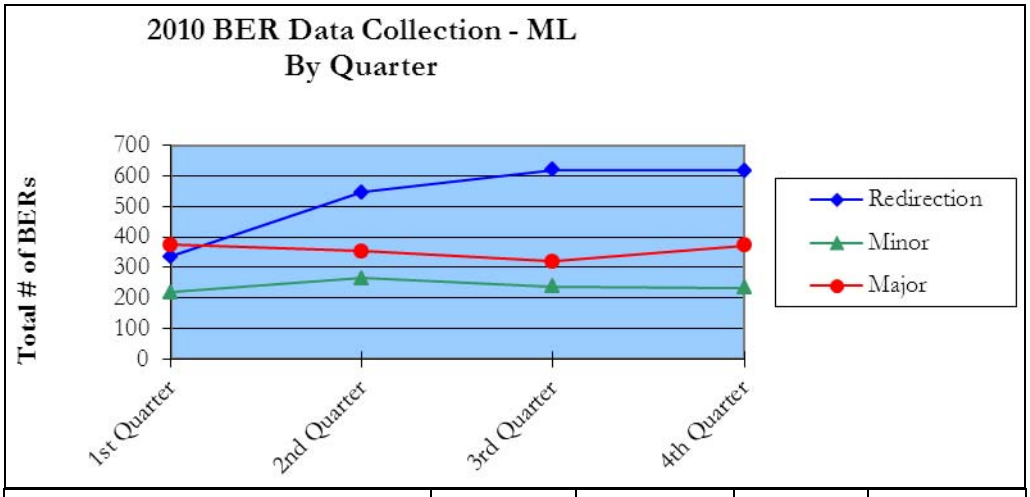
Programming	Location	Total Clients	Percentage
Admissions (non-participants)	Moose Lake	39	6 %
Assisted Living Unit Programming	Moose Lake	22	4 %
Alternative Programming	St. Peter	98	16 %
Behavior Therapy Unit Programming	Moose Lake	15	3 %
Community Preparation Services	St. Peter	6	1 %
Conventional Programming	Moose Lake and St. Peter	252	42 %
Corrective Thinking Programming	Moose Lake	63	10 %
Mental Health Unit Programming	Moose Lake	18	3 %
MSOP Integration Services	St. Peter	23	4 %
Therapeutic Concepts (non-participants)	Moose Lake	59	10 %
Young Adult Treatment Programming	Moose Lake	10	1 %
total		605	100

Please note: Although we have a Unit designated for Non-participants, we also have non-participants residing on other Units.
Example: Behavioral Therapy Programming – 12 out the 15 clients are non- participants
Also, this is not a UNIT census, but rather programming census. A program track can occur across various housing units.

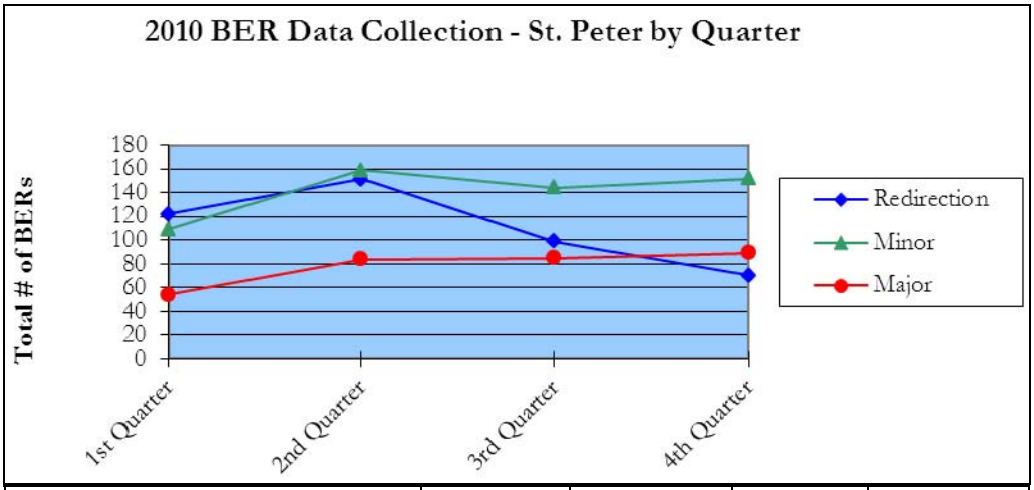
Operational Statistics

Behavioral Expectations

A Behavioral Expectations Report (BER) is a report that is generated when a client is alleged to have violated an established facility rule. The BER is given to the client and must list the client's name, location of incident, date, time, the specific rule violation, and a written summary of the facts surrounding the incident. The client can admit the violation and accept the recommended restriction or challenge the report through the behavioral expectations process.



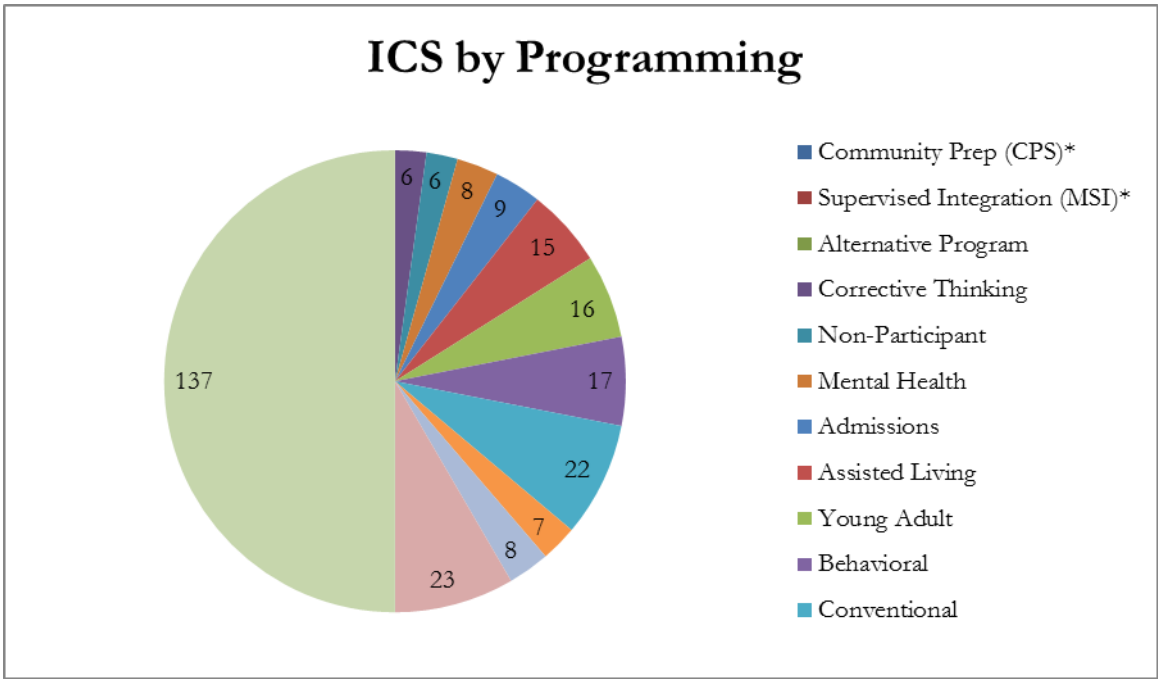
	Q1	Q2	Q3	Q4
Redirection	336	546	620	617
Minor	218	264	237	234
Major	375	353	319	371
Total BERs Moose Lake	929	1163	1176	1222



	Q1	Q2	Q3	Q4
Redirection	122	151	99	70
Minor	109	159	144	152
Major	54	84	85	89
Total BERs St. Peter	285	394	328	311

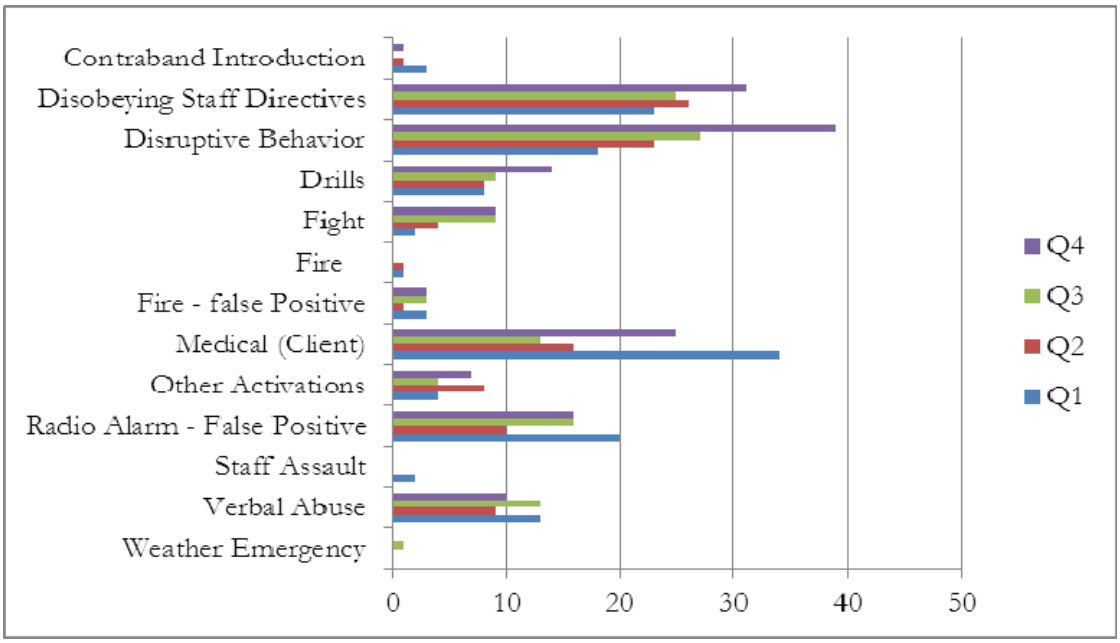
Incident Command System

Incident Command System (ICS) is a unified and consistent communication system utilized by MSOP staff and emergency responders when a behavioral incident, facility emergency, or other significantly unusual event occurs causing disruption to daily operations. ICS allows them to unambiguously communicate with each other, stabilize, isolate, contain, and resolve an incident in a safe and efficient manner to return a unit or area of the facility to normal operations.



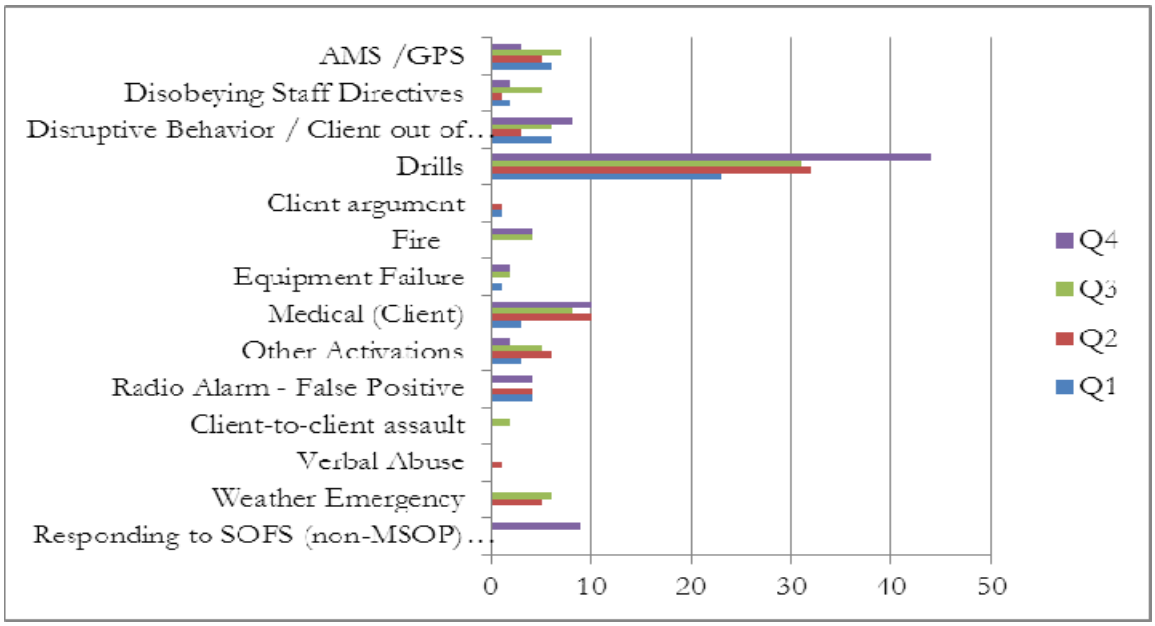
	Q1	Q2	Q3	Q4	Total
Community Prep (CPS)*	0	0	0	0	0
Supervised Integration (MSI)*	0	0	0	0	0
Alternative Program	0	0	0	0	0
Corrective Thinking	6	4	7	7	24
Non-Participant	6	5	8	5	24
Mental Health	8	8	10	8	34
Admissions	9	9	7	7	32
Assisted Living	15	14	4	10	43
Young Adult	16	15	4	2	37
Behavioral	17	17	21	44	99
Conventional	22	20	15	23	80
High Security Area (H.S.A)	7	6	4	3	20
Common Programming Areas	8	10	15	10	43
Other	23	15	3	37	78
Total**	137	123	98	156	514

MSOP ICS CAUSES – MOOSE LAKE



CAUSE	Q1	Q2	Q3	Q4
Weather Emergency	0	0	1	0
Verbal Abuse	13	9	13	10
Staff Assault	2	0	0	0
Radio Alarm- false positive	20	10	16	16
Other Activations	4	8	4	7
Medical (client)	34	16	13	25
Fire- false positive	3	1	3	3
Fire	1	1	0	0
Fight	2	4	9	9
Drills	8	8	9	14
Disruptive Behavior	18	23	27	39
Disobeying Staff Directives	23	26	25	31
Contraband Introduction	3	1	0	1
Total	**131**	**107**	**120**	**155**

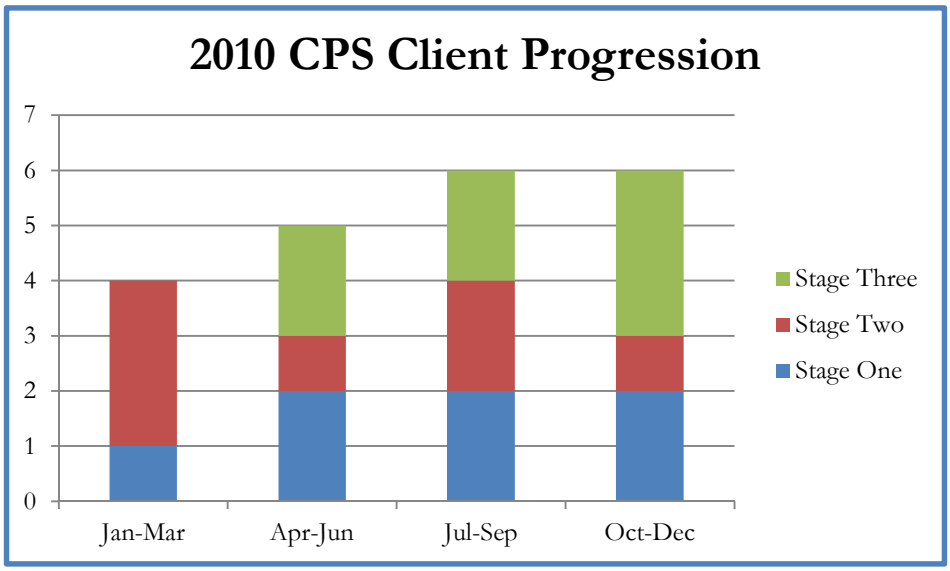
ICS CAUSES – ST. PETER



CAUSE	Q1	Q2	Q3	Q4
Weather Emergency	0	5	6	0
Verbal Abuse	0	1	0	0
Client-to-client assault	0	0	2	0
Radio Alarm- false positive	4	4	0	4
Other Activations	3	6	5	2
Medical (client)	3	10	8	10
Equipment Failure	1	0	2	2
Fire	0	0	4	4
Client argument	1	1	0	0
Drills	23	32	31	44
Disruptive Behavior / Client out of control	6	3	6	8
Disobeying Staff Directives	2	1	5	2
AMS/ GPS	6	5	7	3
Responding to SOFS (non-MOSP) request for assistance	NA	NA	NA	9
Total	**49**	**68**	**77**	**88**

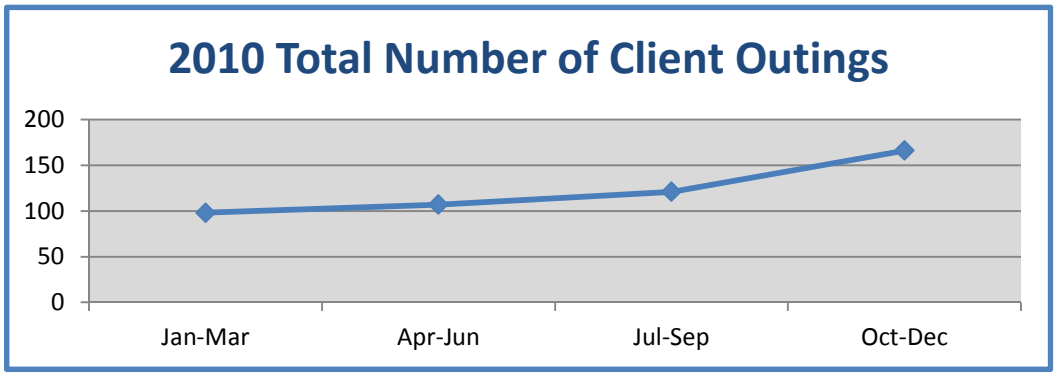
Reintegration Statistics

- CPS clientele grew from four clients in January to six in December.
- Green Acres opened in May to accommodate growth when a fifth client moved to CPS.
- Completed design work for an expansion of CPS space in Green Acres. Fifteen additional beds will be added in 2011.
- By year end, three clients had progressed to Stage 3. Two of them have been approved by the SRB for PD and are awaiting a decision from SCAP.
- Drafted Master Contracts with two halfway house providers and will execute in the first quarter of 2011.
- Hired two additional Reintegration Specialists (f/k/a "Field Agents"), for a total of three, to work with clients while they are in CPS and to supervise and support clients when they are granted Provisional Discharge.

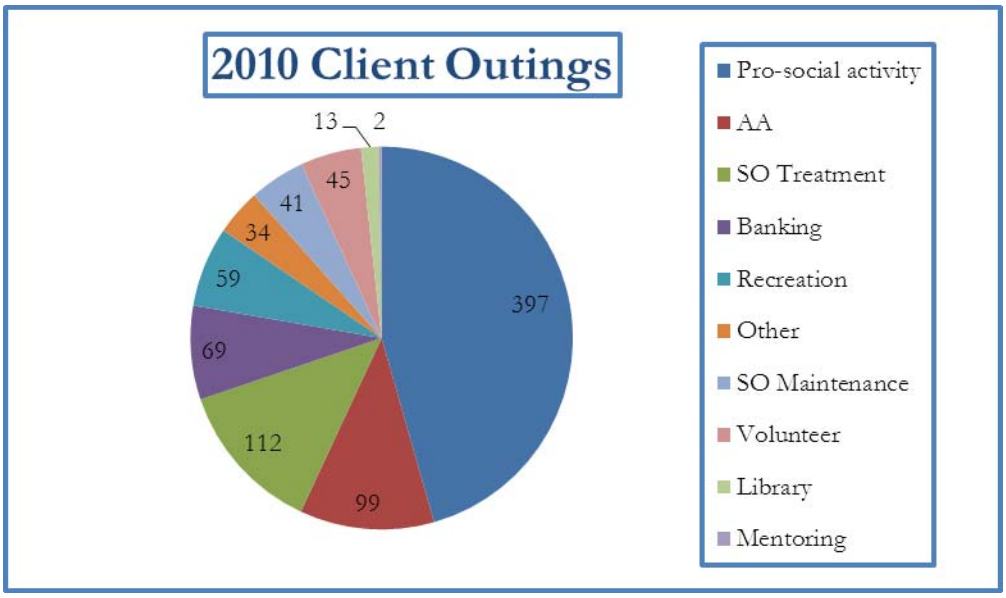


Client Activity

Staff accompanied the six CPS clients on 492 outings into the community in 2010, without incident.



Types of Outings	Total	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Pro-social activity	397	77	87	102	131
AA	99	19	27	27	26
SO Treatment	112	25	26	26	35
Banking	69	15	16	17	21
Recreation	59	8	14	17	20
Other	34	3	8	16	7
SO Maintenance	14	3	13	13	12
Volunteer	45	4	5	10	26
Library	13	7	2	0	4
Mentoring	2	2	0	0	0



Administrative Statistics

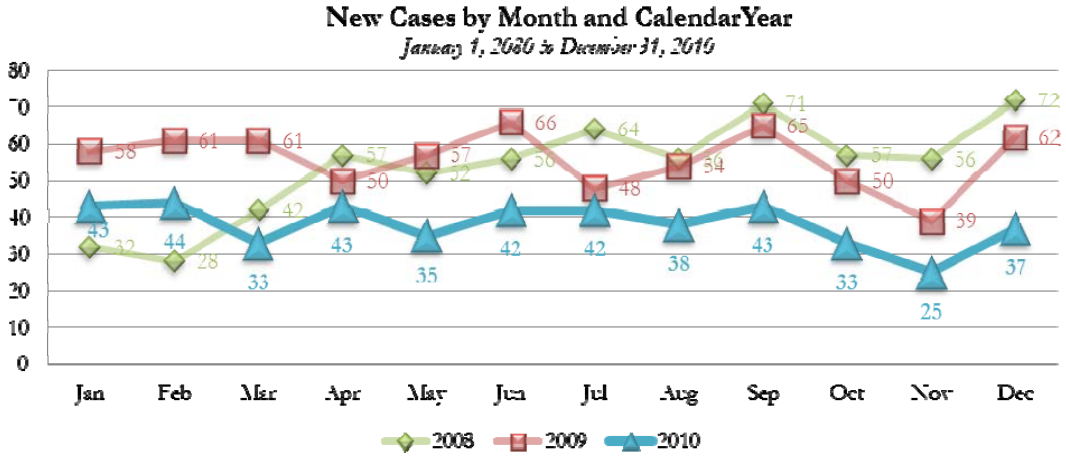
Of the 203 MSOP policies in effect, 148 of these were issued or revised in 2010. There are currently 47 new policies or policy revisions in development. Each policy has an assigned drafting chair and drafting committee responsible for the overall development of the policy, ongoing review, and updating the policy. This approach provides for integrated line staff involvement and collaboration in the development of MSOP operational practices. The MSOP Policy Committee, which includes representation from executive and facility clinical and support staff, reviews and approves each policy before issuance.

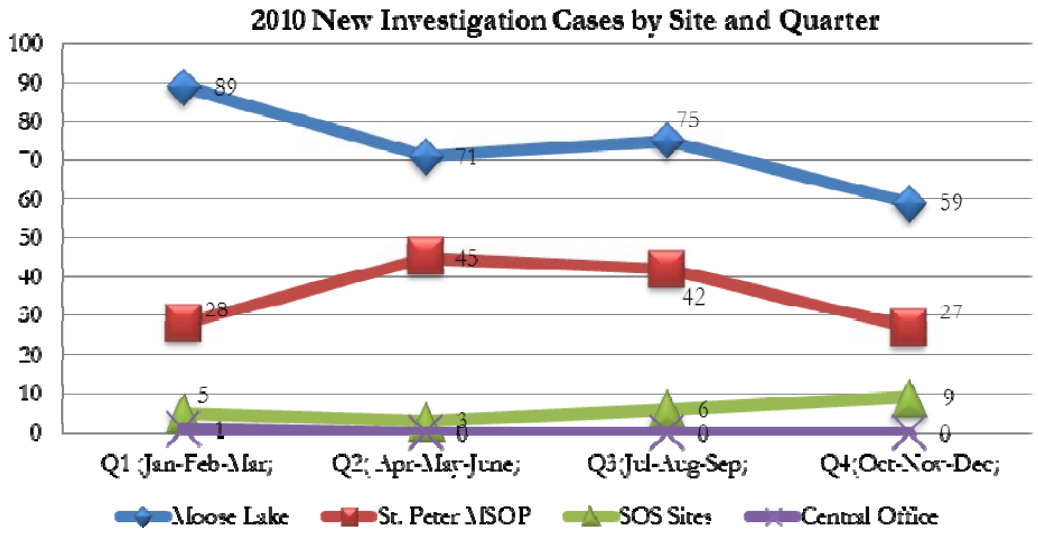
MSOP is operating under a variance from the Department of Human Services Licensing Division. This variance was effective on May 28, 2009. However, the implementation has been incremental due to the need

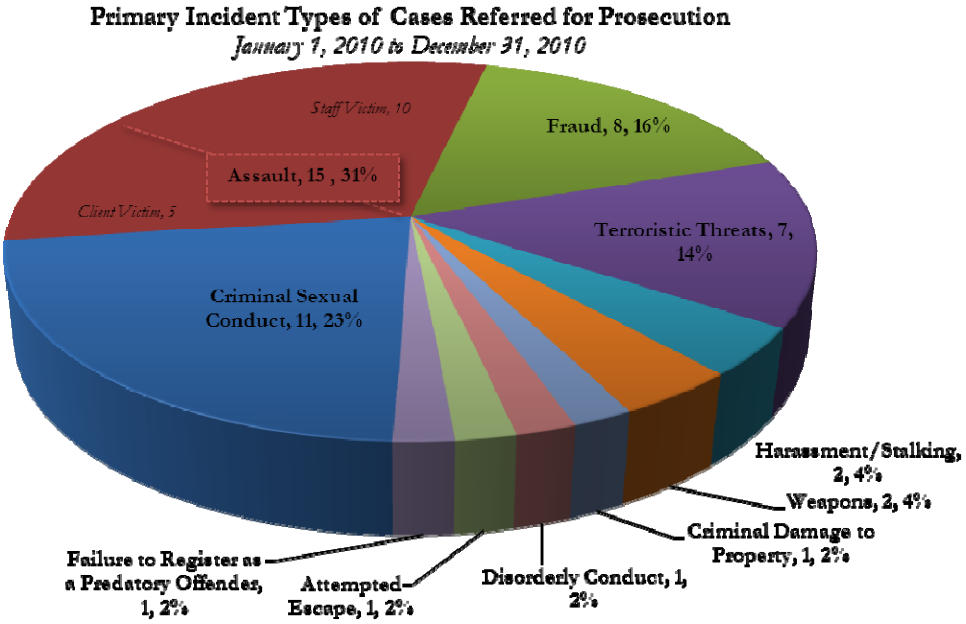
to articulate and develop major policies surrounding admission, high security area, protective isolation status, vulnerable adults, levels of observation, and administrative restriction status, which continue to be refined and adjusted. Many of the policies did not achieve full implementation until November or December 2009. In December 2009, the Licensing Division visited MSOP to review the effectiveness and implementation of the current variance. The Licensing Division determined that the existing variance is in need of additional clarity and modifications to ensure its applicability to MSOP and the MSOP's ability to achieve maximum compliance with the requirements of the Rule. A new variance, which supersedes the May 28, 2009 variance, went into effect on December 7, 2010. Major policies impacted by this variance were revised to reflect variance requirements and to synchronize with the variance's effective date.

Office of Special Investigation (OSI)

- In 2010, OSI completed 461 investigations focusing on client misconduct**.** These investigations resulted in various dispositions. Forty-nine cases were referred for prosecution in 2010.
- There were criminal charges filed in 28 cases (9 from 2009). There were 14,822 incidents with 20,986 incident reports completed (e.g., there is often more than one incident report per event).
- In 2010, 23 clients were returned to DOC for revocations or new convictions. The range for days spent in DOC by MSOP clients in 2010 was 120-766 days with 277 days being the average length of time spent back in DOC
- New Cases Opened: 95 (123 last quarter) (2010: 461 cases)
- Cases Closed: 98 (138 last quarter)
- Documented hours on investigation cases: 692.4 (862 hours last quarter)
- File Maintenance/Data Requests: 60 (88 last quarter)
- Documented hours on File Maintenance/Data Requests: 75.2 (102 last quarter)




2010 New Investigation Cases by Site and Quarter
100
90
80
70
60
50
40
30
20
10
0
89
71
75
59
45
42
38
27
5
3
6
9
1
0
0
0
Q1 (Jan-Feb-Mar)
Q2 (Apr-May-June)
Q3 (Jul-Aug-Sep)
Q4 (Oct-Nov-Dec)
Moose Lake
St. Peter MSOP
SOS Sites
Central Office


Primary Incident Types of Cases Referred for Prosecution
January 1, 2010 to December 31, 2010
Staff Victim, 10
Client Victim, 5
Assault, 15 , 31%
Fraud, 8, 16%
Terroristic Threats, 7, 14%
Criminal Sexual Conduct, 11, 23%
Harassment/Stalking, 2, 4%
Weapons, 2, 4%
Criminal Damage to Property, 1, 2%
Disorderly Conduct, 1, 2%
Attempted Escape, 1, 2%
Failure to Register as a Predatory Offender, 1, 2%

Section VI
MSOP Evaluation Report Required Under Section 246B.03

In effort to maintain a treatment program that is grounded in current best practices, research, and contemporary theories, MSOP contracted with outside auditors to review the treatment program. This team consists of three professionals who are well respected, both nationally and internationally, in the area of sexual abuse treatment. Individually and as a group, they have consulted with similar programs throughout the world. They bring not only a perspective of current practices, but also years of professional experience. In 2010, they visited the Moose Lake facility. The focus of their consultation is the integrity of the clinical program design. The report generated as a result of this visit is contained within Appendix 3.

Appendix 1

Matrix Factors	**Criminogenic Needs/ Dynamic Risk Factors**
Group Behavior	Resistance to Rules/Supervision Negative Social Influences Poor Self-Regulation General Hostility Hostility toward Women
Attitude toward	ChangeOffense Supportive Attitudes
Self-Monitoring	Poor Self-Regulation Impulsivity-Recklessness Sexual Preoccupation Deviant Interests, incl. sexual Sexualized Coping
Thinking Errors	Offense Supportive Attitudes General Hostility Hostility toward Women Callousness
Pro-Social Problem Solving	Negative Social Influences
Emotional Regulation	Poor Self-Regulation Impulsivity-Recklessness
Interpersonal Skills	Emotional Congruence with Children Poor Adult Attachment Negative Social Influences
Cooperation with Rules	Resistance to Rules/Supervision
Sexual Functioning	Sexual Preoccupation Deviant Interests, incl. sexual Sexualized Coping
Use of Personal Time	Unstable Work History

Appendix 2

MSOP Reintegration Path
Phase III Clients in Alternative Programming and MSOP Supervised Integration (MSI)

	Orientation and Adjustment	Staff-Escorted On-Campus Outings	Staff-Escorted Off-Campus Outings	Unescorted On-Campus Outings
	ESTIMATE based on individual treatment needs 3 – 6 Months	ESTIMATE based on individual treatment needs 3 – 6 Months	ESTIMATE based on individual treatment needs 6 – 9 Months	ESTIMATE based on individual treatment needs 6 – 9 Months
ON / OFF CAMPUS PRIVILEGES As approved by the Clinical Team	No campus privileges. Monitored movement to vocational programming. Identify clinical goals with direction toward successful reintegration. Continue to Develop Community Network throughout Reintegration Program.	Take up to two walks per week (1.5 hours each outing including 15 minutes each for pre- and post-processing). In addition: Walk to therapeutic recreational activities as scheduled. Walk to and from on-campus vocational programs.	Continue escorted on-campus walks, vocational programming and therapeutic recreational outings. Begin weekly community outings within a 30-mile radius of the facility, up to four hours per outing, including pre- and post-processing time.	Continue on-campus walks, vocational programming, therapeutic recreational outings and community outings. Begin on-campus walks with a "support peer" for about a month, then proceed to solo walks, up to 16 hours per week.
MONITORING and SUPERVISION	Reside within secure perimeter. AMS used for on-campus movement. Covert/Overt Surveillance.	Reside within secure perimeter. AMS used for on-campus movement. Covert/Overt Surveillance.	Reside within secure perimeter. AMS used for on-campus movement. Covert/Overt Surveillance.	Reside within secure perimeter. AMS used for on-campus movement. Covert/Overt Surveillance.
ADVANCEMENT DETERMINATION	Clinical Team determines when criteria met for advancement in privileges, based on the client's treatment progression.	Clinical Team determines when criteria met for advancement in privileges, based on the client's treatment progression.	Clinical Team determines when criteria met for advancement in privileges, based on the client's treatment progression.	The Supreme Court Appeal Panel must approve the client's transfer to CPS.

Polygraph, PPG and other assessments will be conducted as clinically and programmatically indicated.

MSOP Reintegration Path
Phase III Clients in Community Preparation Services (CPS)

	CPS Stage One: Adjustment	CPS Stage Two: Maintenance and Growth	CPS Stage Three: Prepare for Provisional Discharge
	ESTIMATE based on individual treatment needs **3 – 6 months**	**ESTIMATE based on individual treatment needs** **6 – 9 months**	**ESTIMATE based on individual treatment needs** **6 – 9 months**
ON/OFF CAMPUS PRIVILEGES As approved by the Multi-Disciplinary Team.	Retain existing privilege level. Continue current treatment and rehabilitation programming.	Expand boundaries and venues of off-campus outings beyond the 30-mile radius. Begin community-based programming.	Continue off-campus outings. Further expand venues to prepare for provisional discharge. Continue participation in community-based programming.
MONITORING/ SUPERVISION	Reside outside secure perimeter on St. Peter campus. AMS used for on-campus movement GPS monitoring for off-campus outings Covert/Overt Surveillance	Reside outside secure perimeter on St. Peter campus. AMS used for on-campus movement GPS monitoring for off-campus outings Covert/Overt Surveillance	Reside outside secure perimeter on St. Peter campus. AMS used for on-campus movement GPS monitoring for off-campus outings Covert/Overt Surveillance
ADVANCEMENT DETERMINATION	The CPS Multi-Disciplinary Team determines when criteria are met for advancement to Stage Two, based on the client's treatment progression.	The CPS Multi-Disciplinary Team determines when criteria are met for advancement to Stage Three, based on the client's treatment progression.	Supreme Court Appeal Panel must approve the client's move to the community under a Provisional Discharge.

Polygraph PPG and other assessments will be conducted as clinically and programmatically indicated.

Appendix 3

Minnesota Sex Offender Program Site Visit Report

Site Visitors:	James Haaven, Private Consultant, Portland, Oregon Robert McGrath, McGrath Psychological Services, Middlebury, Vermont William Murphy, University of Tennessee, Memphis, Tennessee
Location:	Minnesota Sex Offender Program, Moose Lake, MN Minnesota Sex Offender Program, St. Peter, MN
Dates of Visits:	September 27 to October 1, 2010
Date of Report:	October 8, 2010

Purpose and Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program. The consultation was a component of MSOP's quality improvement program. This was a follow-up site visit from our previous program reviews in February 2006, October 2007 and April 2009.

During the current review, we spent two days at the Moose Lake site, two days at the St. Peter site, and one half day reviewing and discussing our findings with representatives at both sites via video conference from St. Peter.

Summary of Findings

Since the last site visit, the program has opened a new 400-bed complex, progressed approximately 40 clients to the transitional phase of the program and made considerable strides in refining several clinical aspects of the program.

With respect to the facility, the program opened 400 additional beds in a new complex at the Moose Lake site in July 2009. About 200 clients who were housed in a rented facility from the Department of Corrections have moved into this new complex. The Moose Lake site houses approximately 425 clients; newly admitted clients, treatment refusers, and clients enrolled in a variety of treatment programs. The St. Peter site now houses about 150 clients; clients in Phase III and the later stages of treatment in the conventional program and clients enrolled in the Alternative Program for individuals with lower cognitive functioning.

With respect to client movement through the program, as noted in our previous reports, an over-arching issue is that no one is being released. This is contrary to the intent of the program, impacts the morale of clients and staff, and in the long term this may impact the overall safety of the institution. Since the last site visit, the number of clients who have entered the transitional phase of the program has increased markedly. Approximately 40 clients are now in Phase III of the program and are receiving services to prepare them to reintegrate into the community. A hearing for one client's release is to be scheduled in the near future. The

increased movement of clients into the transitional phases of the program appears to have had a positive impact on the morale of clients and staff.

With respect to the clinical aspects of the program, the program employs several highly experienced and dedicated staff that are committed to running a program that adheres to best practices. Because of vacancies, especially at Moose Lake, there are also a number of new staff being oriented to the program. Since our last site visit, the program has drafted a "Program Manual" (September 2010 draft) that details the overall rational, theory, structure and empirical basis for the program. The program has also finalized and implemented the "Goal Matrix for Phases I, II and III" document. This document clearly links the key dynamic risk factors that should be addressed in an effective sex offender treatment program to the program's phases of treatment. The reviewers recommend that the program develop a "Treatment Manual" to provide clinical staff with more direction about how to facilitate treatment groups in a standardized manner.

Procedures

Prior to the site visit, Jannine Hebert, MSOP Executive Clinical Director, sent the reviewers the MSOP Quarterly Report for the April, May and June 2010 quarter and discussed the purpose of the review and recent program changes during a telephone call with site reviewer Robert McGrath.

During the site visit we engaged in the following activities:

- Met in meetings with senior management;
    - Jannine Hebert, MSOP Executive Clinical Director,
    - Thomas Linquist, Acting Clinical Director at Moose Lake,
    - Nancy Johnson, MSOP Director at St. Peter and
    - Haley Fox, Ph.D., Clinical Director at St. Peter.
- Toured facilities at both sites.
- Attended Morning Report meetings at both sites.
- Met with the following staff groups without their supervisors present at both sites;
    - clinical supervisors,
    - clinicians with two or fewer years experience in the program,
    - clinicians with more than two years experience in the program,
    - rehabilitation staff and administrators,
    - unit managers and
    - security counselors.
- Interviewed clients;
    - eight client unit representatives at Moose Lake,
    - five clients at MSOP's Supervised Integration (MSI) Unit at St. Peter and
    - several clients informally during unit visits.
- Attended three treatment groups at Moose Lake.
- Reviewed the clinical records of three Moose Lake clients and three St. Peter CPS clients.
- Provided verbal feedback of our findings to Jannine Hebert, Executive Clinical Director.
- Provided verbal feedback of our findings to a group of senior clinical and administrative directors and managers.

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

Consultation Approach

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

Findings and Recommendations

The following sections of the report are organized around 12 best practice areas that are linked with effective sex offender treatment programs. We briefly define each key area, assess the program's functioning in that area and make recommendations for continued development.

1. Model of Change

The program has an explicit and empirically-based model of change that describes how the program is intended to work.

Since our last site visit, the program has drafted a "Program Manual" (September 2010 draft) that details the overall rational, theory, structure and empirical basis for the program. The manual describes a program that is broadly cognitive-behavioral and skill based in nature and is very consistent with best practices in the field. The program manual places a strong emphasis on client engagement and therapist style with a focus on positive approach goals. The reviewers recommend that the program finalize the "Program Manual."

2. Risk and Intensity of Services

The intensity of services is matched to the risk level and treatment needs of the clients.

Civil commitment programs focus on a high risk/need population and, therefore, should provide a relatively high level of treatment services.

Since our last site visit, it appears that the typical number of sex offender specific treatment hours a client receives has increased from about 6 to 7.5 hours of per week. In addition, clients receive a broad array of recreational, educational and vocational opportunities that positively impact on dynamic risk factors, although staffing for these services has not kept pace with the increased client census. Clients in the transitional programs also are receiving periodic individual therapy as well as specialized services to prepare them for community integration.

The site visitors' experience in reviewing other civil commitment programs is that they typically provide between six and twelve hours of sex offender specific treatment per week.

3. Treatment Targets

The program assesses clients' changeable problems that are closely linked to sexual and other offending behavior and targets them in treatment. These are commonly called "dynamic risk factors."

Since the last site visit, the program has finalized and implemented the "Goal Matrix for Phases I, II and III." This document clearly links the key dynamic risk factors that should be addressed in an effective sex offender treatment program to MSOP's phases of treatment. Staff and several clients reported that the matrix has been a very useful tool for assessment, treatment planning and measuring treatment progress. An additional strength of the Matrix is that is focuses on positive approach goals. Treatment plans and therapy notes in the charts reviewed indicate that staff have integrated the matrix system as it is intended to operate.

4. Responsivity

The program delivers services in a fashion to which clients can most successfully respond.

This best practice concerns the "responsivity" principle and focuses on how services are delivered. Programs should consider responsivity issues such as clients' motivation, intelligence, psychopathy, mental illness, and cultural issues. Additionally, therapist style is an important responsivity issue. Greater treatment impact is found when the therapist is firm, fair, direct, and empathetic and shows an overall concern for the client's well being.

The program has continued to be sensitive to client responsivity issues. The MSOP has specialized programs for clients high in psychopathy, for young adult clients, for clients with significant mental health issues and for clients with lower IQ and impaired learning ability.

A high percentage of clients in the MSOP (approximately 75%) are currently enrolled in treatment and this compares favorably with other civil commitment programs for sex offenders.

Since the last site visit, clinical and direct line staff have been trained in motivational interviewing. Interviews with staff indicate that they are integrating motivational interviewing techniques into their work with clients.

Several staff requested reviewers' opinions about the optimal composition of clients on the four Alternative Program Units for clients with lower cognitive functioning. The reviewers recommend the following: (a) the approximately eight vulnerable adults in this program should continue to be placed on one unit for safety reasons, (b) Phase III clients should be housed in the same unit and participate in their own Core groups, (c) Phase I and II clients should be mixed in the same groups, (d) behaviorally disruptive clients should be housed across living units and (e) consideration should be given to transferring clients that are severely disruptive or assaultive to the Moose Lake Behavioral Unit.

Program clinical directors should also examine whether groups of two hours in length are appropriate for the learning style and attention span of all clients in the Alternative Program. Rehabilitation staff felt they needed more materials appropriate for this population and more work opportunities consistent with the abilities of this population

Since the last site visit, clients' primary therapists are now staying involved with their clients who are transferred to the Behavior Therapy Unit. This has improved communication between staff and led to shorter stays on this unit. The number of clients referred to the High Security Unit and their length of stays on the unit appear appropriate for the client population served in the MSOP.

5. Program Sequence

The sequence and spacing of services is logical and responsive to clients' treatment needs and learning styles.

Since our last site visit, the program has drafted a "Program Manual" (September 2010 draft) that details the overall program sequence. This sequence is logical and appears to be responsive to clients' treatment needs and learning styles. The Program Manual contains the newly implemented "Goal Matrix for Phases I, II and III" which clearly details client goals for each phase of the program in a logical sequence.

The Executive Clinical Director reports that the program is currently further detailing the sequence and nature of core assignments within each phase of the program and the reviewers believe that this is a critically important initiative.

6. Effective Methods

The program employs methods that have been consistently demonstrated to be effective with clients.

Programs should be skills oriented and utilize techniques such as cognitive restructuring, training in self-monitoring, modeling, role-play, graduated practice with feedback and contingency management. In general, more effective programs allocate about half or more of treatment time to skill building interventions. Overall, programs for offenders that are manualized are more effective than those that are not.

Although the program over the years has developed a series of psycho-educational modules and treatment assignments to help clients address their treatment needs, the program does not have an overarching "Treatment Manual." Consequently, there continues to be considerable variability in how treatment staff deliver treatment. The reviewers recommend that the program develop a "Treatment Manual" to provide clinical staff with more direction about how to facilitate treatment groups in a standardized manner, including prescribing core assignments for each phase of the program and the process for how to run groups. Having a detailed treatment manual would also provide clinical supervisors and program evaluators with a guide for determining the degree to which treatment is being delivered as intended. Given that the majority of clients in the program are in the Conventional Track, priority should be given to developing a manual for this segment of the client population. The Executive Clinical Director reported to the reviewers that she has begun work on addressing this issue. The reviewers encourage to program to seek external feedback from local or other sex offender treatment experts at key stages of the manual's development.

As the reviewers have noted in previous reports, the MSOP uses a number of skill building activities. The reviewers recommend that as the program develops its Treatment Manual, including updating psycho-educational modules, that it ensure that these documents prescribe adequate skill identification, modeling, practice and feedback elements. They should also ensure that the psycho-educational modules address the dynamic risk factors in each phase of treatment. The "Program Manual" and "Goal Matrix for Phases I, II and III" provide an excellent foundation for development of the "Treatment Manual."

Recreation therapy, education and vocational services continue to be an important component in helping clients develop skills to address clients' dynamic risk factors. These services continue to be well developed and are offered during weekdays as well as evenings and on weekends. The reviewers support expanding the current effort to coordinate educational and vocational services to increase clients' ability to become employed.

Due to the increased client population, the placement of clients on larger housing units and the decreased level of security staff placed on treatment units, an increase in rehabilitation services appears warranted. During previous visits, the reviewers noted the important role that security counselors played in assisting clients in generalizing skills that they were learning in other aspects of the program. With the decrease of security counselors, this therapeutic component has been reduced, especially on the larger living units. The program needs to consider how to compensate for these changes to enhance skill generalization.

7. Continuity of Care

Progress that clients make in the institution is reinforced and strengthened by treatment and supervision in the community.

No client has been released from the program in recent years. This is likely attributable to two major factors. First, client movement though the treatment program historically has been very slow. Second, Minnesota statutes have prescribed multiple steps in the release process. Although there have been some relatively recent legislative changes, release from the program still requires two steps. These are approval of the Special Review Board and the Supreme Court of Appeals. In a number of other states there is only one step, such as a judicial hearing in a court in the county of commitment.

Since the last site visit, the number of clients who have entered the transitional phase of the program has increased markedly. Approximately 40 clients are now in Phase III of the program and are receiving services to prepare them to reintegrate into the community. Five Phase III clients were residing in the Halvorson House, a single-family home located outside the secure perimeter on the St. Peter campus. One client has been approved by the Special Review Board and his hearing for release with the Supreme Court of Appeals is to be scheduled in the near future. A second client is scheduled for a hearing before the Special Review Board in the next month.

Several clients in Phase III have been approved for supervised community outings. Outings include participating in sex offender treatment groups in the community and learning basic living skills necessary for successful reintegration into the community, such as buying clothing and groceries and developing community supports. Because clients in the MSOP have typically been institutionalized in prisons or at the MSOP for lengthy periods of times, often exceeding 20 years, they typically need significant assistance in learning basic skills for learning how to live in the community. Consequently, community outings are a critical component of the gradual "step down" process of helping clients transition from an institutional to community living setting.

The program has recently hired a "reintegration director" to assist clients in the transition process and will hire its own "agent" to supervise clients who are released to the community in the future. The reviewers believe that this model will provide the MSOP more control of supervising clients in the community than if they were to contract with a state or county probation or parole agency.

8. Program Monitoring and Evaluation

The program monitors its operation continuously to ensure that services are delivered as intended, the quality of services are improved and the effects of services are evaluated.

As during previous site visits, the reviewers note that processes are in place for monitoring the ongoing functioning of the program. Key staff meet on a regular basis in daily Morning Report meetings, Unit

meetings, and Shift meetings to ensure the proper functioning of the program. Quality assurance procedures are in place to monitor a variety of activities including record keeping and debriefing critical incidents. Each quarterly report details an action plan to address program goals. The present review is a review of the program by external experts and this process is considered a best practice in the field.

9. Staff Training, Supervision and Support

Staffing levels are adequate and staff are appropriately selected, trained and supervised.

The reviewers continue to believe that the program's staff is dedicated and committed to the program. Executive Clinical Director Jannine Hebert has extensive administrative and clinical experience in corrections and the sex client field and has implement several significant improvements in the program during her tenure.

Staff continue to receive ongoing training to upgrade their skills. For example, since the last site visit, international experts have provided clinicians training on psychopathy and the "Good Lives" model of treatment. MSOP staff have provided clinical and security staff training on motivational interviewing, an approach that is designed to increased client engagement in programming and deescalate conflicts between clients and staff. Several staff attended the recent Minnesota ATSA (Association for the Treatment of Sexual Abusers) yearly meeting and clinical supervisors are scheduled to attend the upcoming ATSA national conference. Additionally, the program provides new staff a standard orientation training and all staff periodically receive updated training on such topics as client behavioral expectations and personal safety.

A concern is that the clinical program is currently understaffed, particularly at the Moose Lake site. As a result of understaffing, clinicians' current workload has increased beyond capacity. Current Moose Lake staffing shortages appear largely due to the recent opening of 400 additional beds in the new complex at this site. Four of the nine clinical supervisor positions were unfilled at the time of this review, although the program is in the last round of interviews for these positions. Eighteen of the 48 clinician positions were unfilled at the time of this review, although several new clinicians are scheduled to start by the end of the month. The program's goal is the fill all of these vacancies by the end of the year.

The program continues to provide ongoing clinical supervision to clinicians; about one hour of individual supervision a week for newer staff and about one hour a month for senior staff. All clinical staff interviewed told reviewers that clinical supervisors were readily available for consultation outside normally scheduled supervision meetings when needed. The reviewers support the program's plans to begin video-recording groups as a clinical supervision tool.

Clinical staff are involved in morning Unit meetings with direct line staff and Morning Report and joint meetings with unit directors. In addition, there are regularly scheduled meetings of all clinical staff. The process of communication across administration, clinical staff and direct line staff continues to stand above other programs we have reviewed.

As noted in our previous report, the ratio of security counselors to clients decreased markedly a few years ago and this makes it difficult for these staff to be as involved in the therapeutic aspects of the program as occurs in many of the other civil commitment programs. This is particularly a problem at Moose Lake where two security counselors supervise approximately 90 clients per unit. The security counselor to client ratio is much better on the smaller units that typically house higher need clients, such

as the units serving young adults, individuals with lower cognitive functioning and clients with behavior management problems.

10. Service Documentation

Staff document services in an appropriate, thorough and timely manner.

We did not audit client records to determine whether documentation was up-to-date and we understand that a recent review found that were significant problems in this area. We did, however, review six client records to examine the quality of the documentation. We found assessment reports, treatment plans, and progress notes were all clearly linked to the clients' dynamic risk factors. The program is implementing an electronic record keeping system which should make it easier to enter clinical information and monitor compliance with the program's documentation standards.

11. Facility and Treatment Environment

The facility and treatment environment is safe, secure, and therapeutic.

Since the last site visit, the program opened 400 additional beds in a new complex at the Moose Lake site. About 200 clients who were housed in a rented facility from the Department of Corrections have moved into this new complex. Following other changes in the roles of the program's facilities, the St. Peter site houses primarily clients in Phase III of the conventional program and clients in the Alterative Program for individuals with lower cognitive functioning.

As we have previously noted, the size of some of the new units at Moose Lake (68 and 98 beds) are much larger than ideal to operate a therapeutic milieu. Nevertheless, we were impressed that the use of carpeting, natural light and other features make the living units more appealing than many typical prisons. The current number and size of the group treatment rooms in the new facility is inadequate.

As we have previously noted, the security counselor to client ratio has decreased markedly over the past few years for budget reasons. Staff across disciplines reported security counselors now focus primarily on security issues and generally do not have enough time to interact in a more therapeutic manner with clients. This is particularly a problem on the large units at Moose Lake. Ideally, as is common in other high quality civil commitment programs, the ratio of security counselors to clients would be returned to a more optimal staffing. Staffing levels were more appropriate in the young client, mental health and Alternative Program units. Security staff also expressed concern that they do not know clients as well as they used to as charts are not readily available to them.

Since the last site visit, the program has increased the amount of therapeutic material posted in the facility to enhance the therapeutic nature of the living areas and group treatment room environments. The reviewers support the work of the Therapeutic Environment committee to continue to make improvements in this area.

12. Administrative Structure and Program Organization

The administrative structure and program organization supports the healthy functioning of the program. Staff communicate effectively in order to ensure that clients' services are coordinated.

We continued to find a strong administrative structure and processes in place to ensure ongoing staff communication. As previously noted, these include daily Morning Report meetings, Unit meetings and

Shift meetings. The program has developed a series of policies that reflect the special needs of a civil commitment center for sex offenders. Each client is staffed at least quarterly and undergoes a comprehensive yearly review. The program prepares a report each quarter that details an action plan and time frames to address program goals.