Minnesota Sex Offender Program Annual Performance Report 2013

Minnesota Sex Offender Program
January 2014

Legislative Report

Minnesota Department of Human Services

For more information contact:

Minnesota Department of Human Services
Minnesota Sex Offender Program
P.O. Box 64992
St. Paul, MN 55155-0992
651-431-5800

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I. Executive summary

This past year has been a pivotal one for the Minnesota Sex Offender Program (MSOP). In addition to continued program evolution and enhancements, we are nearing the critical point in regard to the class action lawsuit brought forward by MSOP clients in 2012. Although the lawsuit has brought significant public attention to the program, our work to provide quality treatment that is reflective of research continues. In our efforts to provide comprehensive clinical interventions based on best practices, clients progress through treatment phases toward the goal of transfer to a less restrictive setting or provisional discharge.

Early in 2013, settlement conferences between parties continued, specific to conditions of confinement. The MSOP Program Evaluation Team (MPET), which consisted of national experts appointed by the court late in 2012, analyzed treatment progression within our program and submitted their findings and recommendations to the court in the spring of 2013.

After the Sex Offender Civil Commitment Task Force (SOCCTF) was appointed in 2012, their initial recommendations for less restrictive alternatives for committed clients were submitted to the Department of Human Services Commissioner. A policy bill addressing this issue was passed in the Senate during the 2013 legislative session; however, it did not pass in the House of Representatives. The SOCCTF continued their work throughout 2013 and focused on thoroughly examining the civil commitment process in our state. They submitted their findings and recommendations at the close of the year.

Noteworthy MSOP highlights for 2013 include many operational, programmatic, and clinical changes and improvements. Striving to meet our strategic goals and keeping our mission at the forefront to guide our decisions, is of utmost importance.

The majority of the renovation project for the Shantz Building in St. Peter took place in 2013. The substantial completion date is in late March of 2014. Completion of this bonded project will increase capacity inside our secure perimeter at that site. It also will provide a physical structure that provides improved security as well as enhanced treatment space. In addition, facilities at both St. Peter and Moose Lake are making strides in creating environments that are therapeutic, while at the same time, are maintaining security measures.

MSOP has long been challenged by recruitment and retention of quality clinicians to provide sophisticated treatment services in the rural setting of Moose Lake. Being diligent in the exploration of any and all options, we made significant progress this past year to address this crucial need by creating promotional opportunities, establishing tuition reimbursement, and providing loan re-payment plans through a Memorandum of Understanding.

MSOP departments and disciplines have been instrumental in the ongoing revision and new development of essential internal policy that guides our program into the future, assuring continuity and consistency. In 2013, we separated teams and workflow to create and formalize our Assessment Unit and our Forensic Evaluation Unit. Our Research Department continues to strengthen their overall design and analysis system in the capturing and validating of data and prioritizing research projects for the upcoming year.

Community Preparation Services (CPS) in St. Peter has grown in size and scope this past year with eight client transfers ordered by the court. These clients have moved from inside the secure perimeter to the less restrictive residential facility on the same campus. With continued program expansion, the bonding proposal for MSOP Phase I includes constructing an additional 30 beds to the existing CPS building.

MSOP made significant advances in the development of additional resources for treatment in less restrictive alternative placements. In response to a Request for Proposals (RFP) MSOP has developed four additional housing contracts and five additional treatment contracts, both potentially providing services state wide. The housing contracts are for currently available resources (not new construction or new leases), and we are continuing outreach to other agencies who did not respond to the RFP to engage them further.

Trainings were designed and conducted this past year within staff development which included the development of new intervention techniques on the client interaction continuum. This training teaches our staff the unique skills necessary to successfully and safely intervene with client behaviors. Treatment Design and Philosophy training was also created in 2013 to assist our operational staff in better understanding their individual roles and contributions within our program. Training for using the revised Treatment Theory Manual and the new Clinician's Guide was provided to all clinicians across MSOP in 2013. Outside trainings occurred with national and international presenters as we continue our strength-based approach to sex offender treatment, incorporating a strong motivational philosophy.

II. Background

M.S. 246B.035 requires the electronic submission of an annual performance report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over funding for the Minnesota Sex Offender Program (MSOP) by January 15, 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.

III. 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), 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 **Employee Engagement**

Program Integrity **Responsibility to the Public**

Learning Organization

[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 impaired executive functioningare placed in the MSOP Alternative Program and complete all phases of their treatment at St. Peter.

2013 Strategic Goals:

Goals	2013 Outcomes
1A. Therapeutic Environment: Promote principles of a therapeutic community. In particular, improve the communication and partnerships between clinical and operations staff	
Conduct refresher trainings for all staff on the treatment program and the role all staff play in the therapeutic environment. Measure: Percent of staff that have completed all new and refresher trainings.	• 86% and 100%, of non-clinical and clinical staff, respectively, have completed this refresher training. • Staff feedback suggests an improved understanding of the role all staff play in maintenance of the therapeutic environment.
Increase collaboration between clinical and operations staff.	• Staff were provided strategies for engaging with clients using treatment language to improve uniformity and consistent messaging across the program. • Standing meetings at both sites now include operations and clinical staff. These meetings have improved the working relationships across departments.
1B. Therapeutic Environment: Enhance the therapeutic environment throughout MSOP to help clients develop and practice socially appropriate interactions	
Develop and implement a more therapeutic physical environment at both facilities.	• Visible representations of the program principles are evident at both sites in an effort to remind clients that the mission of MSOP is their treatment. • Projects made by clients in clinical services (e.g., treatment groups, vocational services) are displayed throughout the program.
Establish an open movement environment through Area Monitoring System (AMS) and revised staff duties to ensure appropriate staff coverage and therapeutic environment by December 31, 2013.	Open movement is now standard in daily operations. Continued review of staffing and systems will remain a priority to ensure a therapeutic, safe, and secure environment.
Explore and potentially establish safe and effective means of maintaining positive support systems for the clients through electronic messaging.	• MSOP produced a Request for Proposal in the first quarter; however, the responsibility to put a contract in place rests with agencies outside of DHS. • MSOP continues to offer assistance to Department of Administration and MNIT to expedite this contract for electronic messaging services.
Provide and implement mp3 music kiosks for allowable music downloads onto mp3 players.	• MSOP produced a Request for Proposal in the first quarter. However, the responsibility to put a contract in place rests with agencies outside of DHS. • MSOP continues to offer assistance to Department of Administration and MNIT to expedite this contract for MP3 music services.
Complete renovation and remodeling projects as scheduled and planned.	Construction and remodeling stayed on schedule in 2013. If all goes as planned, the remodeling project of Shantz will be complete in March 2014.

2A. Program Integrity: Organizational efficiency	
Complete a comprehensive upgrade to the client computer network, including new computers, switch boxes, and computer platform (operating system).	MSOP completed the implementation of the vocational, education, and recreation computer network.
Develop, or refine any existing, monitoring tool to track all clinical recruitment outreach and activity including timeframes and results of such efforts.	All recruitment activities and staff movement are now tracked each quarter with information forwarded to MSOP executive clinical leadership for evaluation and development of ongoing strategy.
Establish the necessary variances and waivers in program licensing rules to allow for client population increases, evolution in sex offender treatment, and professional licensing standards.	MSOP successfully negotiated a variance for Rule 26 regarding use of license-eligible staff conducting certain functions under supervision. MSOP was able to re-establish a waiver through the Minnesota Department of Health to allow for increased beds in Moose Lake until the Shantz project is completed.
2B. Program Integrity: Consistency	
Adhere to clinical program design.	• Strategies for establishing and maintaining program integrity include annual program update trainings for all clinical staff, individual and group professional supervision, chart audits, case consultations, and progression panels with senior clinical management. • Maintaining program integrity in a program the size of MSOP with over 100 clinician staff will continue to be a challenge. • There are structures built in to the program design that will assist in maintaining the evidence-based treatment for MSOP clients.
Clarify, for staff and clients alike, the process of program progression across the phases	• One-hundred percent of clinical staff were provided a program update training, including the current program design and application. • In Moose Lake, associate directors are now assigned to participate in treatment team meetings and case consultation. This provides additional resources to staff in determinations of client treatment progression and implementation of program design.
Increase the number of vocational opportunity hours for client at the St. Peter facility relatively comparable to Moose Lake.	• Individual work assignment hours in St. Peter increased from an average of 17 to 20.5 hours. This is slightly less than the Moose Lake site individual averages but implementation of upcoming projects will reduce this discrepancy in 2014. • The St. Peter site added an Aquaponics program, an upholstery program, and an auto detailing crew.

2C. Program Integrity: Safety	
Ensure sufficient psychiatry services are provided to clients who are on psychiatric medications or in any other way in need of psychiatric care.	• The psychiatric needs of all clients are being met with current resources. • MSOP enhanced clinical staff training on use of psychotropic medications for sexually specific diagnoses. • Psychiatric consultation has increased through scheduled rounds with the new full-time psychiatrist.
Reduce the number of "person crimes" committed by clients within the MSOP.	• The Office of Special Investigations (OSI) opened 368 criminal cases, and investigated 170 "person crimes."
Achieve 100 percent compliance with the predatory offender registration (POR) law.	The number of MSOP clients in non-compliance of the predatory registration requirement remained consistent in 2013. OSI will continue to identify those clients that are not fulfilling registration compliance and assist clients in becoming compliant. Approximately 90 percent of MSOP clients are currently compliant.
Demonstrate the program encourages law abiding behavior and holds clients accountable for committing crimes within the MSOP.	OSI referred 23 cases for revocation in 2013 and was successful in the return of 14 non-compliant and disruptive clients back to the Department of Corrections.
Continue to increase safety at the facilities and a safety culture.	MSOP increased safety training, instituted monitoring of injuries, and began documented quarterly safety audits and follow-up. In 2013 Quarter 4, MSOP had three consecutive months with decreased workers' compensation costs.
2D. Program Integrity: Culture of accountability	
Evaluate all rehabilitation programming and develop a plan for improving clients' programming for rehabilitation services.	• Increased cohesiveness of treatment program by communicating programming opportunities to other departments. • Rehabilitation supervisors and staff increased communication about clients' progress with clinical staff, through a variety of meeting venues. • Rehab services were not able to measure clients' participation in programming, as the department is struggling with its current data collection. This objective will be continued in 2014.
Improve quality, accuracy, and timeliness of clinical documentation.	• The program auditors report for 2013 indicated that the quality of the charts reviewed was consistent with current research and professional standards. • The MSOP research and program evaluation department will be implementing systems in 2014 to monitor timeliness in clinical reports.

2E. Program Integrity: Establish and review program evaluation measures for validity and reliability of outcomes	
Enhance the development and maintenance of an integrated and robust data collection and analysis system to verify the effectiveness and efficiency of MSOP services.	• Began to collect data from throughout MSOP and systematically organize and cross validate information. • Staff worked closely with IT and the Macro team to generate a reliable method for extracting information needed for quarterly reports. • The consistency and efficiency of data entry has increased.
3. Learning Organization: Integrate evaluation as part of the learning culture to improve outcomes	
Identify measurable indicators for data collection to evaluate outcomes in each major function of MSOP. This will be assessed in the submission of these measures to the Research and Program Evaluation Department on a quarterly basis.	• MSOP continues to refine internal data collection to assist in internal program evaluation and measurements associated with program integrity. • CPS has worked throughout the year to centralize data related to outings. A plan has been created to capture some initial ideas on how to enter the data.
Develop and provide classes on the use of Phoenix in documentation.	The creation and evolution of the Phoenix computer system has enhanced efficiency and quality of work for all MSOP staff. While the system is still under development, clinical staff have particularly benefited from easier access to client records to coordinate treatment planning and communication across departments.
Enhance the relationship between the Office of Special Investigation (OSI) and higher education partners to increase the involvement of interns within OSI.	The Office of Special Investigations continues to work with higher education partners to increase the involvement of interns within OSI. OSI established a relationship with Minnesota State University-Mankato, resulting in an internship placement for 2014 Quarter 1. OSI will continue to seek to develop effective internship opportunities within the Office for those wishing to explore a future in investigations.
Complete six major Continuous Improvement projects in calendar year 2013, and several other smaller efforts.	Six projects were completed including examination of hiring of security staff, the client request process, behavioral expectations process, scheduling client outings, creating efficiencies in the client property room, and a standardization project in the maintenance department in St. Peter.

4A. Employee Engagement: Promote employee career growth through internal training, external training, and mentorship	
Develop and implement a mentorship program for new clinical staff.	• One-hundred percent of new clinical employees were provided thorough training on the clinical program design during their orientation process. • A mentorship program was designed, the proposal was approved, and the program will be implemented during the first quarter of 2014.
Provide opportunities for career advancement within MSOP. This includes work out of class and job shadowing opportunities, lateral or promotional reassignments.	• Four clinical staff were promoted to clinical supervisors. • One clinical supervisor was promoted to associate clinical director. • Clinicians continue to be provided advancement opportunities as they complete requirements for their professional licensures. • The internship program continues to be a success and has resulted in permanent employment for two psychologists who were former interns. • Moose Lake implemented clinical program therapist 2 classification this year, which provided opportunities for security counselors to work in the clinical department and take on appropriate clinical responsibilities commiserate with the qualifications of the classification.
4B. Employee Engagement: Increase staff retention	
Develop and promote opportunities for pay equity.	Clinical and administrative leadership have been diligent in exploring any and all options in this area. A Memorandum of Understanding was approved with MAPE The memo includes hiring and retention incentives specific to Moose Lake clinical staff.
Promote employee career growth through internal training, external training, and mentorship.	• Clinical and programming staff participated in numerous trainings from national and state experts in several topics, including psychopharmacologic interventions with personality, MSOP matrix factors, and changes to the Diagnostic and Statistical Manual (DSM). • MSOP clinicians were accepted to do professional presentations at MN Association for the Treatment of Sexual Abusers, and the St. Louis County Health and Human Services training.

5A. Responsibility to the Public: Maintain a balance of the provision of solid clinical services within a secure setting, maximizing public safety	
Provide services that will enable clients to achieve the highest level of independence during community reintegration opportunities to assist them in becoming safe community members upon provisional discharge.	CPS has developed processes increasing therapeutic opportunities for clients while maintaining public safety
Increase partnership with reintegration and law enforcement to enhance public safety by conducting covert surveillance operations on MSOP community outings.	• Maintained open communications with local law enforcement and corrections professionals and community contractors. • OSI has conducted surveillance on 170 outings this year and logged 11 law enforcement contacts. OSI and Reintegration meet weekly to discuss OSI observations during surveilled CPS outings.
5B. Responsibility to the Public: Promote transparency by conducting pro-active outreach to stakeholders in community	
Educate the public on civil commitment, MSOP treatment and our reintegration programming.	Community outreach is a conducted at the request or direction of the Executive Director as part of our regular duties. There were 68 contacts with community stakeholders logged this year.
Provide educational opportunities for stakeholders and the public regarding the treatment and supervision of sexual abusers.	MSOP continues to prioritize communication with stakeholders and the public to increase awareness of our program's design, philosophy, and successes in providing treatment and supervision to the clients we serve. This work has occurred in both formal and informal settings with people who represent all areas of our state.
Increase public web content by 50 percent over the next year to improve access to program information	Although all documents on the public webpage are now accessible, the web content was not expanded this year due resources being redirected to litigation and the creation of a new DHS administration, Direct Care & Treatment.
Revise MSOP public documents increase accessibility for those with visual disabilities. This will be measured by the number of documents reviewed and modified each quarter.	All documents on the public MSOP webpage have been updated and have been made accessible for individuals with visual impairments. All documents posted to the public webpage have a scheduled review cycle to ensure the most accurate and current information is available to the public.

IV. Treatment Model and Progression

A. Program Philosophy and Approach

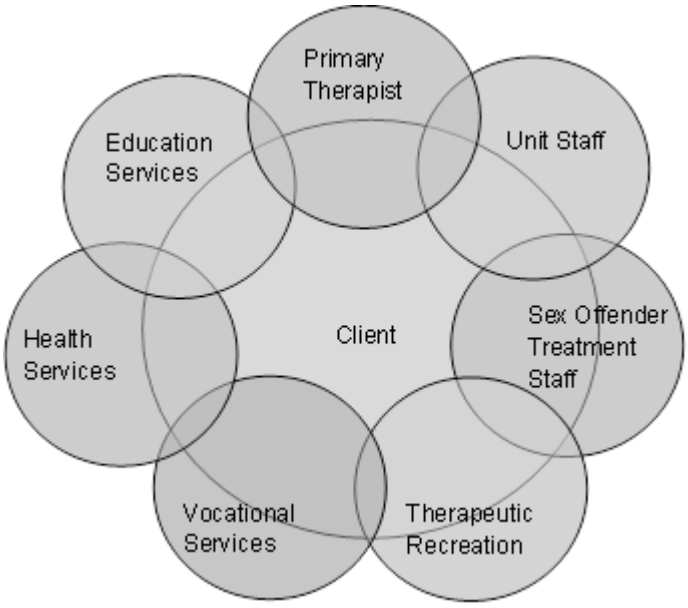
MSOP draws on several contemporary treatment models in its programming. These models include cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by the professional psychological literature in the areas of risk/needs/responsivity and stages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

B. 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.

C. 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. Identifying the problem.

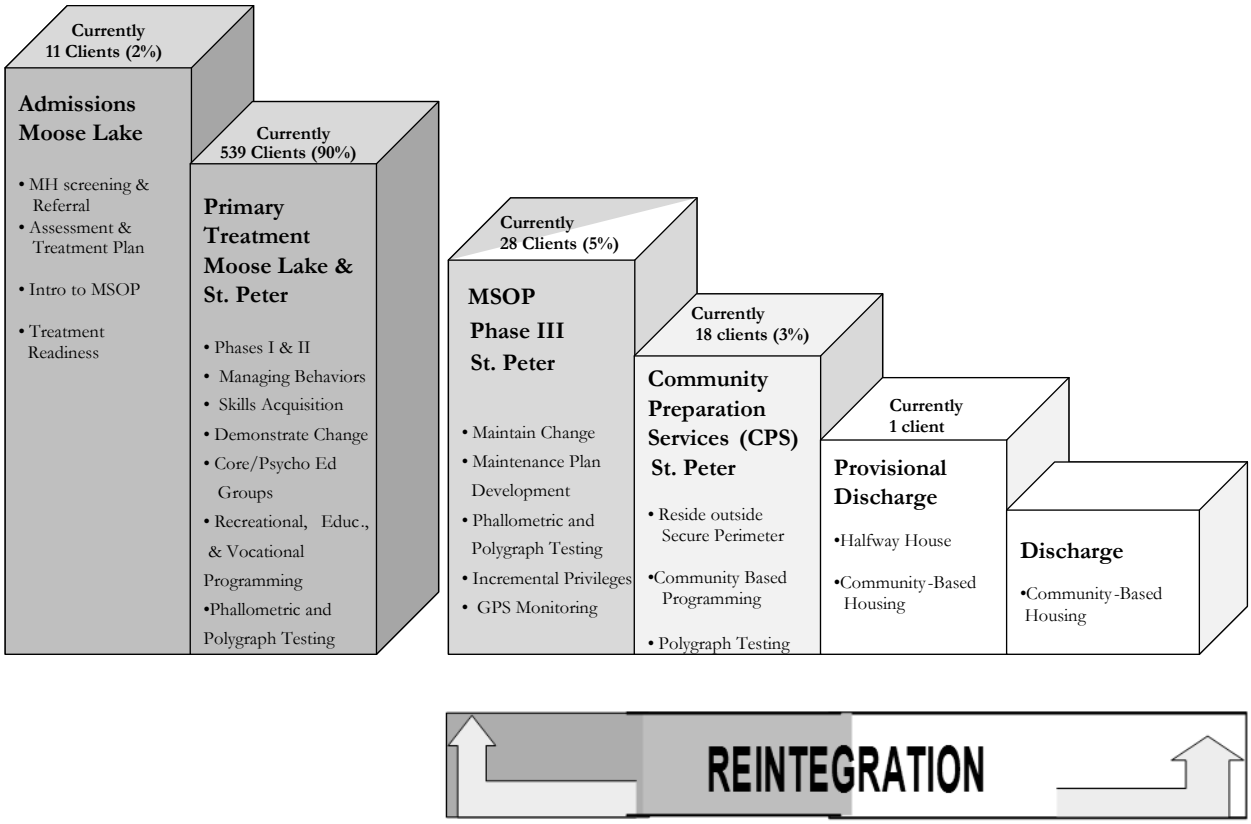
- Presenting the information, including background, resulting from the project and discuss its significance.
- Describing the methodology used in gathering information. Present any survey findings or research done.
- Discussing any issues that were controversial and elaborate on these. Are there other issues to discuss or challenges to meet?
- Describing the overall findings. Summarize them and analyze them to provide the reader with context and expert advice or suggestions that lead to the recommendations in the conclusion.

D. 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. 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



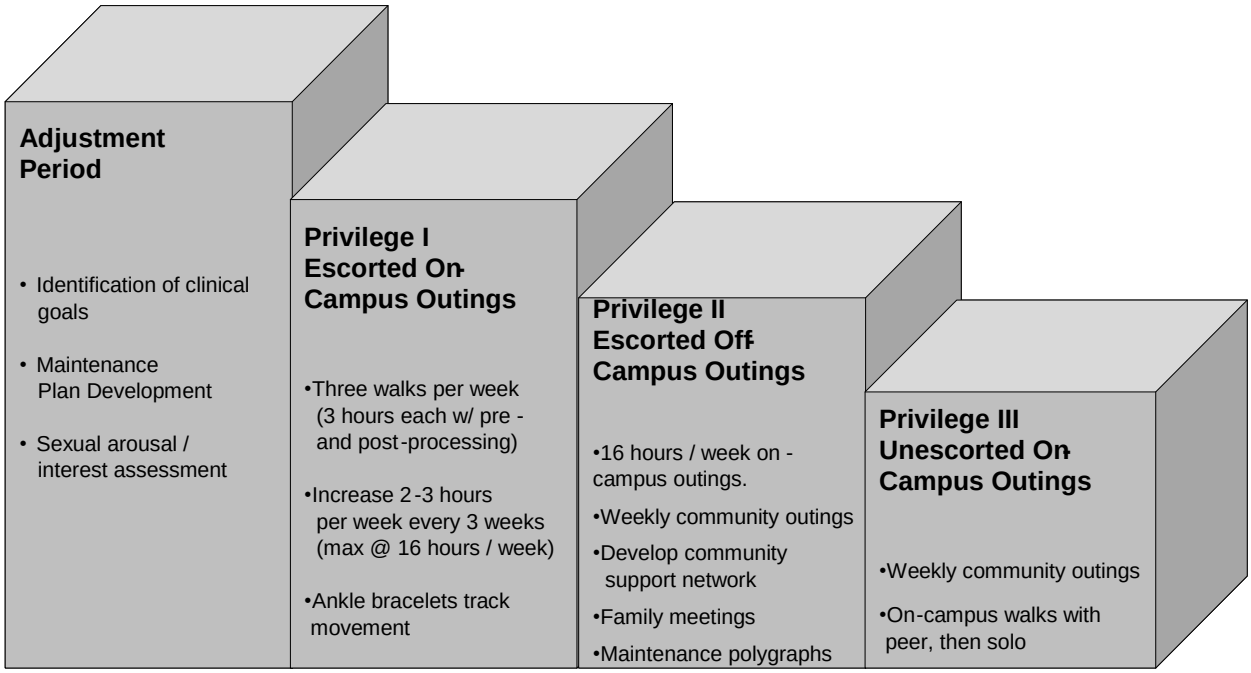
This chart does not reflect the clients who do not agree to participate in treatment after leaving the Admissions Unit (as of 12/31/13, 100 clients). Of the 18 clients in CPS, 16 are in Phase III and 2 are in Phase II.

E. Reintegration

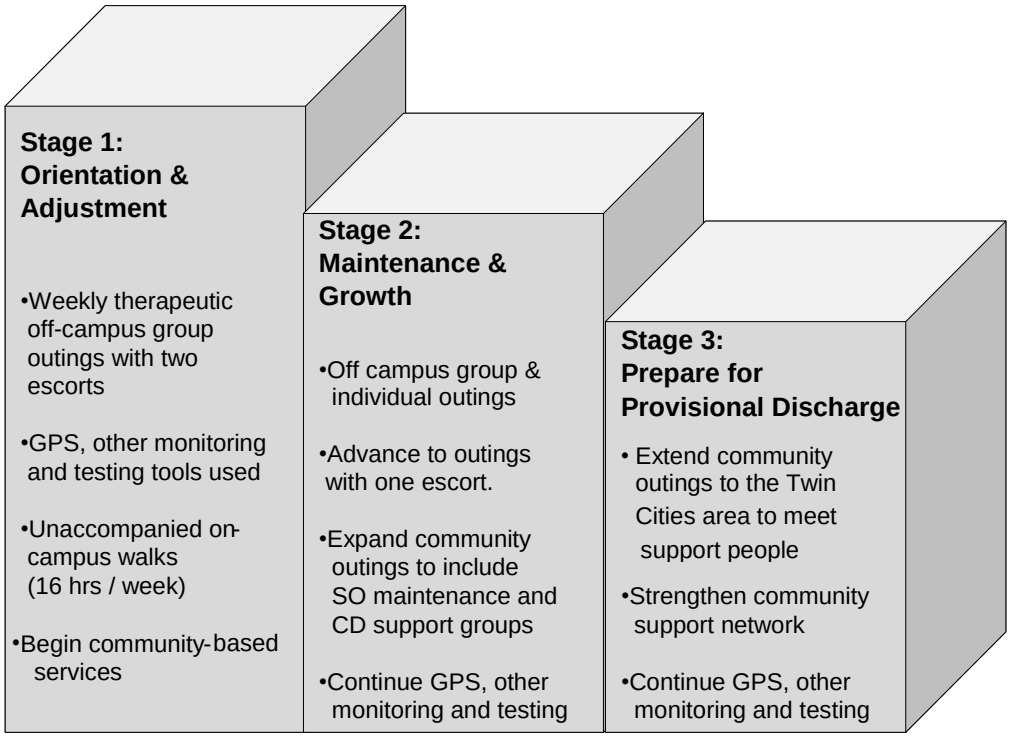
Reintegration is a transitional period designed to provide opportunities for clients to apply their acquired skills and to master increasing levels of privileges and responsibility while maintaining public safety. The focus of treatment during reintegration includes "decompression" from many years (often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

F. 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.



V. 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. 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. Two outcomes may occur as the result of a client participating in this treatment prior to the end of their sentence in DOC:

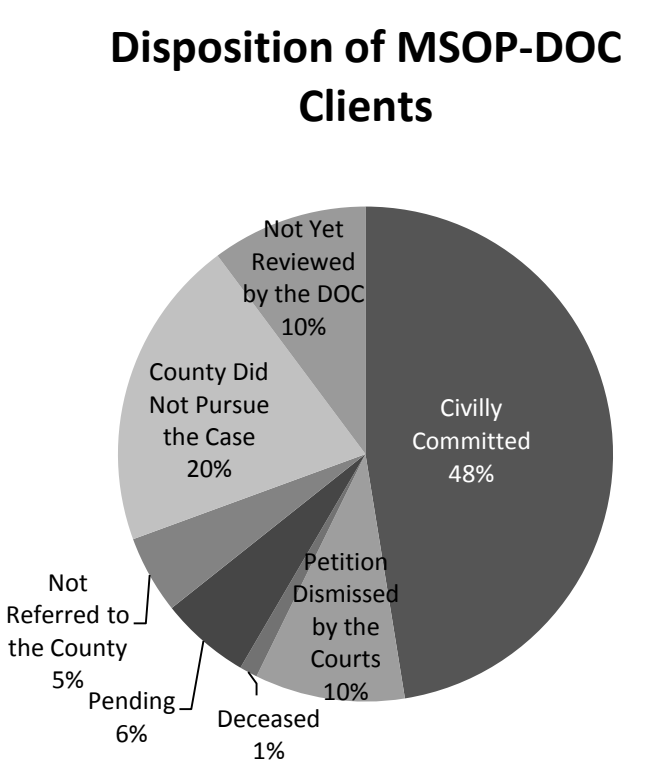
1. The client is viewed as having made such significant progress toward management of risk factors that the county does not petition for civil commitment.
2. The county pursues commitment, and the client is civilly committed to MSOP but is able to start at a later phase in treatment and/or move through 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 307 men who have been admitted to the MSOP-DOC program since 2001. As of January 1, 2014, there are currently 52 clients still in the program. Of the 255 men who have been discharged from the program, 61 (23.9%) are in the DOC and 194 (76.1%) are not.

Commitment Status of Men Discharged from MSOP-DOC:

Of the 255 men discharged from the program:

- 121 (48%) were civilly committed,
- 13 (5%) were not referred to the county for review by the DOC (reside in the community or DOC),
- 52 (20%) the county did not pursue the commitment (reside in the community or DOC),
- 25 (10%) the petition was pursued by the county and dismissed by the courts (reside in the community or DOC),
- 15 (6%) DOC referred the petition to the county and it is pending,
- 26 (10%) 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



VI. Program-Wide Per Diem and Fiscal Summary

Minnesota Sex Offender Program Fiscal Year 2013 & 2014 Per Diem

Description	FY 2013 Annual $$	Per Diem	FY 2014 Annual $$	Per Diem
Direct Costs				
Clinical	**14,760,094**	**58.35**	**16,645,130**	**61.71**
Healthcare and Medical Services	**5,902,718**	**23.34**	**5,302,238**	**19.66**
Security	**31,886,571**	**126.06**	**32,587,185**	**120.81**
CPS & Communuity Preparation	**1,053,122**	**4.16**	**1,033,828**	**3.83**
Dietary	**2,079,563**	**8.22**	**2,152,263**	**7.98**
Physical Plant & Warehouse	**7,832,925**	**30.97**	**8,540,536**	**31.66**
Program Support	**9,897,007**	**39.13**	**10,507,821**	**38.96**
Total Direct Costs	**73,412,000**	**290.23**	**76,769,000**	**284.61**
Operating Per Diem		**290**		**285**
Indirect Costs				
Statewide Indirect	**37,030**	**0.15**	**108,925**	**0.40**
DHS Indirect			**0**	**0.00**
Building Depreciation	**3,689,097**	**14.58**	**3,689,097**	**13.68**
Bond Interest	**5,065,200**	**20.02**	**5,065,200**	**18.78**
Capital Asset Depreciation	**175,797**	**0.70**	**119,324**	**0.44**
Total Indirect Costs	**8,967,124**	**35.45**	**8,982,546**	**33.30**
Total Costs	**82,379,124**	**325.68**	**85,751,546**	**317.91**
Average Daily Client Count (ADC)	**693**		**739**	
Published Per Diem Rate		**326**		**318**

*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 2014 is $318 and 2013 is $326. The marginal per diem, which is the estimated additional costs for each new admission into MSOP, is currently $151.

VII. Annual Statistics

Current Program Statistics as of December 31, 2013

Total MSOP Clients	**696**
Clients by Location	
Moose Lake	505
St. Peter	191
Clients by Age	
18-25	22
26-35	153
36-45	164
46-55	183
56-65	109
Over 65	65
Average Age	**46**
Youngest	19
Oldest	91
Race*	
American Indian/Alaskan Native	52
Black/African American	97
White Caucasian	518
Other/Unknown	30

* At least one client self-reports under more than one category.

Education	
0-8 Years	30
9-12 Years	66
High School Degree	321*
GED	218*
High School degree and GED	8
Some college or college degree	31*
Unknown	23
Civilly Committed Offenders by County	
Hennepin	144
Ramsey	67
Olmsted	33
Dakota	29
Anoka	28
Beltrami	17
Other Counties	378
Metro Counties (7-County Area)	292
Non-Metro Counties	404

* 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. Also, some clients may fall under more than one category, e.g., if a client who has not yet completed High School or a GED has taken some college courses.

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, 2013, there were 12 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	7
Clients on judicial hold status in the DOC/jails	5
Total on judicial hold status	**12**

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 determined if the individual met the statutory criteria for civil commitment. If this burden was met, the individual was initially committed and transferred to MSOP (if the client was 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 2013*	17
Clients previously committed whose cases were reviewed and finalized for commitment during 2013	4
Total civil commitments to the MSOP during 2013	**21**

**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 (14 clients in 2013). 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.

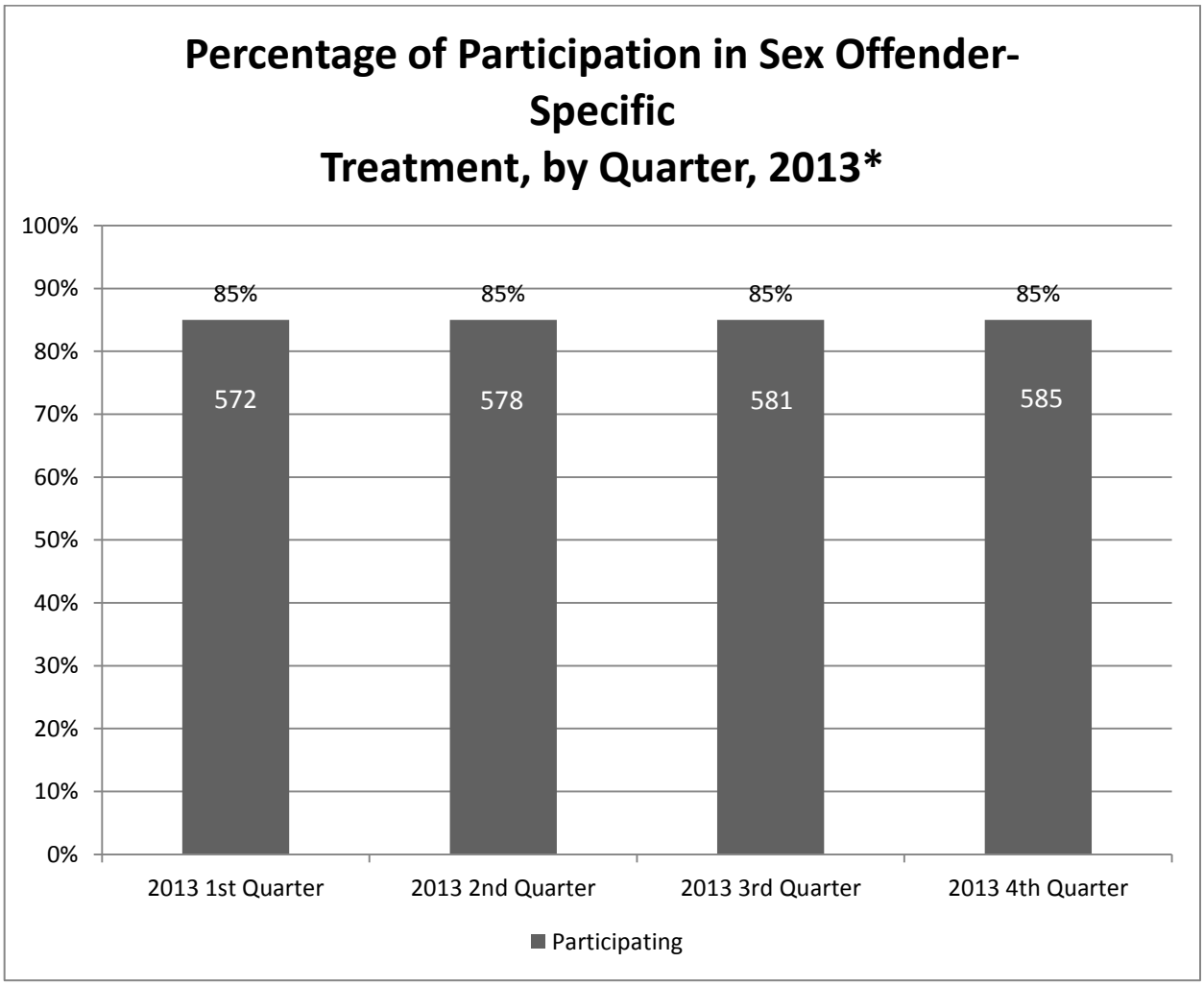
Dually-Committed Clients:

Clients who are under civil and DOC commitment in the MSOP	177
Clients who are under civil commitment and in a DOC or federal prison	31
Total number of dually committed clients as of December 31, 2012	**208**

Clinical Statistics

Treatment Participation

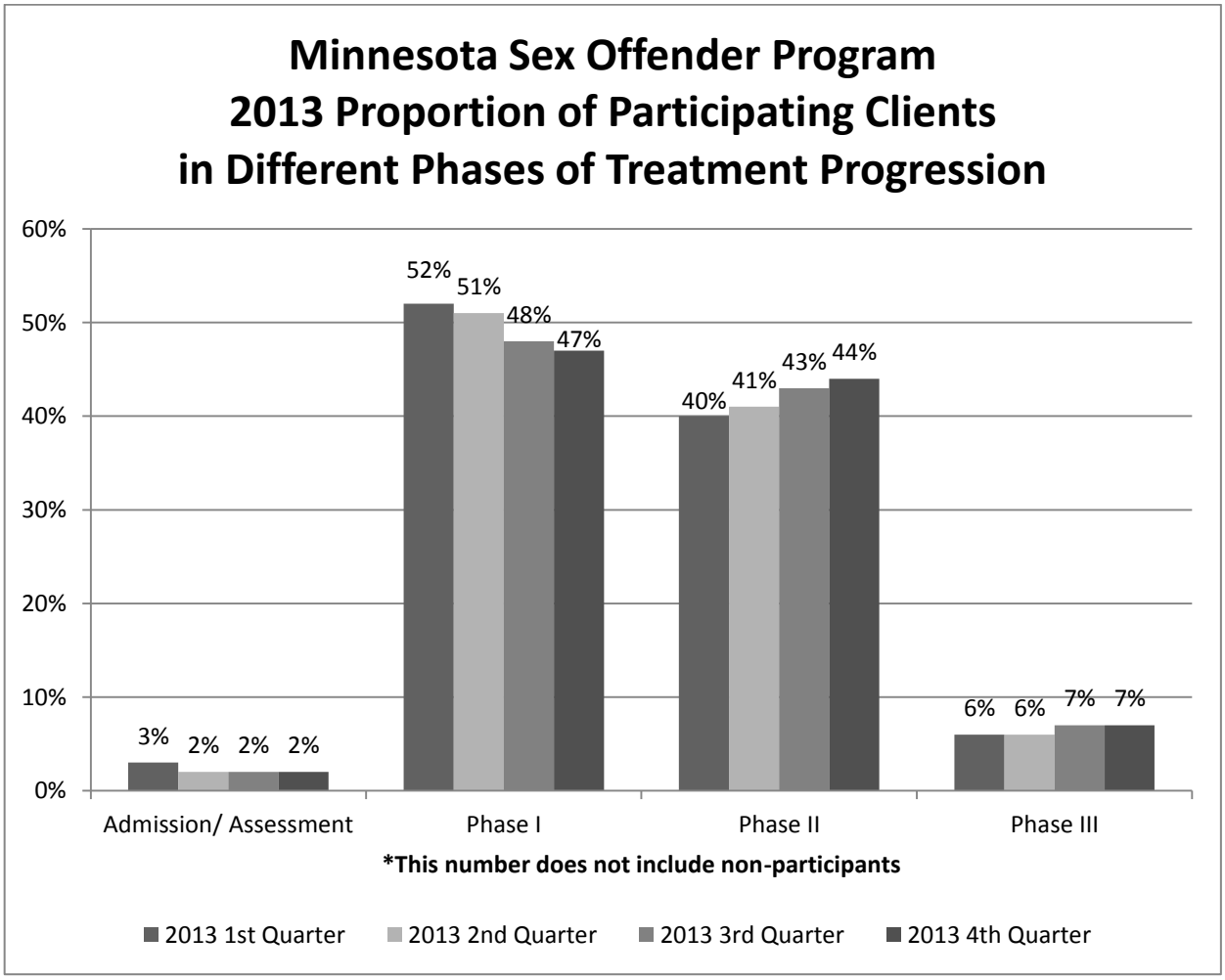
All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment, approximately 85 percent were participating at the end of 2013.



** 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



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 40 percent of the clients residing on units that provide specialty programming while 58 percent reside on units providing Conventional Treatment. The remaining 2 percent of the population resides on the Admissions (ADM) programming unit, which does not provide sex-offender specific treatment.

Programming	Location	Total Clients	Percentage*
Admissions (non-participants)	Moose Lake and St. Peter	11	2%
Alternative Programming	St. Peter	111	16%
Assisted Living Unit Programming	Moose Lake	18	3%
Behavioral Therapy Unit Programming	Moose Lake	21	3%
Community Preparation Services	St. Peter	18	3%
Conventional Programming	Moose Lake and St. Peter	407	58%
Corrective Thinking Unit Programming	Moose Lake	64	9%
Mental Health Unit Programming	Moose Lake	21	3%
Young Adult Treatment Unit Programming	Moose Lake	25	4%
Total		696	*

**Due to rounding, the total percentage is 101%*

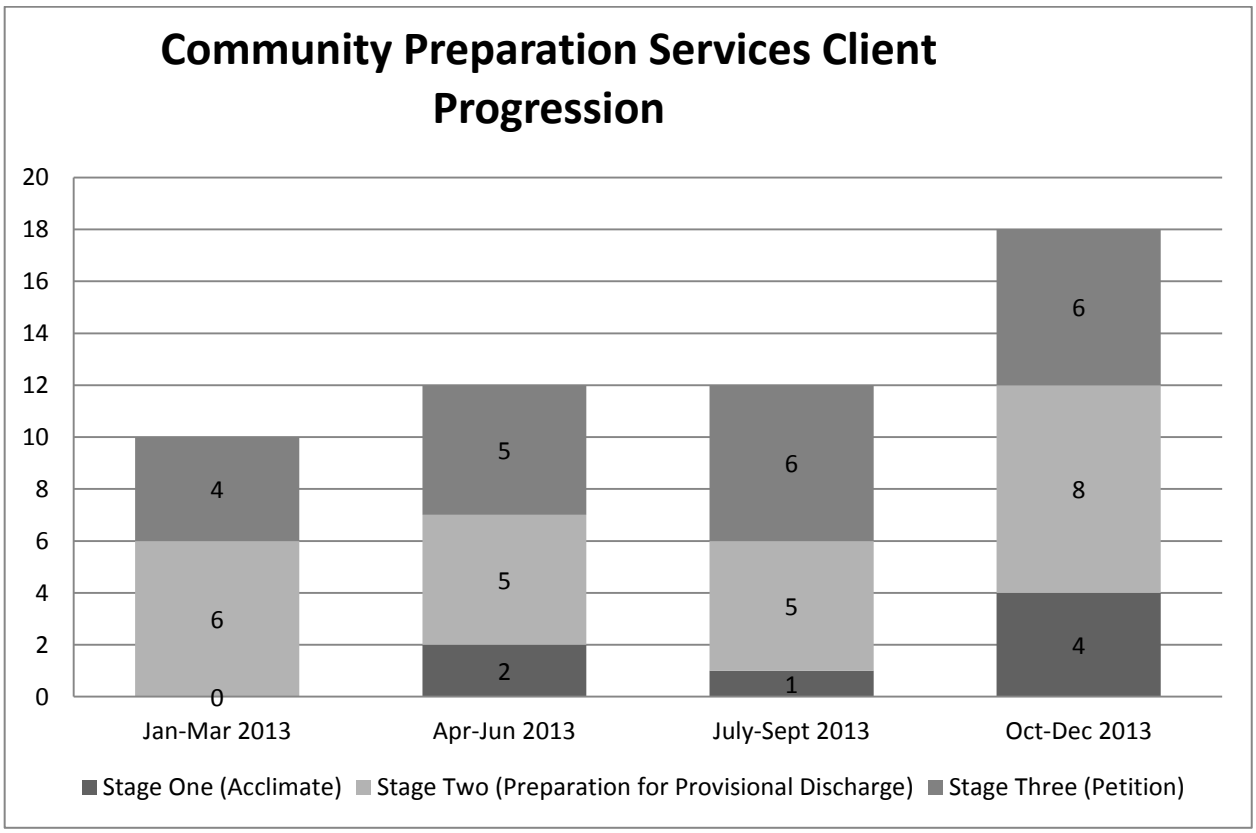
Note: Non-participants now reside on various units. Also, this is not a housing unit census, but rather a programming census. A program track can occur across various housing units.

Reintegration Statistics

As of December 31, the end of quarter four, 18 clients were residing in Community Preparation Services (CPS) at the Green Acres facility.

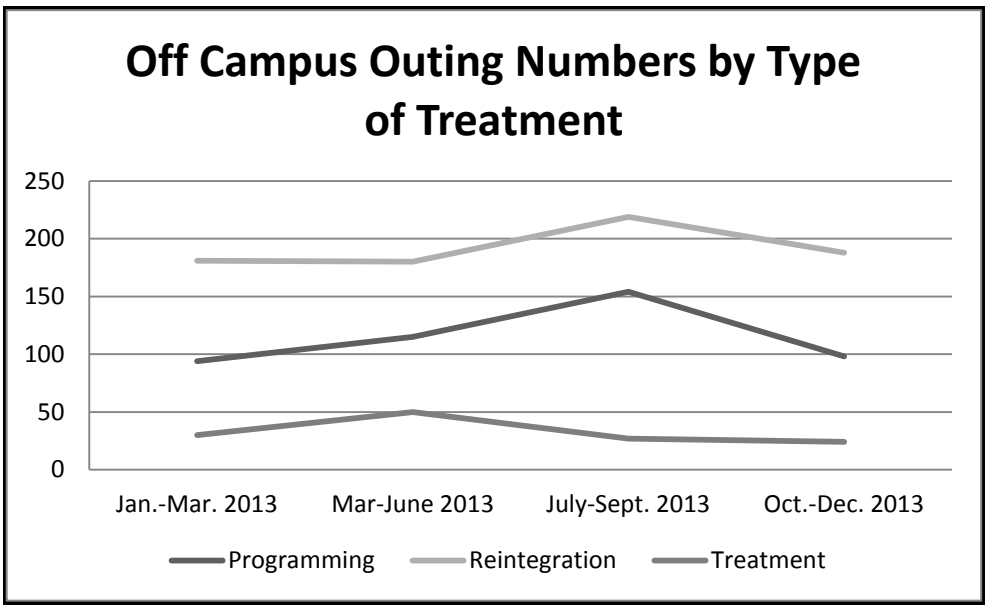
At year end:

- Four clients were in CPS Stage 1 (Acclimation – to progress, a client must be in Phase III and at CPS for at least one month, successfully following the expectations of CPS Stage 1);
- Eight clients were in Stage 2 (Preparation for Provisional Discharge – to progress, clients will successfully follow the expectations of CPS Stage 2, which include opportunities to widen their experiences accompanied by staff in the community, and begin developing their Provisional Discharge plans; this stage lasts for at least three months); and
- Six clients were in Stage 3 (Petition – clients will finalize their Provisional Discharge plans and petition for Provisional Discharge. This stage's length is based on the courts).



Client Outings

Staff accompanied CPS clients on 1,077 outings into the community in 2013, without incident. Clients participate in more than one activity on some of their outings, and this number includes trips with one or more.

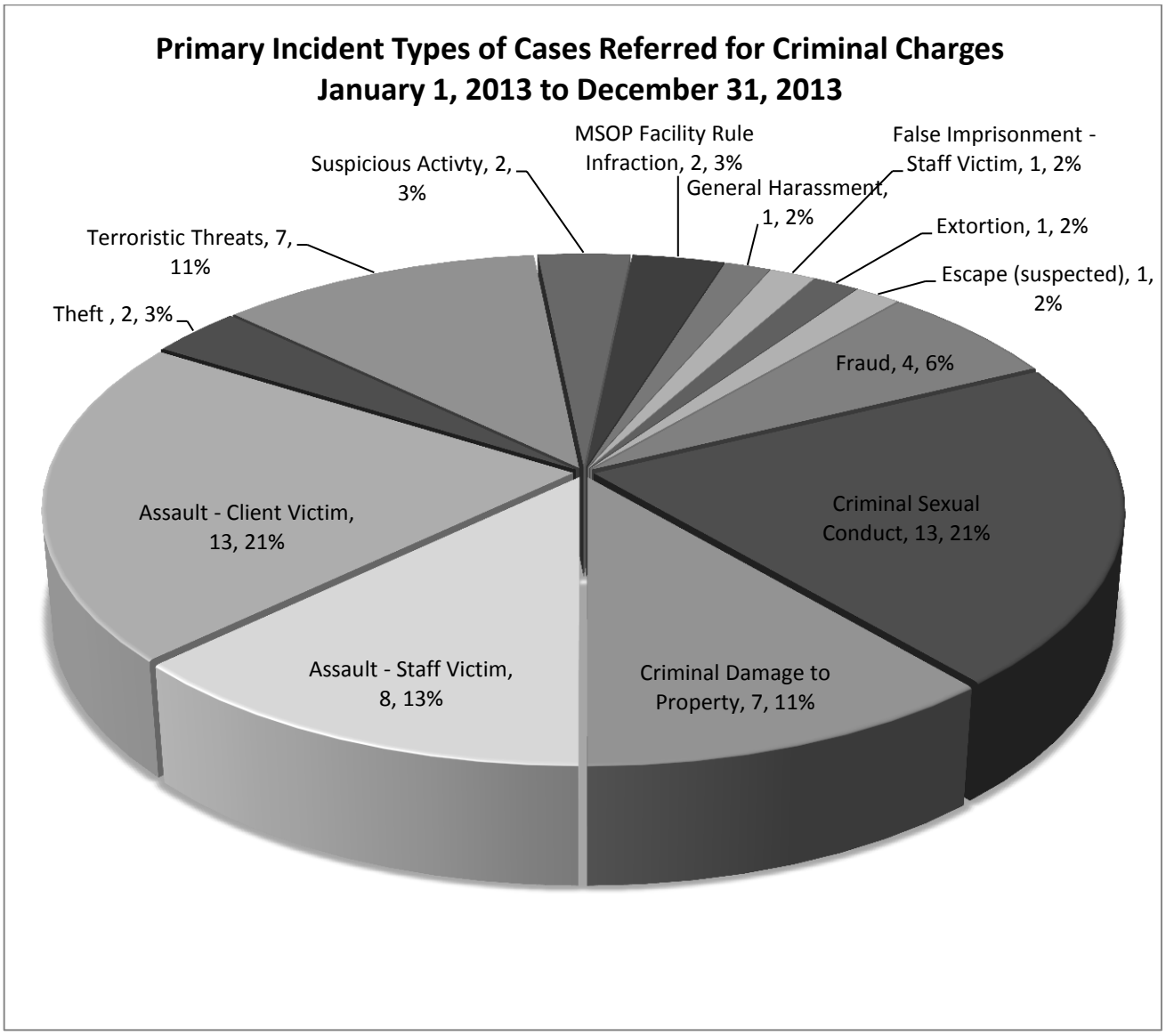


Types of Outings	Jan-Mar. 2013 Outings	Hours	Mar-June 2013 Outings	Hours	July-Sept. 2013 Outings	Hours	Oct.-Dec. 2013 Outings	Hours
Programming Outings								
AA	51	114	65	160.75	99	296.25	72	131.50
SO Maintenance	43	95	50	61	55	92	26	56
Treatment Outings								
SO Treatment	30	99	28	82	27	80	24	56
Reintegration Outings								
Banking	9	4	10	1	12	4.75	13	3.25
Recreation	19	51.75	23	131	37	125.51	28	94.25
Volunteer	61	194	70	216	43	168.50	63	194.25
Library	4	4.5	3	3	0	0	0	0
Pro-Social Activity	61	293.25	64	341.50	123	342.50	73	314.50
Mentoring	0	0	0	0	0	0	0	0
Other	27	22.5	10	5.5	4	4.5	11	16.5

Office of Special Investigation (OSI)

The Office of Special Investigations (OSI) provides 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 2013, OSI completed 372 investigations focusing on client misconduct (there were 386 in 2012). Sixty-two of these cases were referred for criminal charges, with charges being filed in 39 cases (seven from 2011 referrals, 16 from 2012 referrals, and 16 from 2013 referrals). OSI also provides information to the Department of Corrections (DOC) regarding non-compliant clients who are on conditional release from the DOC. In 2013, 14 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 90 to 730 days, with 218 being the average.


Primary Incident Types of Cases Referred for Criminal Charges
January 1, 2013 to December 31, 2013
MSOP Facility Rule Infraction, 2, 3%
False Imprisonment - Staff Victim, 1, 2%
Suspicious Activty, 2, 3%
General Harassment, 1, 2%
Extortion, 1, 2%
Terroristic Threats, 7, 11%
Escape (suspected), 1, 2%
Theft , 2, 3%
Fraud, 4, 6%
Criminal Sexual Conduct, 13, 21%
Assault - Client Victim, 13, 21%
Assault - Staff Victim, 8, 13%
Criminal Damage to Property, 7, 11%

VIII. 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 2013, they visited both the Moose Lake and Saint Peter facilities. The focus of their consultation is the integrity of the clinical program design. The report generated as a result of these visits is contained within Appendix 1.

IX. Appendix: Minnesota Sex Offender Program Site Visit Report 2013

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 16-20, 2013
Date of Report:	January 7, 2014

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, December 2011, and December 2012.

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

The MSOP operates within the standard of care for programs of this nature. Over the past few years, the program has made several positive changes. These include completing the program Theory Manual and Clinician's Guide, implementing a structured treatment needs and progress measure, developing a series of treatment manuals for psycho-educational modules, and decreasing the length of time it takes to move through the program.

Nonetheless, major concerns exist about the program census. Minnesota has the highest per capita number of civilly committed sex offenders of any state and the lowest rate of release from commitment. The MSOP is not responsible for who is committed to their facilities or responsible for making final decisions about when a client is released from their facilities. The MSOP, however, is responsible for providing timely and effective treatment designed to help clients reduce their risk to sexually reoffend and reintegrate back into the community. Client movement through MSOP treatment phases has historically been very slow, but recently, an increased number of clients have progressed from the earlier to later phases of the program.

The recommendations contained in this report are targeted to improve the functioning of the existing program, which is based on a strong clinical and administrative foundation. Historically,

the program has experienced frequent major changes in program design, and this has led to changes in benchmarks for measuring client progress and resulted in slowed client movement through the program. Continued progress over the last five years has been largely attributable to the MSOP having a relatively stable clinical and administrative team.

Procedures

We reviewed the following written materials:

- MSOP Theory Manual (January 2013)
- MSOP Clinician's Guide (January 2013)
- MSOP Quarterly Reports
- Sex Offender Civil Commitment Advisory Task Force Report (December 2013)

During the site visit we engaged in the following activities:

- Met in individual and group meetings with senior management, including:
    - Nancy Johnson, Executive Director
    - Jannine Hebert, Executive Clinical Director
    - Kevin Moser, Director at Moose Lake
    - Peter Puffer, Clinical Director at Moose Lake
    - Tom Lundquist, Associate Clinical Director at Moose Lake
    - Susan Persons, Associate Clinical Director at Moose Lake
    - Jim Berg, Associate Clinical Director
    - Bonnie Wold, Director at St. Peter
    - Haley Fox, Clinical Director at St. Peter
    - Elizabeth Barbo, Reintegration Director at St. Peter
- Toured both facilities, with particular attention to the following:
    - Omega Units at Moose Lake
- Met with the following staff groups without their supervisors present at both sites:
    - clinical supervisors (10 individual meetings)
    - clinicians (12 individual meetings)
    - treatment psychologists (2 individual meetings)
    - rehabilitative services directors and staff
    - unit managers
    - security counselors
- Attended client meetings:
    - Client Representative Meetings at Moose Lake and St. Peter
    - informal client interviews during unit visits and group treatment sessions
- Attended the following treatment groups:
    - three core treatment groups at Moose Lake.
    - three psycho-education module groups at Moose Lake
    - no treatment or psycho-education groups were held at St. Peter during the visit as it was a Modified Programming week and these groups were not held
- Attended Modified Programming activities at St. Peter
- Attended Vidyo psychiatry rounds

- Attended two therapeutic unit community meetings, one at each site
- Reviewed the clinical records of six St. Peter clients
- Observed a SRB Hearing at St. Peter by Vidyo
- 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 sex offender programs, in particular other civil commitment 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 completed documents that form a foundation for staff training and guide delivery of treatment. These are:

- MSOP Program Theory Manual (January 2013). This manual details the overall rationale, theory, structure, and empirical basis of the program.
- MSOP Clinician's Guide (January 2013). This manual provides clinicians with direction about how to deliver clinical services.

The Theory Manual and Clinicians Guide describe the program model as primarily cognitive behavioral, structured, and skill based which is consistent with best practices in the field and with research. As we have noted in previous reviews, the St. Peters conventional track uses

approaches in treatment that appear psychodynamic in nature. Considerable emphasis is placed on insight and less on skill practice. If the program believes that this is an appropriate emphasis, the program should document supporting rationale in the Theory Manual and Clinicians Guide.

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 Moose Lake and St. Peter sites are both providing approximately nine hours of clinical treatment per week. This includes core groups, psychoeducational modules, community meetings, and formal individual sessions. We believe that this is an adequate dose and it is similar to that provided in other civil commitment programs. Additionally, clients are typically involved in structured work, recreational, and educational programming provided by qualified professionals for up to several hours 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."

The program continues to use 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. The program has trained almost all staff on how to understand matrix factors and develop a common language for talking about treatment goals and progress in the program. The program has trained all clinical staff on how to score the Matrix with the exception of a few newer staff. We support the program's current work on developing more precise definitions of anchors for each Matrix item. The program needs to develop a process of regular reliability checks to ensure maintenance of scoring accuracy and minimize scoring drift.

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.

The program continues to maintain relatively high level client participation (83%). Staff interviewed consistently recognized the importance of therapeutic alliance and engagement in the treatment process. Although Moose Lake is still understaffed, improvements in staffing patterns have lead to greater stability among client's primary and group therapists.

The new psycho-education modules need to be adapted and written at a comprehension level appropriate for clients in the Alternative Program.

The Behavioral Management Units (Omega 1, 2 and 3) continue to manage the most behaviorally disruptive clients. These programs appear to individualize treatment, maintain relatively short lengths of stay, and focus on ensuring continuity of care with the clients' parent units. Mental health unit staff appear to understand the unique needs of this population and provide quality care. This program, in addition to addressing disruptive behavior, has also integrated continued sex offender specific treatment for the individuals on this unit.

The MSOP has conducted a quality improvement study of Behavioral Expectation Reports (BERs) and found that the frequency of BER's across program sites was very similar and that a small percentage of clients received the vast majority of BERs. The program has developed a brief informational sheet that stresses that BER's are but one method of shaping behavior and that staff should continue to employ other strategies such as encouragement, relationship building, natural consequences, and positive reinforcement.

5. Program Sequence

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

The overall program sequence is logical and appears to be responsive to clients' treatment needs and learning styles.

All staff has been trained in the Matrix, which details client goals for each phase of the program. Recreation, education, and vocational services have developed draft documents that translate the Matrix goals for use in these services. The evaluation team views this as a very positive development and encourages these programs to complete and implement this process.

As shown in Table 1 on the following page, the number of clients progressing from the earlier to later phases of the program continues to increase. The program should continue to evaluate whether the criteria to move between phases is overly stringent. The program also needs to ensure that factors considered for program movement are related to risk to reoffend.

Table 1. Participants by Program Phases

Program Phase	3rd Quarter 2011	3rd Quarter 2012	3rd Quarter 2013
Phase I	378	350	286
Phase II	106	182	255
Phase III	24	22	25
CPS	8	9	18

At the time of our last visit, three clients had been recommended for provisional discharge. At the time of the present review, five clients are in the legal process for provisional discharge.

In addition, 12 clients who have significant disabilities that prevent them from making further substantial treatment progress and live independently were referred for placement at a less restrictive facility in Cambridge, MN. However, the Governor of Minnesota recently directed DCF to place a moratorium on such placements pending legislative review of release issues. Six of these clients were from the Alternative Unit and six clients were from the Assisted Living Unit.

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 developed and implemented a series of structured treatment manuals for psycho-educational modules. Overall, staff report that they have found the modules well designed and useful. Currently, of 82 planned modules, 53 have been completed and are available for use, 13 are at the proofreader or are being loaded on the web, and 16 are waiting on a contract for development.

As we have noted in previous reports, core groups for clients in Phase II and III in the Conventional Program at St. Peter emphasize psychodynamic approaches, although somewhat less so than in previous years. Psychodynamic approaches places an emphasis on psychological insight as opposed to skill building.

Our review of treatment records, staff interviews, and group observation at both sites indicated that use of skill teaching and practice in core and psycho-education groups was very infrequent. By skill teaching and practice, we mean a structured process that is

commonly used across a variety of correctional programs. The steps in this process commonly include the following: (1) identify the skill to teach; (2) help the client identify the usefulness of the skill; (3) model the skill, as in a demonstration role play; (4) have the client practice the skill in the treatment session; (5) provide corrective feedback; (6) assign skill practice outside of treatment sessions; (7) provide opportunities and encouragement to enhance the skill. The goal is to ensure enough skill practice that the client achieves lasting changes in their thinking and behavior.

During the lat year, the program did provide specific training in role playing, but this appeared to be more from a psychodrama perspective than a skill enhancement perspective as described above. Interviews with clinical staff suggest there may be confusion between experiential exercises that may enhance learning and engagement versus skill teaching and practice.

The Alternative Program at St. Peter has purchased supplies and is planning on introducing Sand Tray Therapy for some clients on the Alternative Unit. The evaluation team is concerned that this is not standard treatment in civil commitment or sex offender programs. This technique might not be well accepted in the general intellectual disability community. Concerns include not respecting the dignity of intellectually disabled adult clients. If the program is going to use this therapeutic technique, we recommend that it develop a written document that provides the rationale and supporting literature for its use with this population and clarify what clients are appropriate for its use.

The evaluation team continues to be impressed with the range of services offered by recreational therapy, education, and vocational services. There is a high level of client participation in these services. These services are an important part of therapeutic programming and assist clients in generalizing skills that they learn in other aspects of the program. As we have previously noted, we support current efforts to integrate Matrix factors in these services. We also support plans for Rehabilitation Services to co-facilitate psycho- education modules.

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 an established and well-designed process to gradually "step-down" clients to the community through programming in Phase III and Community Preparation Services (CPS). There are now over 40 clients in Phase III and CPS. An ongoing issue is that clients who are judged ready for provisional discharge are having discharges blocked by systems outside of the program. As we have noted previously, the multiple required legislative steps for discharge required by Minnesota hampers the program's effectiveness and is demoralizing to clients and staff.

Since our last review, the program did develop alternative discharge strategies for clients in the Alternative Program and clients from the Assisted Living Unit who will never be able to

live independently. However, transfer to the Cambridge facility has been placed on hold. These individuals will need to be in supported living environments in the community and the amount of risk reduction expected from these clients is and should be less than by clients in the Conventional program who have the potential to live independently.

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 we have noted previously, the program has in place processes for monitoring the ongoing functioning of the program and these processes continue to function well. These include daily Morning Report meetings involving senior staff from all departments, unit meetings, shift meetings, and quality assurance procedures to monitor a variety of activities. Quarterly reports detail action plans to address program goals and progress attained in reaching these goals.

Since last year, most staff has received training in the Goal Matrix and it has been well received. Staff appear to be using a common language to describe client progress.

In our last report, we recommended that the program consider whether the risk management committee should focus on reviewing progress from Phase III to CPS rather than from Phase II to Phase III. The Executive Clinical Director discussed this issue with the consultants at this year's visit and the program believes that it is important that the risk management committee continue to review progress from Phase II to Phase III. The rational is that the program wants to ensure that the client is ready for the increased freedom of movement and community visits associated with Phase III.

Although there is increased movement between phases, we recommend, as we did last year, that a formal system be developed to clinically review those clients who, in a reasonable time period, are failing to progress between phases. This process should involve clinical and associate clinical directors. Results of such reviews should be documented with recommendations of any change in treatment focus or approaches that may be needed to assist client progress.

9. Staff Training, Supervision and Support

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

The presence of the same Executive Clinical Director over the past five years has enabled the program to maintain consistent progress in developing and refining the program. Historically, the program has experienced frequent changes in clinical leadership, which in turn has led to frequent changes in the program's direction. When the program has made significant clinical leadership changes in the past, benchmarks for measuring client progress have changed and slowed client movement through the program.

The program has continued efforts to recruit and retain clinical staff, which has been particularly challenging at the Moose Lake site over the past several years. Recent strategies, such as instituting signing and retention bonuses appear to have shown some success. At Moose Lake, 40 of 66 clinician positions were filled, 11 of 12 clinical supervisor positions were filled, and 6 of 11 treatment psychologist positions were filled. At St. Peter, all 25 clinician positions were filled, 3 of 5 clinical supervisor positions were filled, and 4 of 5 clinical psychologist positions were filled. Even with some staff vacancies, the program appears to be continuing to provide the expected number of treatment hours.

During the last year, all clinical, security, and operations staff received refresher training about the goals of the program, how it is suppose to work, and the role each staff member should play in the therapeutic environment. The Unit Directors at Moose Lake and St. Peter continue to be an asset to the program and show an excellent understanding of the therapeutic goals of the program. The ability of security counselors to spend time with clients in therapeutic activities has diminished someone over the past few years due to reductions in staffing levels.

The program continues to provide regular staff training on a variety of relevant clinical and other topics and maintains training logs for each staff member to ensure that they meet expected training requirements. Over the past year, 206 staff attended the recent Minnesota ATSA (Association for the Treatment of Sexual Abusers) yearly meeting and 16 staff attended the ATSA national conference. The program has brought in national experts (Franca Cortoni, Ph.D., Brad Johnson, M.D., and Peter Byrne, Ph.D.) for onsite training. There have been a number of trainings specifically on developing supervision skills. In the last year all new clinical staff participated in the 40 hour DOC training. Providing continuing education training to staff continues to be strength of the program.

Overall, clinical supervisors are now receiving supervision on a regular basis. For the most part, clinical supervisors are providing regular clinical supervision to primary therapists and this is a significant improvement over last year. However, supervisors rarely conduct direct observation of staff leading groups. Supervision could be improved by developing a group therapist rating scale that sets key group therapist performance expectations. The program needs to develop a formal system for auditing the frequency of supervision of clinical supervisors and primary therapists.

Since the last review, the program has enhanced the efficiency of psychiatric services. The program has added psychiatric rounds and a full-time psychiatrist provides services through ITV, which appears to be working effectively. We support the program's continued effort to hire a full-time on-site psychiatrist.

Staff interviews indicate good working relationships exist between direct line staff and clinical staff 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. Overall, staff view this program as largely operating independently with little collaboration with other departments.

10. Service Documentation

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

A limited review of five charts at St. Peter indicated that individual treatment plans continue to be appropriately tied to treatment goals. We continue to note that many of the progress reports in the files for the conventional program at St. Peters continue to reflect a psychodynamic approach with a focus on insight.

11. Facility and Treatment Environment

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

The ankle monitoring system (AMS) has been fully implemented and, except for a few technical problems with the equipment, is working adequately. As a result, the environment is less restrictive and clients have more freedom of movement. Overall staff were positive about the more open movement. Another change this year is allowing clients to visit clients on other units which clients evaluate positively.

The program is in the process of developing seating areas outside the units where clients can have a place to sit and visit. Furniture is being ordered and this is a positive addition to the therapeutic environment.

During this year's visit we attended two Client Representative meetings, one at each site. These meetings had set agenda, were well run, and focused on problem solving. Our observations were that staff at both sites were respectful to clients in these meeting, resolved client concerns when possible, and provided reasonable explanations about why some issues could not be addressed.

11. 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 continues to have a strong administrative structure with processes in place to ensure ongoing staff communication. There continues to be stability in senior leadership, except for a new Clinical Director at Moose Lake. Moose Lake now has two new Associate Clinical Directors, which given the size of the facility is appropriate. The Clinical Director and Associate Clinical Directors at Moose Lake have extensive experience in sex offender programming.

The administrative structure of CPS warrants review. Presently, clinical staff report to clinical administrators at St. Peter's and reintegration staff report to Dr. Elizabeth Barbo. As

the CPS program grows and more clients are on Provisional Discharge, having a Director of CPS who supervises both clinical reintegration staff may enhance service coordination.