Minnesota Department of **Human Services**

MINNESOTA SEX OFFENDER PROGRAM ANNUAL PERFORMANCE REPORT 2012

January 2013
Minnesota Sex Offender Program
444 Lafayette Road North
Saint Paul, MN 55155-0992

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Executive Summary

For the Minnesota Sex Offender Program (MSOP), the past year has been one filled with significant challenges, opportunities, accomplishments, and changes. Our ever-evolving program continues to progress in the provision of comprehensive, evidence-based sex offender treatment within safe and therapeutic living environments.

Noteworthy program highlights for 2012 include the retirement of Executive Director, Dennis Benson early in the year. Nancy Johnston, a long-term employee with MSOP, was appointed as the new Executive Director and is now serving in that leadership capacity. Since that time, organizational re-structuring at the executive level has been implemented, thus enhancing overall service delivery and operational oversight.

The second provisional discharge in the history of the program occurred in 2012. A well-attended Community Notification meeting took place prior to the client moving into the Golden Valley community. After several months at a halfway house residential setting, he moved to a permanent apartment residence where he currently lives. With solid treatment planning, close supervision and monitoring, and collaborative clinical and security efforts, this client has been experiencing successful reintegration in the community.

Construction completion at our Moose Lake facility took place this past year and the new 120,000 square foot Support Building became operational. This two-year project resulted in a necessary infrastructure providing additional space for programming, vocational opportunities, treatment groups, maintenance, and dining. In St. Peter, construction was completed for the 15-bed expansion within Community Preparation Services. Renovation of the Shantz Building, also at the St. Peter facility, began in 2012. The completion of the project in 2014 will provide an additional 72 beds to the program.

During 2012, MSOP implemented the use of the Area Monitoring System (AMS) across our program. By placing AMS bracelets on our clients, we have been able to put an "open movement" concept into practice. Utilization of AMS technology enhances the quality of life and overall treatment environment due to increased freedom of movement for our clients. In addition, this highly effective tracking system provides additional security measures regarding client location and accountability.

MSOP departments and disciplines have been instrumental in the ongoing revision and new development of critical internal policy that guides our program into the future, assuring continuity and consistency. Exciting changes occurred this year within staff development for MSOP in overall structure, content, and training requirements. The *Treatment Theory Manual* was updated and the *Clinician's Guide* was developed at the end of 2012, along with establishing a new 90-module curriculum for clients. Building and maintaining a strength-based approach to sex offender treatment, and incorporating a strong motivational philosophy, are key components in our quest for continued quality programming.

During 2012, a Class Action Lawsuit was brought forward by several clients in the program. Treatment progression and conditions of confinement are the two areas that are being addressed through mediation with a Federal Magistrate. In addition, a Task Force was ordered by the federal

court to thoroughly review and make recommendations regarding both the civil commitment process in Minnesota as well as the development of less restrictive alternatives to civil commitment.

The Department of Human Services (DHS) Commissioner appointed the Task Force members in early fall of 2012 and that group convened and has begun their challenging work. The first set of recommendations were submitted to the Commissioner of DHS in December, 2012, outlining the details of less restrictive alternative residential settings and a Request for Information was published.

To address treatment progression issues, the federal court ordered a five-member evaluation team consisting of experts within the field of sex offender treatment to evaluate internal MSOP processes that measure client progress through treatment phases. This team will visit the program in February and audit client charts. Their recommendations to the Commissioner will then be made in April, 2013.

Although this lawsuit has drawn media attention, brought about MSOP employee concern, and will be a time-consuming process, it also provides an excellent opportunity for our state to thoroughly examine our civil commitment system and, in the end, may prompt positive and needed change for Minnesota.

Background

M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for 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. The St. Peter campus has two missions: reintegration and programming for alternative clients. Clients in phase III progress through privileges that allow opportunities 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 executive functioning due to learning disabilities, developmental disabilities, head injury or trauma, and other neuropsychological issues. These clients do all three phases of programming on the St Peter campus.

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 opportunities. MSOP staff observe and monitor clients in treatment groups as well as in all aspects of daily living to determine and provide feedback on how clients are applying new knowledge and prosocial skills.

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

Priorities: MSOP is committed to 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.

MSOP executive leadership has established strategic goals geared toward clarifying the treatment model, fostering cohesiveness and consistency in staff implementation of programming, and identifying areas in which efficiencies could be increased. These strategic goals are organized under the five themes of:

> **Therapeutic Environment**: Establish MSOP as a world class, research-based treatment program that is client focused and has a clear progression across the continuum of care.
>
> **Program Integrity**: Create a values-based environment.
>
> **Learning Organization**: Establish a dynamic culture of learning in all levels of our world-class organization, which recognizes the many faces of learning.

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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.

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

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

2012 Strategic Goals:

Goals	2012 Outcomes
1. Therapeutic Environment:	
Increase collaboration between clinical and operations staff.	The focus on increasing collaborative opportunities has been quite successful. Face-to-face consultations between clinical and operations are now routine and expected. Community meetings are interdisciplinary and opportunities for joint learning and networking such as "Lunch & Learns" are now a part of the program environment. In addition to the frequency of interactions, qualitatively, staff report there is less defensiveness and more conversation across disciplines. In 2013, this goal will be expanded to increasing similar collaborations with Security Counselor Leads.
Develop visible presence of treatment at both sites.	The most noticeable accomplishment in this area was the completion of the infrastructure building at the Moose Lake facility. Completion of this project obviously provided sorely needed space for clinical programming In addition, "matrix cards" were distributed to all clients based on their placement in treatment. These tools serve as external cues for clients in modifying their behavior but also assist staff in working more effectively with clients based upon their individual needs. The MSOP Assistant Executive Clinical Director and the Moose Lake Clinical Director increased their unit rounds to increase their accessibility to staff and clients alike.

Goals	2012 Outcomes
Improve quality of service delivery consistent with research and current practice.	There were significant advances made in this area during the last year. All psycho-educational modules (approximately 90) were revised and updated consistent with advances in the clinical literature. To increase consistency in service delivery, all clinicians have been trained on the new modules and MSOP continues to work toward standardization of the components. *The Program Theory Manual* was also updated with inclusions of new practice developments within the field of sex offender treatment. A *Clinician's Guide* was also developed to assist staff in accurately and consistently implementing clinical services across the program. Additional training and professional development for early-career clinicians has been established *via* routine professional development mentoring groups with more seasoned staff.
Complete construction projects: • Moose Lake Support Building (2012) • St. Peter Green Acres Expansion (2012) • St. Peter Shantz Expansion (June 2013)	The Moose Lake Support building was opened in August. The remodel of the Main Building in Moose Lake is scheduled to be completed in mid-February 2013. Both of these projects were critical to the delivery of secure clinical services and to increased efficiency in operations (e.g., centralized dining). The Green Acres expansion was completed and licensed in the first quarter of 2012. Ten clients currently reside in this residence (capacity 23). Construction on the Shantz Building began in December 2012. Phase I and Phase II of this projected are currently on track for completion in June 2013 and March 2014, respectively.
Increase clinical partnerships with clinical and security staff and work towards reducing the number of "person crimes" committed by clients within the MSOP.	Staff from Clinical, Security and the Office of Special Investigation (OSI) attend daily multi-disciplinary meetings and all serve on the community outings review team. OSI and the Clinical staff also collaborate on the administration of polygraphs. The average number of "person crimes" in 2011 was 168 and that dropped to 152 in 2012.

Goals	2012 Outcomes
2. Program Integrity:	
Establish clear and accurate data collection and recording system to establish baseline clinical services provided in MSOP.	This has been a significant project in the last year. In the first quarter of the year, the clinical department began manually tracking clinical services provided to clients until the computerized system, Phoenix, was online in the third quarter. This system will enhance the ability to track services as well as extract research. The process of centralizing all program data with the research department has started and it is anticipated this will allow the program to develop and measure outcomes independent of the number of provisional releases.
Demonstrate MSOP encourages law-abiding behavior and hold clients accountable for committing crimes within the program.	According to the Bureau of Criminal Apprehension (BCA), there are 60 MSOP clients who are not compliant with their registration requirement. This represents a 91% compliance rate. Of note, only two of these clients are at the St. Peter facility, which includes clients in the later phases of treatment.
3. Learning Organization:	
Research and implement tools which measure qualitative treatment experience of clients.	Now that the new curriculum and theory manual have been introduced to staff, it is anticipated this goal will show additional progress in the coming year. The Executive Clinical Director and Research & Program Evaluation Director have identified some potential tools to assess the change process within the program. As mentioned above, a new computer system for recording client participation in clinical services is online. It is anticipated this electronic recording system will advance research and internal program reviews.
Develop and implement Special Review Board (SRB) member orientation and sustaining training.	In 2012, the first training plan and accompanying materials were developed and delivered to the SRB. Providing current research within the sexual offense treatment and assessment field is critical for board members reviewing client petitions seeking provisional discharge. These training opportunities also keep the SRB abreast of changes in the program. An update meeting and training session now occur on a quarterly basis. This practice will continue into 2013.

Goals	2012 Outcomes
Increase MSOP's safety culture by updating training, improving communication; reducing staff injuries and creating backup staff for the MSOP Safety Director.	While there was initial progress with this goal over the last year (e.g., assessment of safety concerns at each facility), progress on this goal is stalled. In the first quarter, MSOP hired a Safety Director but he resigned from this position within the last quarter of the year. Safety continues to be a priority in MSOP so this position will be filled as soon as possible with the safety assessment process finishing up shortly thereafter.
MSOP will work towards the goal of 25% reduction in workplace injury incidents over the next three years by reducing the frequency and severity of employee injuries. This will be accomplished through regular review and follow-up of staff injuries utilizing Workers' Compensation data and staff input.	The number of recordable injuries, as well as Workers' Compensation claims, ranged from 4 to 11 over the course of 4 quarters. These numbers, which serve as baseline data, will be compared against the quarterly data moving forward.
Research options for combatting the use of cell phones by unauthorized persons within the MSOP.	The Deputy Director of the Office of Special Investigation attended the National Technical Investigators Conference in July to research this topic. While there is no single solution there are several products on the market that report they block cell phone signal within secure environments. OSI will research these products in terms of effectiveness and cost and will report back to MSOP executive staff in early 2013.
4. Staff Development:	
Provide training opportunities for staff to increase competencies in sex offender treatment and assessment.	This goal continues to be a strength for the program, which is significant given the number of new staff and the challenges of working with this complex client population. Externally, staff attended numerous conferences specific to research advancements, best practices, and clinical assessment tools for sex offender treatment. Staff has also been very involved in developing competency in continuous improvement. These techniques have been applied throughout the program to assess operational processes. In several cases, these evaluations have resulted in revised and more efficient program processes (e.g., incident reports). MSOP has also increased the use of internal experts

Goals	2012 Outcomes
	to provide training within the program (e.g., sharing information from conferences, clinicians presenting their expertise on specific issues or populations).
Provide opportunities for staff to increase their professionalism and competencies in conducting investigations, polygraphs, staff supervision, and surveillance in order to enhance public safety.	The Office of Special Investigation staff has utilized Century College, professional organizations, and other agencies to participate in quality training.
5. Responsibility to the Public:	
Develop partnerships with community stakeholders and professionals who will be interacting with civilly-committed sexual offenders reintegrating in the community.	There was a significant increase in positive and productive activity on this goal during the last year. Reintegration staff have developed a solid network of community relationships with nonprofits that advocate for reintegration resources for those with criminal backgrounds. Several appropriate housing resources have been identified and two half-way house contracts and one long-term housing contract are currently in place, even though there is only one client on provisional discharge. These efforts are actively supported through all levels of the program with on-site visits by the Reintegration Director, Executive Clinical Director and/or the Executive Director of MSOP.
Position MSOP as a resource on sexual violence prevention and sexual offender treatment for outside stakeholders and partners.	During the past year, MSOP developed a position for a Prevention Policy Director, who surveyed all of the current prevention efforts occurring within all administrations of the Department of Human Services. MSOP will remain actively engaged with sexual violence prevention partners in the community. However, in 2013, this position will be shifted to a more centralized role within DHS so the various prevention efforts within the agency can be coordinated and integrated rather than isolated or replicated.

Goals	2012 Outcomes
Put Public Safety at the forefront of all program policies and decisions.	MSOP facilitated the first court-ordered discharge in several years. MSOP collaborated with the DOC Community Notification Unit, and half-way house staff for a successful community notification meeting. MSOP Reintegration Specialists provide intensive and integrated transition services for the provisionally discharged client. Within the program, MSOP has developed several systems of "checks and balances" to create safe opportunities for community reintegration. MSOP uses the Community Outings Review team to review all outing requests for therapeutic value and community safety. The Reintegration Steering Committee provides consultation on, and directs, policy needs and changes with regard to the Reintegration Program.
Promote transparency by conducting pro-active outreach to stakeholders in community to educate them on civil commitment, MSOP treatment and our reintegration programming.	MSOP staff have provided, and in many cases initiated, several tours and presentations to increase awareness about the commitment process, nature and effectiveness of treatment, and reintegration programming. During the past year there has also been a focus on meeting with county and state government officials and nonprofit housing providers to explore housing, employment, and social support resources for individuals with sex offense histories. MSOP is also partnering with other state agencies with similar needs in hopes of reduce replication or competition for scarce resources.
Increase Special Review Board (SRB) capacity.	Within the last year, it was established the SRB would meet four times a month to match the need of review hearings for submitted petitions. By mid-year, all of the reviews were up to date. During the third quarter, MSOP identified the need for additional SRB members if the hearings were going to keep up with the demand. By the close of the year, the SRB had 15 members with nine vacancies. These vacancies will be posted in 2013 to increase members from 15 to 24 to conduct more hearings.

Goals	2012 Outcomes
Implement "End of Confinement Review Committee" (ECRC) for program.	This committee is responsible for reviewing clients provisionally discharging from the program who do not have a risk level for community notification, as required by statute. Most clients are reviewed and provided with such a level by the Department of Corrections (DOC). However, for clients who were not assigned a level (e.g., they were incarcerated before level assignment became law), this review must be completed by MSOP. During 2012, MSOP legal staff have been developing an ECRC policy, and MSOP staff have consulted with DOC staff as to how the current ECRC process works. It is anticipated the formal MSOP policy on ECRC will be in place in early 2013, well in advance of the need to implement such a committee as MSOP clients are approved by the court for Provisional Discharge.
Increase partnership with Reintegration and law enforcement to enhance public safety by conducting covert surveillance operations on MSOP community outings.	MSOP's Office of Special Investigation has conducted surveillance on 183 outings this year and logged 13 law enforcement contacts during the year. To increase the integration of the surveillance into the client' overall progress assessment, the OSI and the Reintegration Directors meet on a weekly basis to discuss observations during community outings.

Section II
Treatment Model and Progression

Program Philosophy and Approach

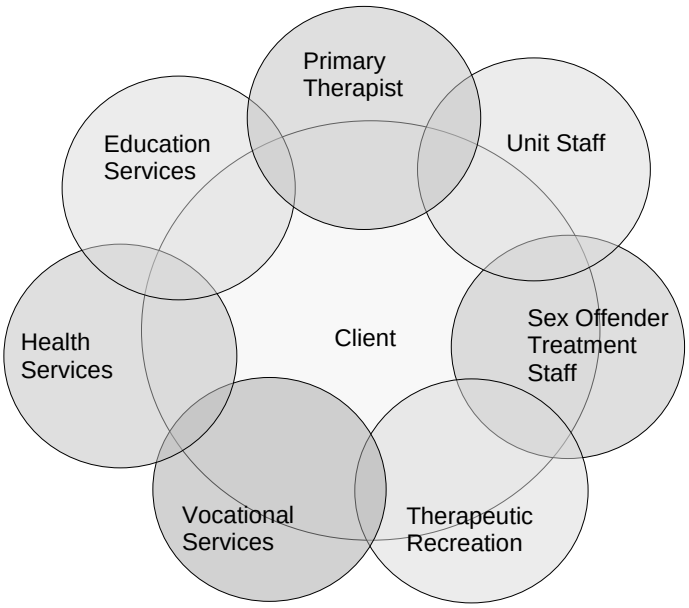
MSOP draws on several contemporary treatment models in its programming. These models include cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by the professional psychological literature in the areas of risk/needs/responsivity and stages 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 and the client's primary therapist, 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.

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: Clients newly admitted to MSOP and/or involved in the commitment proceedings but who have not been 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 they 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 (e.g., assaults on staff/peers, thefts, predatory type behaviors, etc.) are treated on this unit with the goal of returning clients to their units once the treatment-interfering behaviors have been resolved.

Conventional Programming Unit (CPU): Clients who are 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.

Mental Health Unit (MHU): 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): A former unit for clients refusing to actively participate in sex-offender-specific treatment programming. During the third quarter of 2012, those clients were integrated into the other living units alongside clients who are participating in treatment to provide added encouragement and incentives for them to decide to enter into treatment participation.

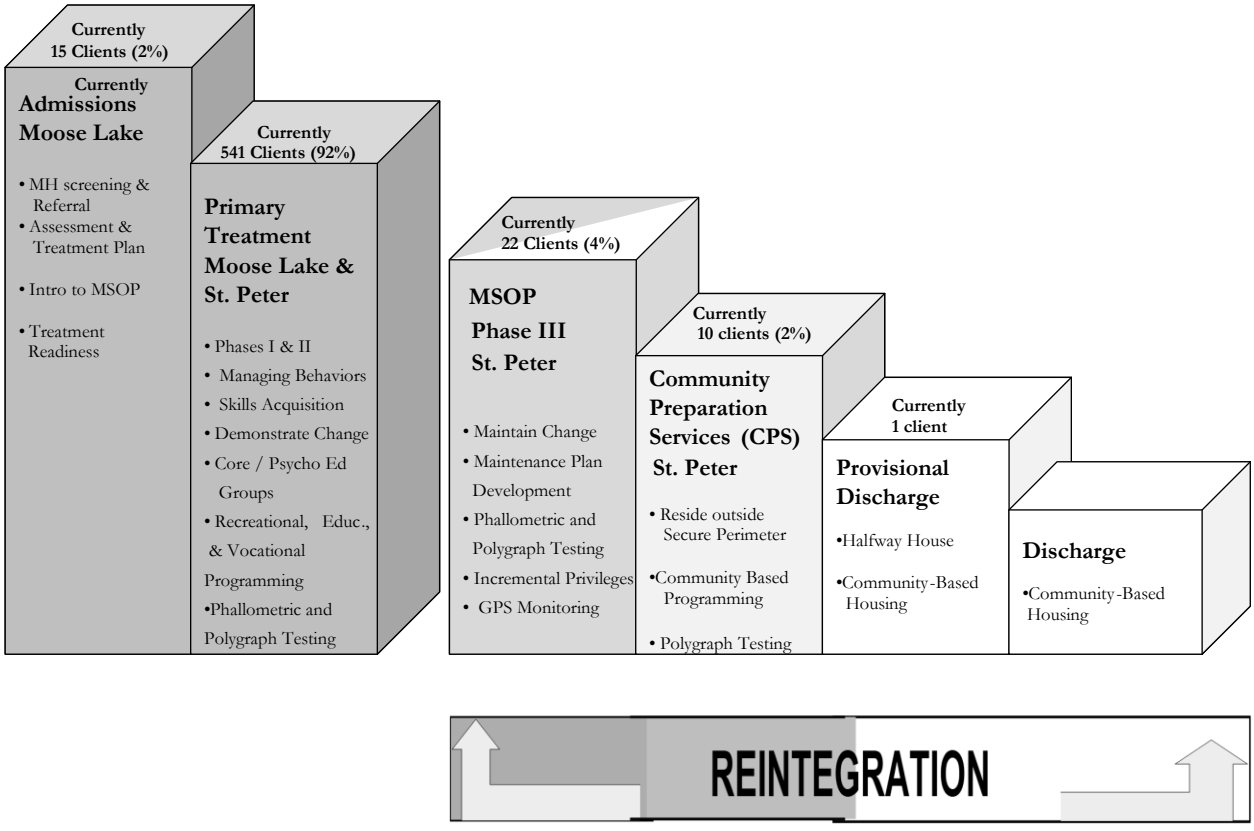
Young Adult Unit (YTU): Clients who are between the ages of 18 and 25 and do not meet criteria for the Alternative Program or CTU programming. Most of these men have not been incarcerated as an adult.

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. On a quarterly basis, each client conducts a self-assessment and the results are compared to those the client's primary therapist and treatment 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.

MSOP Treatment Progression Model



* This chart does not reflect the clients who do not agree to participate in treatment after leaving the Admissions Unit (as of 12/31/12, 90 clients).

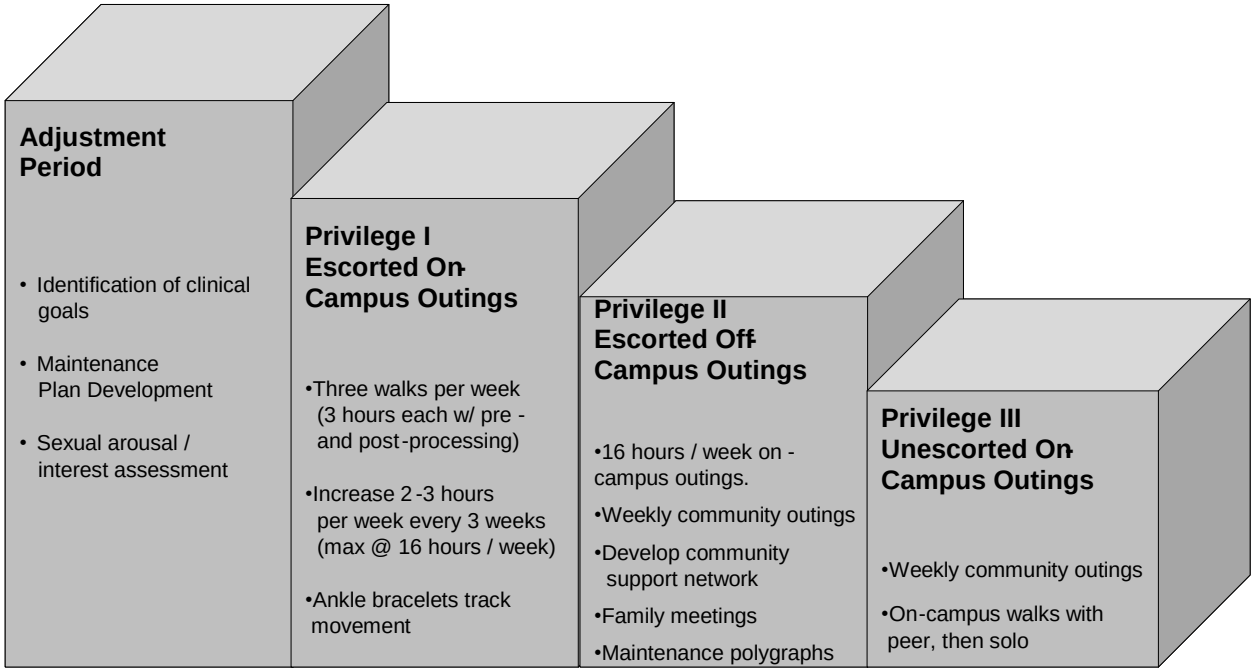
Reintegration

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

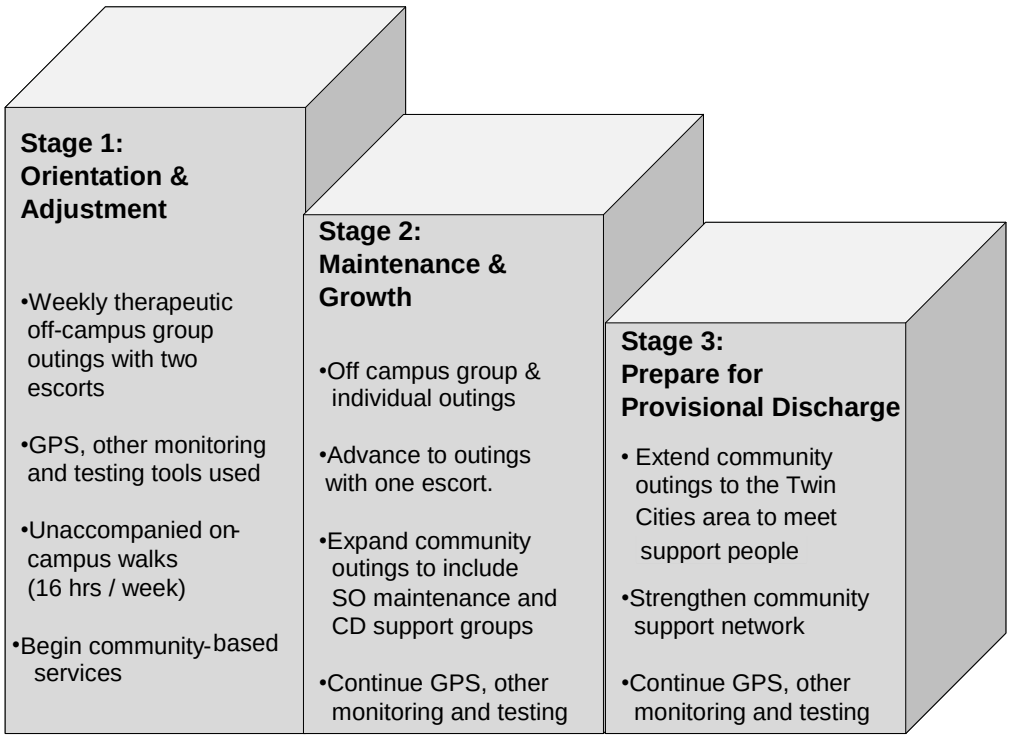
15-20) of institutionalization. Clients are provided opportunities at a gradual pace to apply internalized treatment skills and behavioral changes.

Reintegration Progression Model

Phase III: Clients in Phase III are in the beginning of the transitional phase of treatment at MSOP and focus on solidifying skills for living safely in the community. After an adjustment period, clients progress and obtain increased privileges: accompanied on-campus, accompanied off-campus, and unaccompanied on-campus liberties. All Phase III clients with these privileges have Area Monitoring System (AMS) electronic monitoring bracelets.



Community Preparation Services (CPS): After Phase III, 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. CPS clients typically participate in on-campus vocational opportunities, and are allowed campus privileges and escorted community outings.



Section III
MSOP Treatment at the Department of Corrections

MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. Program participants are still serving their correctional sentences and have histories that indicate they are likely to be referred for civil commitment. Two 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 civil commitment.**

2. **The county pursues commitment, and the client is civilly committed to MSOP and is able to begin treatment where he left off from the DOC site.**

There have been 287 men who have been admitted to the MSOP-DOC program since 2001. As of January 1, 2013, there are currently 50 clients in the program. Of the 237 men who have been discharged from the program, 70 (29.5%) are still in DOC and 167 (70.5%) are not. Commitment Status of Men Discharged from MSOP-DOC:

Of the 237 men discharged from the program:

→ 117 (49%) were civilly committed,

→ 11 (5%) were not referred to the county for review by the DOC (reside in the community or DOC),

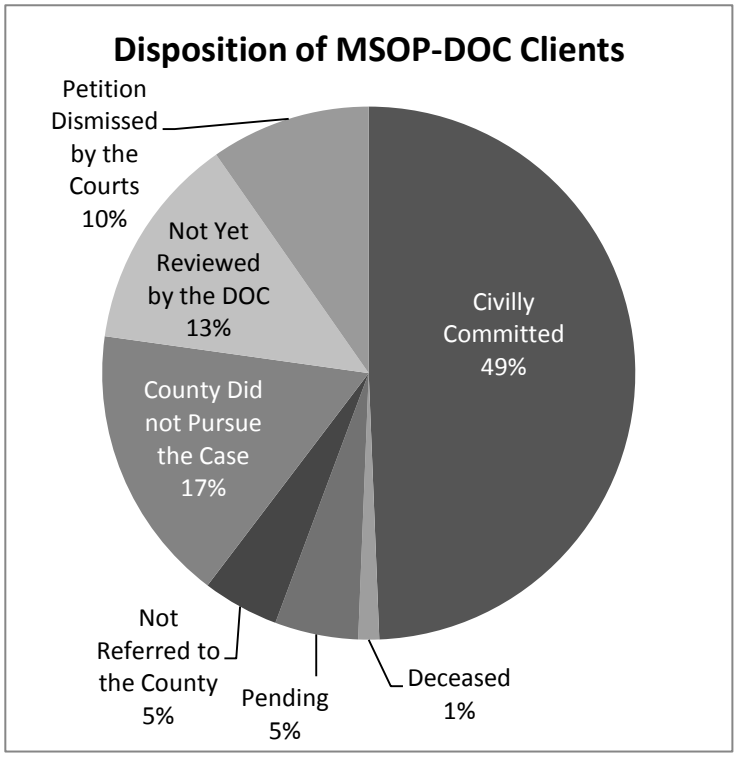
→ 40 (17%) the county did not pursue the commitment (reside in the community or DOC),

→ 23 (10%) the petition was pursued by the county and dismissed by the courts (reside in the community or DOC),

→ 12 (5%) DOC referred the petition to the county and it is pending,

→ 31 (13%) have not yet been reviewed for referral by the DOC (reside in DOC not yet reviewed due to Scheduled Release Date)

→ 3 (1%) are deceased



Section IV

Minnesota Sex Offender Program
Fiscal Year 2012 & 2013 Per Diem

Description	FY2012 Annual $$	Per Diem	FY2013 Annual $$	Per Diem
Direct Costs				
Clinical	13,993,781	58.28	14,760,094	58.35
Healthcare and Medical Services	5,792,482	24.13	5,902,718	23.34
Security	30,572,076	127.33	31,886,571	126.06
CPS & Community Preparation	1,033,455	4.30	1,053,122	4.16
Dietary	1,955,667	8.15	2,079,563	8.22
Physical Plant & Warehouse	7,195,980	29.97	7,832,925	30.97
Support Services	9,872,559	41.12	9,897,007	39.13
Total Direct Costs	70,416,000	293.28	73,412,000	290.23
Operating Per Diem		**293**		**290**
Indirect Costs				
Statewide Indirect	390,799	1.63	37,030	0.15
DHS Indirect	0	0	0	0.00
Building Depreciation	2,105,764	8.77	3,689,097	14.58
Bond Interest	3,070,200	12.79	5,065,200	20.02
Capital Asset Depreciation	193,224	0.80	175,797	0.70
Total Indirect Costs	5,759,987	23.99	8,967,124	35.45
Total Costs	76,175,987	317.27	82,379,124	325.68
Average Daily Client Count (ADC)	656		693	
Published Per Diem Rate		**317**		**326**

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

*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.

MSOP Per Diem

While there are 21 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 year 2012 is $317 and for fiscal year 2013 is $326. The marginal per diem, which is the estimated additional costs for each new admission into MSOP, is currently $151.

Section V
Annual Statistics

Current Program Statistics
As of December 31, 2012

Total MSOP Clients	**678**
Clients by Location	
Moose Lake	498
St. Peter	180
Clients by Age	
18-25	17
26-35	146
36-45	158
46-55	184
56-65	104
Over 65	69
Average Age	**46**
Youngest	19
Oldest	90
Race	
American Indian/Alaskan Native	51
Black/African American	90
White Caucasian	510
Other/Unknown	27

Education	
0-8 Years	30
9-12 Years	77
High School Degree	320*
GED	207*
High School degree and GED	6
Some college or college degree	20*
Unknown	18
Civilly Committed Offenders by County	
Hennepin	143
Ramsey	63
Olmsted	36
Dakota	26
Anoka	25
Beltrami	17
Other Counties	368
Metro Counties (7-County Area)	280
Non-Metro Counties	398

* These numbers are more specific than in prior years due to a new computer data query option. In prior years, some of the high school graduates and GED recipients were included in a more general "12+" category.

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 (210 days maximum) or to be admitted to MSOP. As of December 31, 2012, there were 20 individuals on hold status. It is a cost savings to the MSOP when individuals choose either to be held in a county jail or to remain in a DOC facility.

Clients Pending Civil Commitment:

Clients on judicial hold status in the MSOP	9
Clients on judicial hold status in the DOC / jails	11
Total on judicial hold status	**20**

Until May, 28, 2011, the civil commitment process in Minnesota had two phases after a county attorney filed a 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 the former statute, MSOP was required to submit a report to the committing court indicating whether or not the client's status remained the same. Specifically, did the client still meet the statutory criteria for civil commitment? If the court determined there had not been significant change since the initial commitment, the client's indeterminate commitment was made final.

Effective May 28, 2011, a change in Minnesota statutes eliminated the second phase of the civil commitment process for SPP/SDP commitments to MSOP and, thereby, the 60-day review of the commitment to MSOP.

Clients Civilly Committed to the MSOP:

Clients who have been initially and finally committed during 2012*	20
Clients previously committed whose cases were reviewed and finalized for commitment during 2012	21
Total civil commitments to the MSOP during 2012	**41**

*Includes only those clients who needed just the initial commitment process due to the amended statute

Many clients who are civilly committed to the MSOP also still 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 (15 clients in 2012). However, even in DOC custody, these clients still remain under civil commitment and will return to the MSOP upon completion of their periods of incarceration. This is a pending cost liability for the program and its bed spaces.

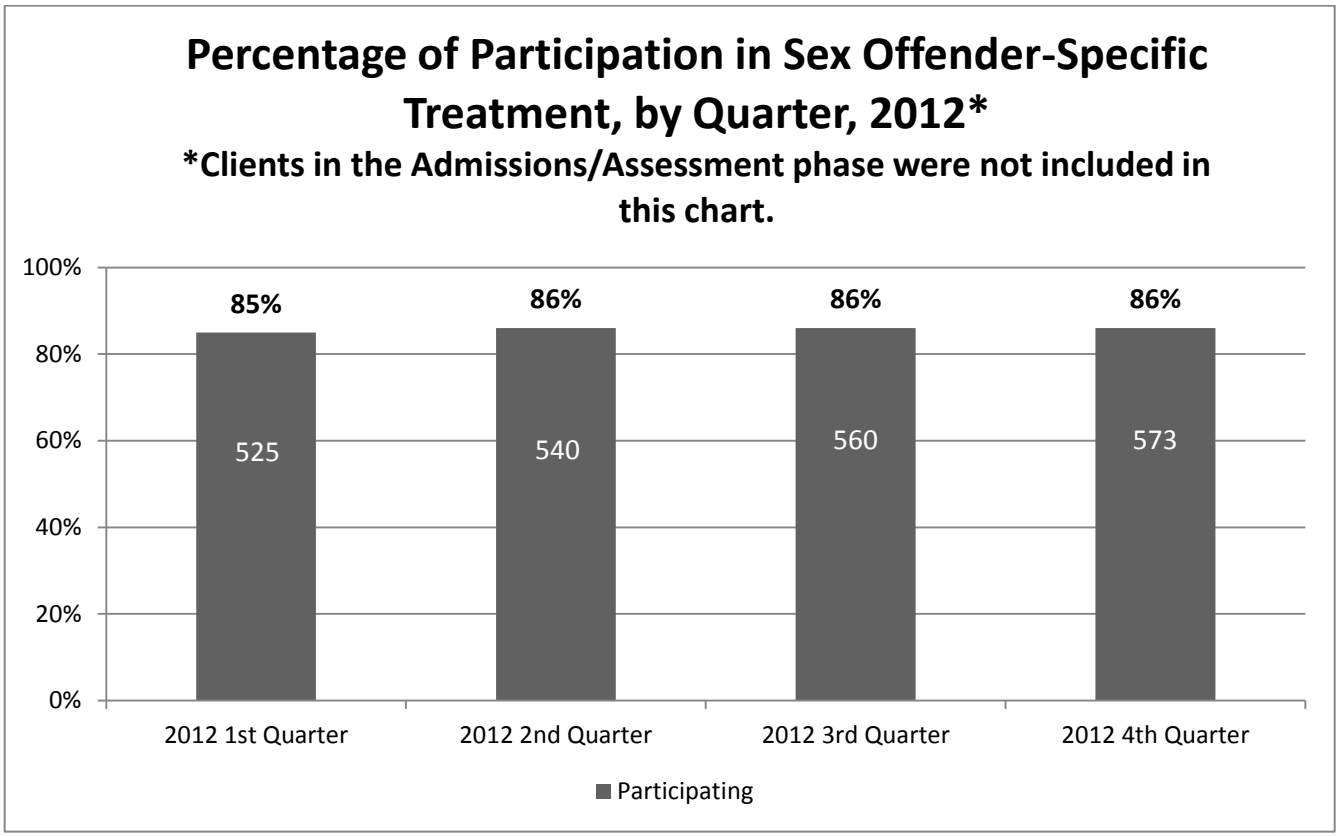
Civilly-Committed Clients Currently in Correctional Facilities:

Clients who are under civil and DOC commitment in the MSOP	203
Clients who are under civil commitment and in a DOC or federal prison	35
Total number of dually committed clients as of December 31, 2012	**238**

Clinical Statistics

Treatment Participation

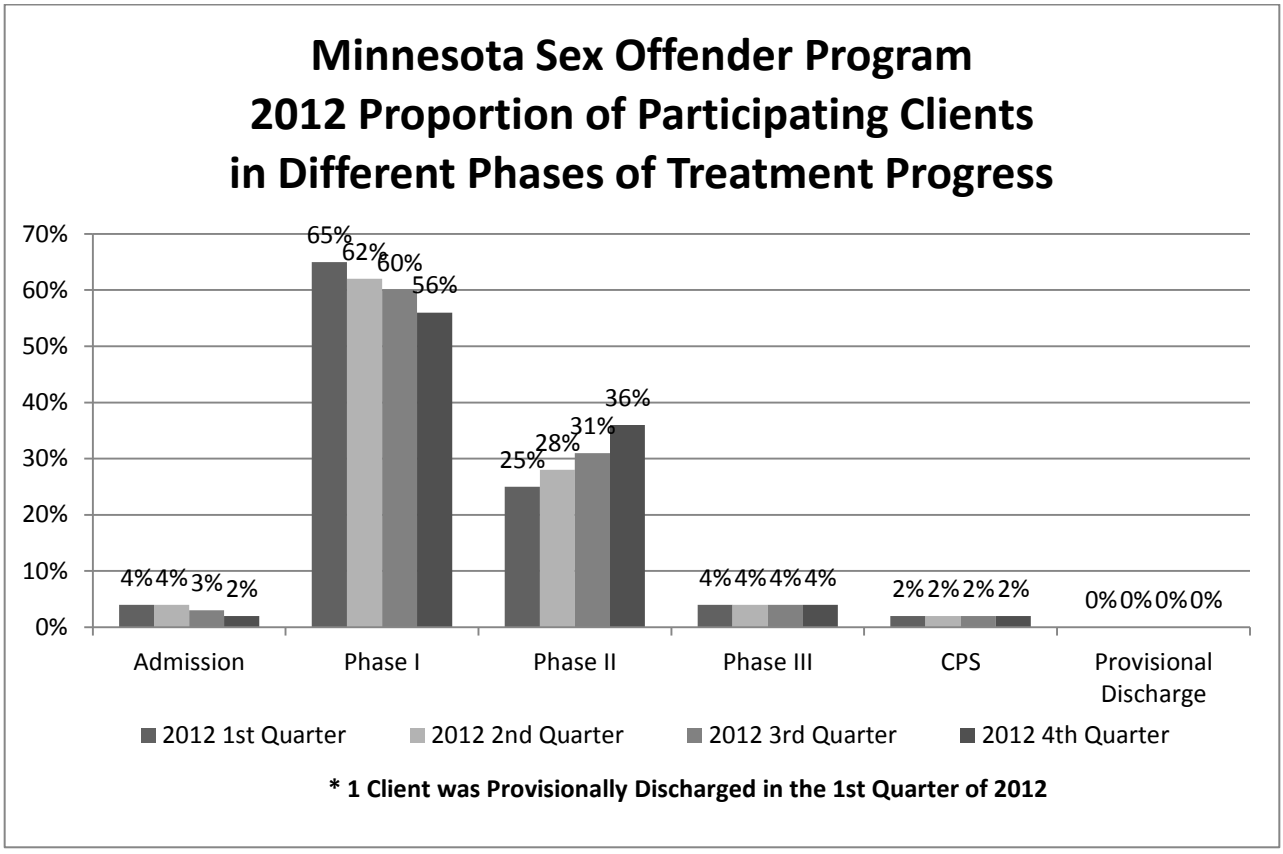
All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment, approximately 86% were participating at the end of 2012.



* 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 or she 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 43% of the clients residing on units that provide specialty programming while 42% reside on units providing Conventional Treatment. The remaining 15% 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	15	2%
Alternative Programming	St. Peter	107	16%
Assisted Living Unit Programming	Moose Lake	21	3%
Behavioral Therapy Unit programming	Moose Lake	13	2%
Community Preparation Services	St. Peter	10	1%
Conventional Programming	Moose Lake and St. Peter	403	60%
Corrective Thinking Unit Programming	Moose Lake	66	10%
Mental Health Unit Programming	Moose Lake	22	3%
Young Adult Treatment Unit Programming	Moose Lake	21	3%
Total		678	100%

Note: There is no longer a unit designated for non-participants, who now reside on various units.

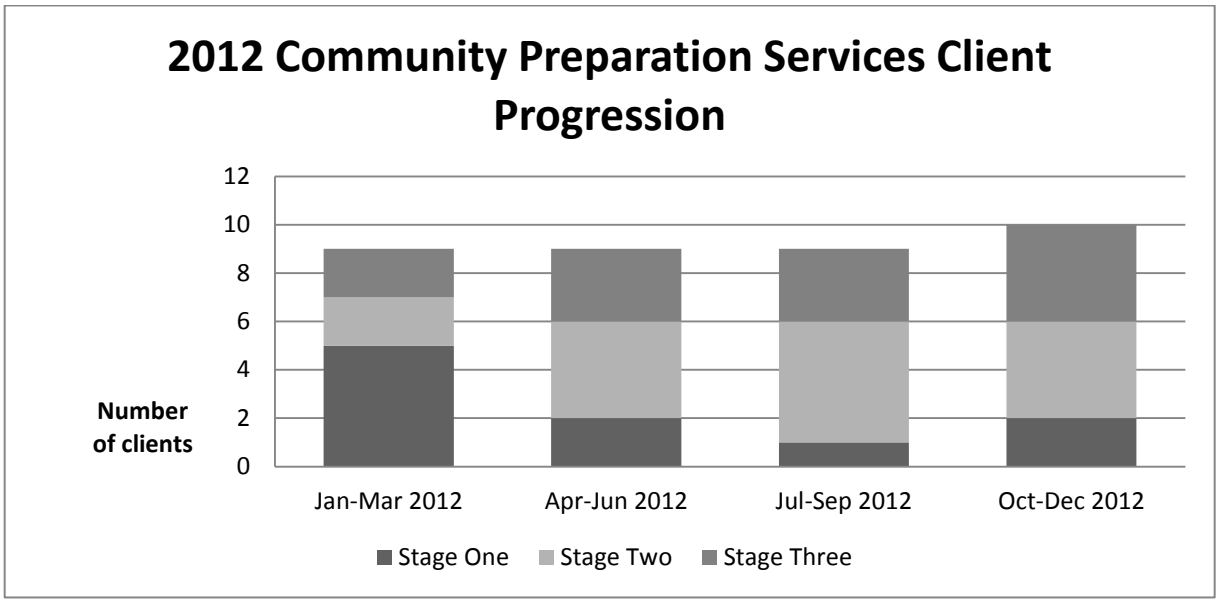
Also, this is not a housing unit census, but rather a programming census. A program track can occur across various housing units.

Reintegration Statistics

As of December 31st, the end of quarter four, ten clients were residing in Community Preparation Services (CPS) at the Green Acres facility.

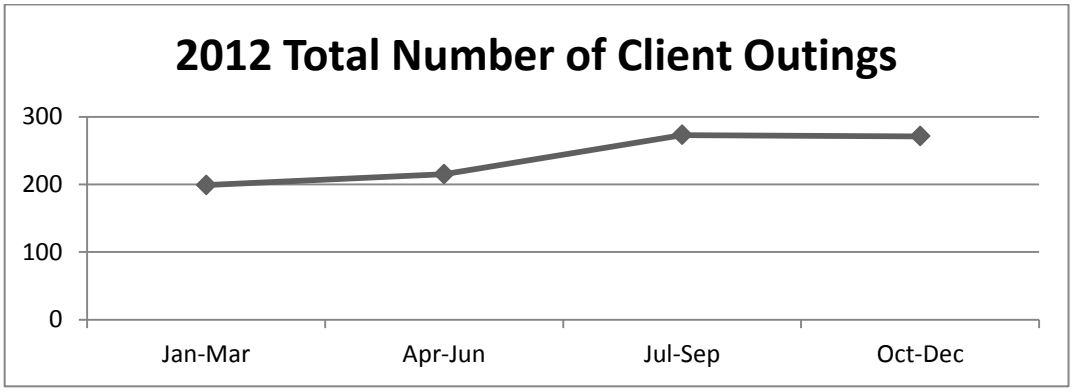
The construction for the new expansion project at CPS which began in October, 2011 was finished on schedule during the first quarter of 2012. This expansion of the Green Acres facility increased the CPS unit occupancy from eight to 23 beds.

At year end, four clients were in CPS Stage 3, four clients were in Stage 2, and two clients were in Stage 1.



Client Outings

Staff accompanied the nine to ten CPS clients on 958 outings into the community in 2012, without incident. Clients participate in more than one activity on some of their outings.

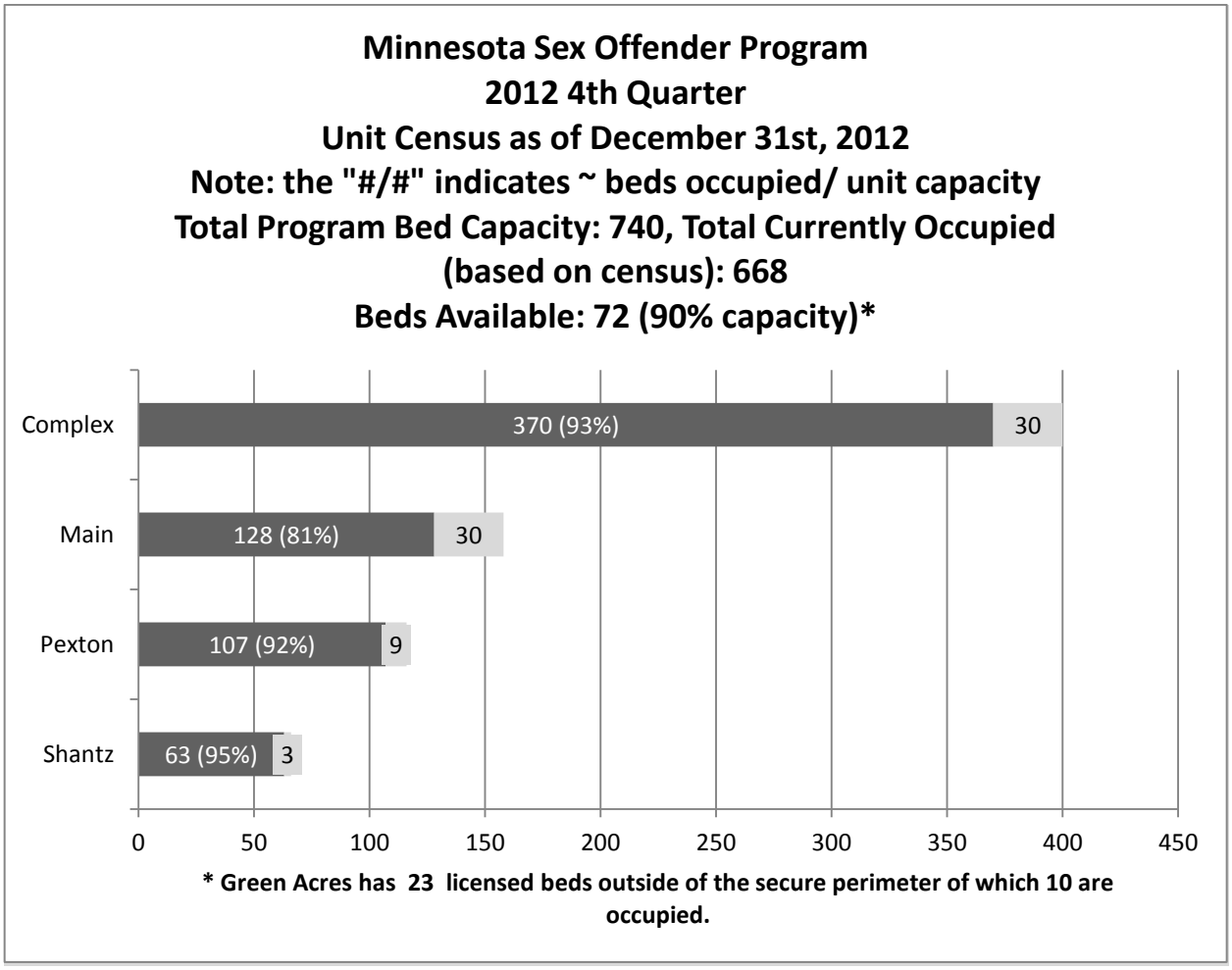


	Jan-Mar 2012	Apr-Jun 2012*	Jul-Sep 2012	Jul-Sep 2012	**Oct-Dec 2012**	**Oct-Dec 2012**
Types of Outings	Number of outings	Total Hours	Total Hours	Number of outings	**Total Hours**	**Number of Outings**
Programming:						
AA	58	150	125.5	56	**150**	**60**
SO Maintenance	25	61	107	37	**86**	**30**
Treatment:						
SO Treatment	26	178	131	42	**92**	**35**
Reintegration:						
Banking	8	6	3.75	8	**3**	**3**
Recreation	20	167	197.25	38	**88.75**	**20**
Volunteer	26	91	148.25	49	**204.5**	**58**
Library	3	1	1	1	**1.75**	**3**
Prosocial activity	24	180.7	169.75	21	**317.75**	**41**
Mentoring	0	0	0	0	**0**	**0**
Other	9	18	53.75	21	**51**	**21**

* During the 2nd quarter, April – June, 2012, the data measured changed from number of outings per quarter, to the total number of client hours per activity.

Program Census Report

Unit Census

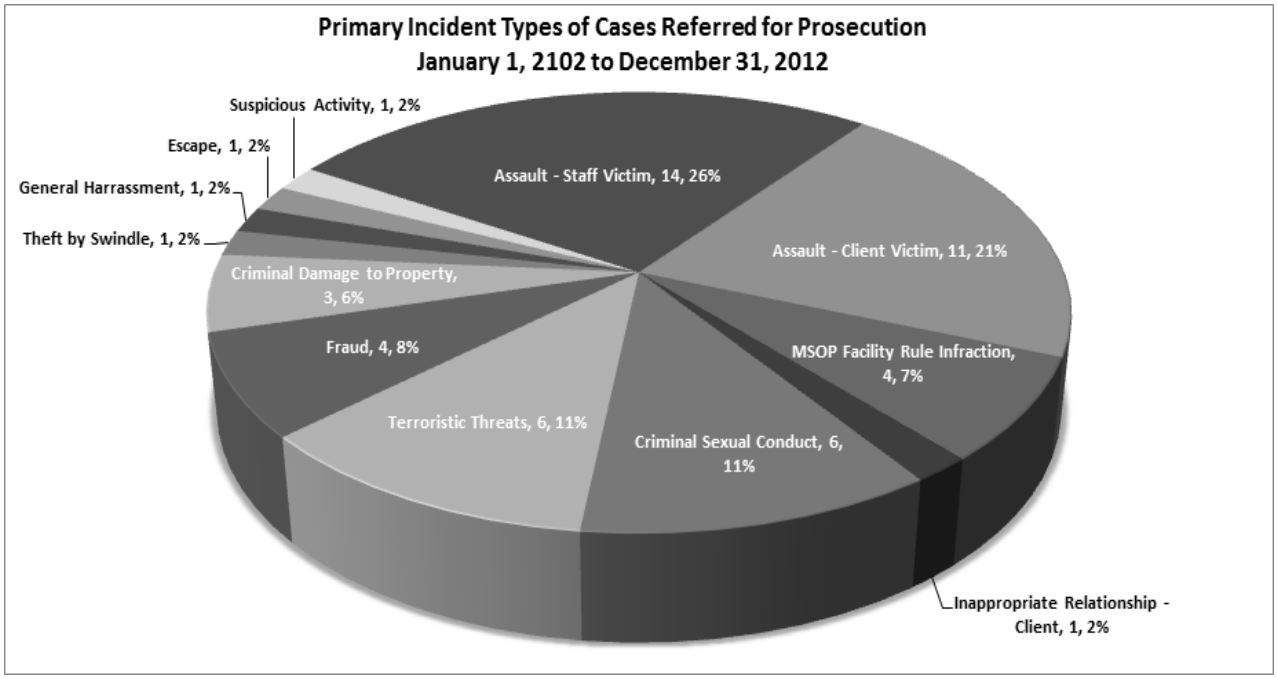


Key	
	Beds Occupied
	Beds Available

Office of Special Investigation (OSI)

The Office of Special Investigations (OSI) provides the Minnesota Sex Offender Program (MSOP) with coordinated investigative services with the goal of aiding MSOP staff in providing a safe and secure treatment environment and to enhance public safety. In the event that illegal activities are suspected, OSI is responsible for conducting an investigation and providing information and reports to local law enforcement if it is believed a crime has occurred. Responsibilities of OSI include (but are not limited to) investigation of suspected criminal activity, coordinating information collection and dissemination on security threat groups and individuals, conducting covert surveillance on clients escorted into the community and those on provisional discharge, investigating circumstances that pose a threat to the security of the facility, and serving as the official liaison with local, state, and federal law enforcement agencies.

In 2012, OSI completed 386 investigations focusing on client misconduct (there were 439 in 2011). Fifty-three of these cases were referred for criminal charges, with charges being filed in 39 cases (one from 2009, one from 2010, and ten from 2010). OSI also provides information to the Department of Corrections (DOC) regarding non-compliant clients who are on conditional release from the DOC. In 2012, 17 clients were returned to DOC for revocations of conditional release or new criminal convictions. The range for days spent in DOC by MSOP clients was 64 to 2093 days, with 302 being the average.



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 2012, 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 1.

Appendix 1

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:	December 10-14, 2012
Date of Report:	December 27, 2012

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, April 2009, October 2010, and December 2011.

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 the Executive Clinical Director and representatives at both sites via video conference from St. Peter.

Summary of Findings

Overall, the program has a strong foundation and is moving in several positive directions. The program continues to have a competent clinical and administrative leadership team. Staff report good collaborative working relationships between security and clinical staff at both sites. The leadership team recognizes and is working to address deficiencies in the program. In particular, slow movement through the program is an ongoing concern, and only one client has been provisionally discharged in recent years.

Since our last site visit, the program has updated documents that guide delivery of services in the program. The program has updated the "MSOP Program Theory Manual" (December 2012 draft), which details the overall rationale, theory, structure and empirical basis of the program. The program has prepared the "MSOP Clinician's Guide" (December 2012 draft), which provides clinicians with direction about how to deliver clinical services. Program administrators have scheduled to roll out these documents to program staff in trainings scheduled for January 2013.

The program has made considerable progress developing and implementing a series of treatment manuals for 65 psycho-educational modules. This is a significant accomplishment. The modules

are accessible to clinicians via an Internet web site. Of the 65 modules, 32 have been completed, 12 are scheduled for completion by January 2013, 13 by April 2013, and the last 8 by July 2013.

The program is using the "Goal Matrix for Phases I, II and III" of the program. The Matrix focuses on dynamic risk factors that are linked to sexual reoffending. The Matrix is used to identify treatment needs, measure treatment progress, and benchmark criteria for moving between phases of the program. The program continues to experience challenges scoring clients reliably on the Matrix and has scheduled staff trainings to address this problem.

St. Peter continues to maintain clinical staffing levels as intended by program design. Although clinical staffing levels at Moose Lake had improved at the time of our last review in December 2011, clinical staffing levels at the site have since dropped, and this is a significant concern.

The percentage of clients in the MSOP who are enrolled in treatment remains at a relatively high level (84%), which compares favorably with other civil commitment programs for sex offenders.

Construction of the new Moose Lake complex is complete, with construction continuing in the main building. The new facility provides enhanced vocational areas and appropriately sized group rooms and other clinical space. Construction at the St. Peter site is underway to expand the number of program beds.

In terms of movement through the program, there has been a significant increase in the last year in the number of clients progressing from Phase I to Phase II of the program. However, the number of clients in Phase III of the program has remained relatively constant. In the Community Preparation Services (CPS) Program, the last phase of the program, the census has stayed about the same as at the time our last review. Whereas in the 3rd Quarter 2011 eight clients resided in the CPS Program, during the 3rd Quarter 2012, nine clients resided in the CPS Program.

Of the three clients who the program has recommended for provisional discharge, one has been provisionally discharged, one withdrew his petition for provisional discharge, and one was turned down for provisional discharge by the Supreme Court of Appeals.

As a result of a class action lawsuit against the program, the federal court has ordered formation of the Sex Offender Civil Commitment Advisory Task Force and charged it with examining and providing recommended legislative proposals on various areas of the Minnesota civil commitment system for sex offenders.

Procedures

We reviewed the following written materials:

- Updated draft "Theory Manual" (December 2012 draft)
- Draft "MSOP Clinician's Guide" (December 2012 draft)
- MSOP Quarterly Reports

During the site visit we engaged in the following activities:

- Met in individual and group meetings with senior management:
  - Nancy Johnson, Executive Director
  - Jannine Hebert, Executive Clinical Director
  - Kevin Moser, Director at Moose Lake
  - Bonnie Wold, Director at St. Peter
  - Haley Fox, Clinical Director at St. Peter
  - Thomas Lundquist , Clinical Director at Moose Lake
  - Elizabeth Barbo, Reintegration Director at St. Peter
- Toured facilities at both sites
- Met with the following staff groups without their supervisors present at both sites:
  - clinical supervisors (6 individual meetings)
  - clinicians (13 individual meetings)
  - rehabilitative services directors
  - unit managers
  - security counselors
- Interviewed clients:
  - six clients in individual meetings at Moose Lake
  - several clients informally during unit visits and group treatment sessions at both sites
- Attended three treatment groups at Moose Lake and four treatment groups at St. Peter
- Attended two therapeutic unit community meetings, one at each site
- Reviewed the clinical records of six Moose Lake clients and four St. Peter 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 at both sites via video conference from St. Peter

The administrative and clinical team provided site visitors with access to all documents requested, all areas of the facilities requested, and 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 updated documents that guide delivery of treatment. These are:

- MSOP Program Theory Manual (December 2012 draft), which details the overall rationale, theory, structure, and empirical basis of the program
- MSOP Clinician's Guide (December 2012 draft), which provides clinicians with direction about how to deliver clinical services

Program administrators have scheduled to train staff on these documents beginning January 2013.

The program Theory Manual and Clinician's Guide describe the program theory as broadly cognitive-behavioral, structured, and skill based, which is an approach that is very consistent with best practices in the field. A strong emphasis is placed on client engagement and therapist style with a focus on positive approach goals, and these elements also have support in the research literature.

As we have noted in past reviews, some clinical practice in the program is at odds with what is set out in the program Theory Manual. First, a considerable portion of treatment time is spent in relatively unstructured process groups, which do not emphasize skill teaching, modeling, and practice. Second, Level II and III groups in the Conventional Program at St. Peter emphasize psychodynamic approaches, which place emphasis on psychological insight as opposed to skill building. We recommend a stronger emphasis on skill building and less emphasis on psychological insight as a treatment target.

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.

The goal of the program is to provide about 8 hours of treatment to each client per week, and the program appears to be meeting this goal. This treatment dose is similar to that provided in other civil commitment programs.

Phase I treatment is designed to provide 4 hours of Core process groups per week and 3 hours of psycho-educational modules. Compared to recent years, this represents 2 hours less of Core groups per week and slightly more hours of psycho-educational groups per week in Phase I. We support this shift in emphasis. Phase II and III treatment, in general, is designed to provide 6 hours of Core process groups and at least 1.5 hours of psycho-educational modules per week. At St. Peter, clients typically receive an additional two individual therapy sessions per month. Individual treatment sessions in the Conventional Program are typically about 50 minutes, and in the Alternative Program individual treatment session length is matched to the client's attention span. Individual therapy is not provided at Moose Lake for Phase II clients.

Since our last visit, the program has begun conducting one-hour weekly therapeutic community meetings on each living unit. It has been challenging to conduct these meetings on the large 68 and 98 bed units at Moose Lake. The therapeutic community meetings in the Alternative Program and the smaller units appear to be working as intended.

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."

The program uses the "Goal Matrix for Phases I, II and III" as its primary dynamic risk measure. The Matrix is used to identify treatment needs, measure treatment progress, and benchmark criteria for moving clients between phases of the program. Having a structured system for measuring progress is consistent with best practices.

Since our last site visit, the program has printed the Matrix treatment goals on pocket size cards and provided them to clients and staff. We support this transparency of program treatment goals among clients and staff throughout the facilities.

Clinical directors are scheduled to provide further training to clinical therapists in January 2013 on scoring the Matrix. This is important because clinical staff and clients commonly indicated that some confusion exists about the definitions of and how to score some items on the Matrix.

We recommend that security, education, and recreational staff receive training on the Matrix to maximize their role in addressing clients' specific treatment goals. Further, we recommend that the program develop a formal system for regular structured chart audit to assess Matrix scoring accuracy. The program should survey staff on the scoring criteria and areas that lead to difficulties in scoring. Refresher training should be offered on at least a yearly basis. We

also recommend that the program develop mock cases for clinical staff to score to test scoring accuracy.

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. Therapist style is an additional 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.

As a broad indicator of program responsivity, the percentage of clients enrolled in treatment remains relatively high (84%), and this compares favorably with other civil commitment programs for sex offenders.

Since our last program review, the program provided all clinical staff one-week trainings on building therapeutic alliance and motivational approaches in sex offender treatment. As during past reviews, clients generally reported relatively good working relationships with primary and group therapists.

Frequent staff turnover and program growth, primarily at Moose Lake, has led to less experienced staff and frequent changes in clients' primary and group therapists. These problems have impacted therapeutic engagement negatively. As a result of low clinical staffing levels, group size is larger than ideal, which does not allow sufficient time to cover therapeutic assignments in a timely manner.

Additionally, low clinical staffing levels at Moose Lake has resulted in Phase II clients not receiving individual therapy as they do at St. Peter, which results in the Phase II programs at the two sites being non-equivalent.

Since our last review, the program has dispersed non-program participants across program units rather than congregating them on a single unit. Staff consistently report that this approach has resulted in a reduction of behavior problems and increased non-participants' enrollment in treatment. The program has instituted a policy whereby clients have input with respect to roommate assignments.

The new psycho-education modules are written at a comprehension level appropriate for most clients in the Conventional Program. Staff recognized that these modules require some adaptations for clients in the Alternative Program and have initiated a plan to make adaptations.

The program has developed Behavioral Management Units (Omega, Omega 2 and Omega 3) and appears to be being using them effectively. Staff monitor client length of stay closely, and timely return of clients to their parent units appears to be taking place.

5. Program Sequence

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

We continue to believe that the overall program sequence is logical and appears to be responsive to clients' treatment needs and learning styles. The program sequence is broadly set out in the Goal Matrix for Phases I, II and III which details client goals for each phase of the program.

Since the last visit, the Executive Clinical Director has completed the Program Theory Manual. The Program Theory Manual more clearly articulates which treatment goals for each matrix area are to be completed within each phase. In addition, the manual specifies specific psycho-educational modules for each phase and links these to specific dynamic risk factors. Such specification is consistent with best practices.

In the last year, the Executive Clinical Director also has developed a Clinician's Guide that specifies criteria, based on Goal Matrix goals and scores, to move between Phases. These appear to be sequenced logically.

As shown in Table 1, there has been a significant increase in the last year in the number of clients progressing from Phase I to Phase II of the program, but the number of clients in Phase III and Community Preparation Services (CPS) has remained relatively constant. One client was provisionally released from the MSOP during the last year.

Table 1. Participants by Program Phases

Program Phase	3rd Quarter 2011	3rd Quarter 2012
Phase I	378	350
Phase II	106	182
Phase III	24	22
CPS	8	9

Of the three clients who the program has recommended for provisional discharge, one client has been provisionally discharged, one withdrew his petition for provisional discharge, and one was turned down for provisional discharge by the Supreme Court of Appeals.

The Goal Matrix may address some of the factors contributing to the apparent slow movement through the program. However, as noted in our last review, we suggested that the program continue to examine this issue. In particular, we have some concerns that staff may have overly high expectations for movement between Phases II and III of the program. Other possible impediments to program movement include the degree of treatment emphasis placed on therapeutic processing versus skill building and practice, and the amount of credit given for past programming. Clients consistently expressed concerns that slow movement through the program, including the fact that only one individual has been released in recent years, was demoralizing, increased hopelessness, and negatively impacted motivation and engagement.

6. Effective Methods

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

Programs should be structured and 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 correctional programs allocate about half of treatment time to skill building interventions focused primarily on clients' criminogenic needs. Overall, programs for offenders that are manualized are more effective than those that are not.

The program has made considerable progress developing and implementing a series of structured treatment manuals for 65 psycho-educational modules. This is a significant accomplishment. Of the 65 modules, 32 have been completed, 12 are scheduled for completion by January 2013, 13 are to be completed by April 2013, and the last 8 by July 2013.

Overall, the group psycho-educational modules place a greater emphasis on skill development than do the core process groups. However, the structure of the psycho-educational groups is that when homework is assigned, it is to be reviewed in the core groups. Therapists and clients stated consistently that this did not happen. Therapists reported that there was insufficient time to review the homework given other activities relegated to core group such as reviewing Behavioral Expectation Reports and Treatment Memos. Groups have also increased in size at Moose Lake since our last review. Additionally, some therapists have the perception that it is solely the clients' responsibility to request time for homework. Often, the therapist in the core group did not know what homework clients were assigned in their psycho-educational modules and did not know the content of certain modules. For homework to be optimally effective, it needs to be reviewed in a timely fashion.

As we have noted earlier in the Model of Change section of this report, Level II and III groups in the Conventional Program at St. Peter emphasize psychodynamic approaches, which places an emphasis on psychological insight as opposed to skill building. We recommend a stronger emphasis on skill building throughout all aspects of the program and less emphasis on psychological insight as a treatment target.

The evaluation team continues to be impressed with the services offered by recreational therapy, education, and vocational services. At Moose Lake, recreational services are offered seven days a week, including evenings, and a St. Peter every day except Sunday. Vocational programs are better developed at Moose Lake and work is ongoing to increase vocational services at St. Peter. These services are an important part of therapeutic programming and assist clients in generalizing skills that they learn in other aspects of the program. Rehabilitation services address a number of social and life skills groups that focus on dynamic risk factors listed on the Matrix. These should specifically be integrated into each client's Individual Treatment Plan.

In the past, individual therapy had been offered on some of the special units at Moose Lake. Both therapist and security staff reported that the availability of individual therapy had a positive impact and decreased disruptive behavior. However, due to staff shortages, individual therapy could not be continued. We recommend restarting these services when staffing levels increase.

7. Continuity of Care

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

The program has components in place to gradually "step-down" clients to the community through programming in Phase III and CPS. The number of clients in Phase III and CPS are about the same at during our last site visit. Of the three clients who the program has recommended for provisional discharge, one has been provisionally discharged.

The program continues to provide community outings as part of the "step-down" process. We support this policy and its focus on ensuring that these outings are linked to treatment goals. During the last year, the recreational therapy department has developed programs to involve CPS clients in appropriate community service activities to "give back" to the community, and we support this initiative.

We continue to note the need for discharge options for clients in the Alternative Program who have reached maximum program. Many clients in the Alternative Program will always need 24/7 supervision, but their risk could be managed in a less restrictive community settings. The level of risk reduction needed for Alternative Program clients to live safely in supported living environments in the community is different from clients in the Conventional Program, who at some point may live independently.

As we have noted in past reports, the program has in place appropriate components for helping clients prepare for discharge and reintegrate in the community, however, only one has been discharged in recent years. Slow movement through the program and the multiple required legislative steps for discharge in Minnesota hampers program effectiveness. The lack of clients "getting out" can be demoralizing to clients and staff, and in the long run may increase security concerns.

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.

The program continues to have processes in place for monitoring the ongoing functioning of the program. These include daily Morning Report meetings involving senior staff from all departments, unit meetings, and shift meetings. Quality assurance procedures are in place to monitor a variety of activities including record keeping and debriefing critical incidents.

Quarterly reports detail action plans to address program goals and progress attained reaching goals. The present review is a review of the program by external experts, and this process is considered a best practice in the field.

The Goal Matrix is an important component of measuring client progress. We stress that all staff should receive training on the Goal Matrix.

Since our last visit the program has introduced a risk management panel composed of the senior clinical leadership. This committee has reviewed treatment team recommendations for movement from Phase II to Phase III. Many analogous systems have similar risk management committees to review significant risk related decisions. We suggest, however, that the program consider whether this review committee would best be reserved for movement from Phase III to CPS. The evaluation team also recommends instituting a quality assurance process in which clinical review is triggered when a client is not making progress or progressing through Phases in a timely manner.

9. Staff Training, Supervision and Support

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

As noted in previous reviews, staff across disciplines appear to be dedicated and committed to the program. Executive Clinical Director Jannine Hebert has continued to provide needed program stability after several years of multiple changes in clinical leadership. Her work this year on the psycho-educational modules and continued implementation of the Goal Matrix continues to refine and improve the program.

St. Peter continues to maintain clinical staffing levels as intended by program design. Although clinical staffing levels at Moose Lake had improved at the time of our last review in December 2011, clinical staffing levels at the site have since dropped, and this is a significant concern. At the time of the present site visit, of 54 clinical positions at Moose Lake, 16 positions were vacant. Of 11 clinical supervisor positions, two positions were vacant. Despite these staff vacancies, the program appears to continue to provide the expected number of treatment hours, but at the expense of increased group size.

We are concerned, however, about the decrease of clinical staff on the Behavioral Management Units as well as Mental Health Unit. Nevertheless, we note that the treatment psychologist and unit directors on those units appear to be maintaining therapeutic environments under challenging circumstances.

The program has taken a number of steps to improve staff retention and morale. The program provides new staff free outside supervision to meet licensure requirements. The program has increased pay and provided flexible work hours. The program facilitates a weekly group for new therapists to orient them to the program. The rural location of Moose Lake will likely continue to make staff recruitment and retention difficult.

In terms of psychiatric staffing, across both sites, the program has a full-time psychiatric nurse practitioner and 12 hours of psychiatrist time per week. We concur with program leadership that the level of psychiatric services appears to be low for a program of this size.

The evaluators continue to be very impressed with the Unit Directors at Moose Lake and St. Peter. In our experience, this is clearly a strong and committed group who work to balance the therapeutic and security aspects of the program. At Moose Lake, given frequent clinical staff and clinical supervisor turnover, Unit Directors provide stability at the line management level. However, the Unit Director to client ratio has been reduced in recent years and the units are larger, which makes it more difficult for them to have a presence on the units. This is especially true at Moose Lake. The program should evaluate whether the current staffing pattern of Unit Directors is appropriate.

Staff interviews indicate good working relationships exist between Unit Directors and Clinical Directors in all programs and generally among security, recreational, and clinical staff in most programs. The notable exception was that multiple staff expressed concerns that clinical staff in the Conventional Program at St. Peter tended to exclude other disciplines with respect to information sharing and collaborative decision-making.

The program continues to provide staff ongoing training to upgrade their skills. In the last year, recognized experts provided training on developing therapeutic relationships and another on healthy sexuality. Program administrators reported that all clinical and rehabilitative services staff attended the recent Minnesota ATSA (Association for the Treatment of Sexual Abusers) yearly meeting. Approximately 20 staff attended the ATSA national conference. Providing continuing education training to staff is a strength of the program.

In most instances, the program continues to provide regular clinical supervision to clinicians; about one hour or more of individual supervision a week for newer staff and about one hour a month for senior staff.

10. Service Documentation

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

We conducted more limited chart reviews this visit than in previous years, as we are scheduled to conduct more detailed chart reviews at a later date. We note that since the new electronic record has been implemented, notes have become more limited and not as directly tied to Matrix goals. The program recognizes and is addressing this issue. On the other hand, individual treatment plans continue to be appropriately tied to Matrix goals.

11. Facility and Treatment Environment

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

The correctional design of the new Moose Lake housing units continue to make it difficult to operate a therapeutic milieu. As we noted last year, staff softened the environment by using carpeting, painting, and other features to make the units more appealing than typical prisons. The program has begun holding therapeutic community meetings on these units in an attempt to create and encourage a more positive environment. It will take some time to see if these efforts are effective.

Other positive changes include removing a fence around the outdoor space of the Phase II housing units, and this provides a more open environment with less of a correctional feel. A major complaint of clients over the last few years, especially at Moose Lake, has been the introduction of a more restrictive movement policy. The program introduced an ankle monitoring system (AMS) for Phase II clients and is in the process of introducing the same system for Phase I clients. As a result, fewer restrictions on movement now exist. Although some clients resent the AMS, most report the result of more open movement as a positive program change. Clients are also being allowed to choose roommates with staff approval, which the clients also see as positive.

St. Peter continues to have smaller units for all clients in the Alternative Program and Phase II Conventional Program. The smaller size and involvement of more advanced clients lend to more therapeutic client interactions among clinical and security staff. St. Peter is in the process of remodeling two more units, which will increase their bed capacity.

As noted in our previous reports, the ratio of security counselors to clients decreased markedly a few years ago, and this makes it difficult for security staff to be as involved in the therapeutic aspects of the program. We still believe that this makes it more difficult for security staff to know clients and to be able to respond to the security and therapeutic goals of the program. Additional staffing exists for specialized units (young adult, mental health, and behavior), which have greater needs for supervision.

The new Moose Lake complex is complete and provides much needed programming space. It also provides more dining, vocational, recreational, and educational space. These spaces are well designed and address many of the needs at Moose Lake. There is a therapeutic environment committee, which has client involvement, and they are assisting in choosing wall decorations in the new areas.

In the Alternative Program, a high level of engagement is evident between the security counselors and therapists. In particular, Alternative Program security counselors expressed a desire to have a more active role in the therapeutic program.

In recent years, the program had increased client restrictions and security staff took on a more exclusive security role. As we noted in our last report, Kevin Mosher, Director of Moose Lake, took a lead role in promoting an increased therapeutic milieu without

compromising security needs at the facility (e.g., removal of a fence and increased client movement).

Although infrequent, some clients have committed serious assaults on staff and other clients. To date, the program has had only limited success in gaining cooperation from local prosecutors in prosecuting serious felonies. To protect staff and clients, we support criminal prosecution of serious criminal offenses within the facility and believe that this is an area that needs attention.

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.

The program has a strong administrative structure and processes in place to ensure ongoing staff communication. There is stability in clinical leadership. Although some senior leadership staff retired in the past year, the individuals who filled these positions have proven leadership skills and are very knowledgeable about the program. The program continues to staff clients at least quarterly and conduct comprehensive yearly reviews.