Minnesota Sex Offender Program Annual Performance Report 2014

Minnesota Sex Offender Program
February 2015

Legislative Report

Minnesota Department of Human Services

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $6,000.

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I. Executive Summary

In 2011 the *Karsjens* class action lawsuit was filed by clients of the Minnesota Sex Offender Program (MSOP), initiating a long period of negotiations and settlement conferences between plaintiffs and the state. Recently those ended and litigation preparation began in the federal *Karsjens* lawsuit. In February of 2014, Judge Donovan Frank issued an order that appointed four Rule 706 court experts to evaluate MSOP clients and the program. Those experts conducted their review for several months and submitted their report with recommendations to the court in November of 2014. Other orders were also issued in the past year regarding the *Karsjens* case, and our employees have been involved with numerous affidavits, depositions, discovery, and hearings over the past year. On February 9th, 2015 *Karjsens* went to trial.

Today clients who have been determined appropriate for a less restrictive setting by the Supreme Court Appeal Panel (SCAP) are moving through our system and being transferred to Community Preparation Services (CPS) on the St. Peter campus. CPS experienced significant growth again this past year and the total client population at the close of 2014 was 27. A bonding request was approved during the 2014 legislative session to expand bed capacity at CPS and that project is now well underway. In December a third MSOP client was provisionally discharged by the courts to the community of Le Center. This client is residing in an adult foster home and transitioning well.

In an effort to strengthen and enhance outside support networks for MSOP clients in later phases of treatment, our first Annual Family Support Day took place this past fall in St. Peter. This is a critical component in ensuring that clients have the kind of support networks in place to provide them the most opportunities for positive therapeutic experiences. This will in turn help them successfully progress through treatment and reintegration.

The completion of the bonded Shantz renovation project in St. Peter took place in 2014. The renovation of this building increased capacity inside our secure perimeter at that site and provided 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 enhancing environments that are therapeutic, while at the same time maintaining security measures.

Through the efforts and generosity of our employees, MSOP was able to raise over $10,000 for the Combined Charities Campaign this last year. Silent Auctions and other events were hosted at both facilities with all departments actively participating in the campaign.

The Minnesota Safety Council awarded MSOP's St. Peter site the Meritorious Achievement Award in Occupational Safety. The MSOP Safety Director was in attendance to receive this award on behalf of the program at the 2014 Minnesota Safety and Health Conference.

MSOP departments and disciplines have been instrumental in the ongoing revision and new development of essential internal policies that guide our program into the future, assuring continuity and consistency. 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.

Noteworthy MSOP highlights for 2014 include many operational, programmatic, and clinical changes and improvements. Striving to meet our strategic goals—chief among them the safety of clients, staff and the public through high quality and effective therapy—guide our decisions. Due to the multi-disciplinary approach and dedication of our staff, MSOP continues to provide the necessary treatment and security to meet the complex needs of our clients.

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.

Because annual program statistics are closed out on December 31 of each year, it is quite difficult to complete the needed analysis of performance on strategic goals and report by the current statutory deadline of January 15. MSOP requested and received an extension to February 15 because the program is committed to providing a complete and accurate report in addressing the necessary areas defined by the state. MSOP will be pursuing a legislative change reflecting this practice in the 2015 session.

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 compromised 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]

All clients enter MSOP through the admissions unit at the Moose Lake facility. Conventional program clients begin their treatment at Moose Lake; those assessed as being appropriate for the Alternative Program are transferred to St. Peter for all phases of treatment. After successfully progressing through the majority of their treatment in Moose Lake, conventional 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 recreation 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 following five program values:

Therapeutic Environment **Employee Engagement**

Program Integrity **Responsibility to the Public**

Learning Organization

[1] As discussed in section V, 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.

2014 Strategic Goals:

Goals	2014 Outcomes
1. Therapeutic Environment:	
Continue to refine and enhance the therapeutic living environment for clients across sites.	Through increased rehabilitative programming and physical improvements made within MSOP facilities, MSOP continues to build upon a positive therapeutic environment for all clients.
Increase the quality of interdepartmental collaboration between clinical, operations, rehabilitation, and health services staff.	Through the development and ongoing utilization of team case conferences, staff debriefings, staff shift changes, clinical training, and therapeutic community meetings, an overall improvement in team communication and cooperation has been demonstrated.

2. Program Integrity:	
Build a robust and integrated data collection and analysis system within the MSOP Research Department.	Operational definitions were developed for a coding manual to organize data, a template to ensure consistency for the quarterly report process was created, and a solid database for collection of client information was designed this past year.

3. Learning Organization:	
Continue staff development and training in client verbal and physical interventions that promote program principles and treatment philosophy.	Verbal intervention, self-defense, and control tactics training was designed and approved. The rollout of this training for all staff began in 2014 and will continue into the new year.

4. Employee Engagement:	
Empower staff to be agents of change using proactive interventions and to increase the overall culture of engagement.	MSOP participated in the DHS-wide Employee Engagement Survey in 2014. The results were tabulated and shared with MSOP staff and the top two areas to address were identified. A multi-disciplinary committee to represent all MSOP employees was convened to determine ways in which employees might become better engaged at their workplaces. Strategies and suggestions are currently being adopted to implement in the coming year.

5. Responsibility to the Public:	
Develop and formalize external relationships with county and state emergency responders for preparation in the event of a large-scale incident.	Detailed planning, table-top drills, and facility tours for outside emergency responders took place this past year. A large-scale drill was successfully conducted at the St. Peter site involving a tri-county SWAT team. A large-scale drill for Moose Lake is currently being developed.

IV. Treatment Model and Progression

A. Program Philosophy and Approach

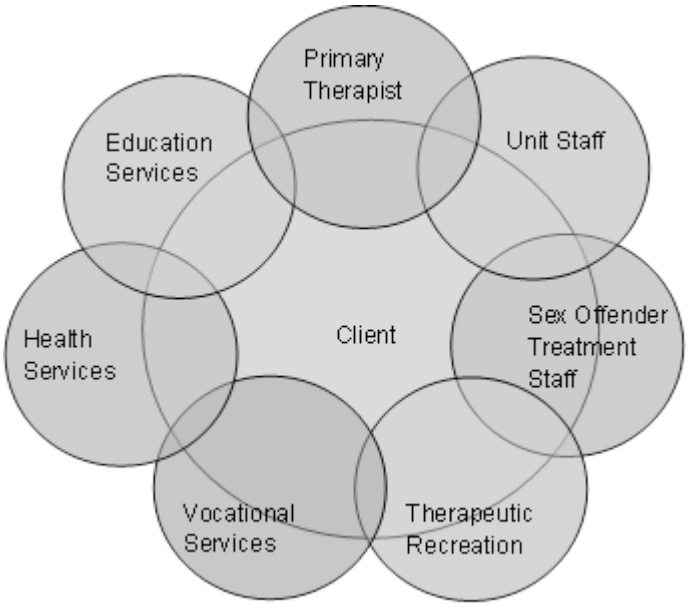
MSOP draws on several contemporary treatment approaches in its programming. These include cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by the professional psychological literature in the areas of risk/needs/responsivity and stages of 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 acclimate to treatment and 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 while they work on deinstitutionalization and community reintegration.

B. Comprehensive and Individualized Treatment

MSOP provides a comprehensive treatment program. Clients acquire skills through active participation in psychoeducational modules and 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. Each plan is developed with the client and the client's primary therapist, and is grounded in 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 in the conventional treatment track, admissions and some clients who choose to not participate in treatment. Individuals who have successfully demonstrated meaningful change and have progressed through treatment are transferred to St. Peter to focus on 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 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, which relies heavily on talk therapy and written assignments 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.

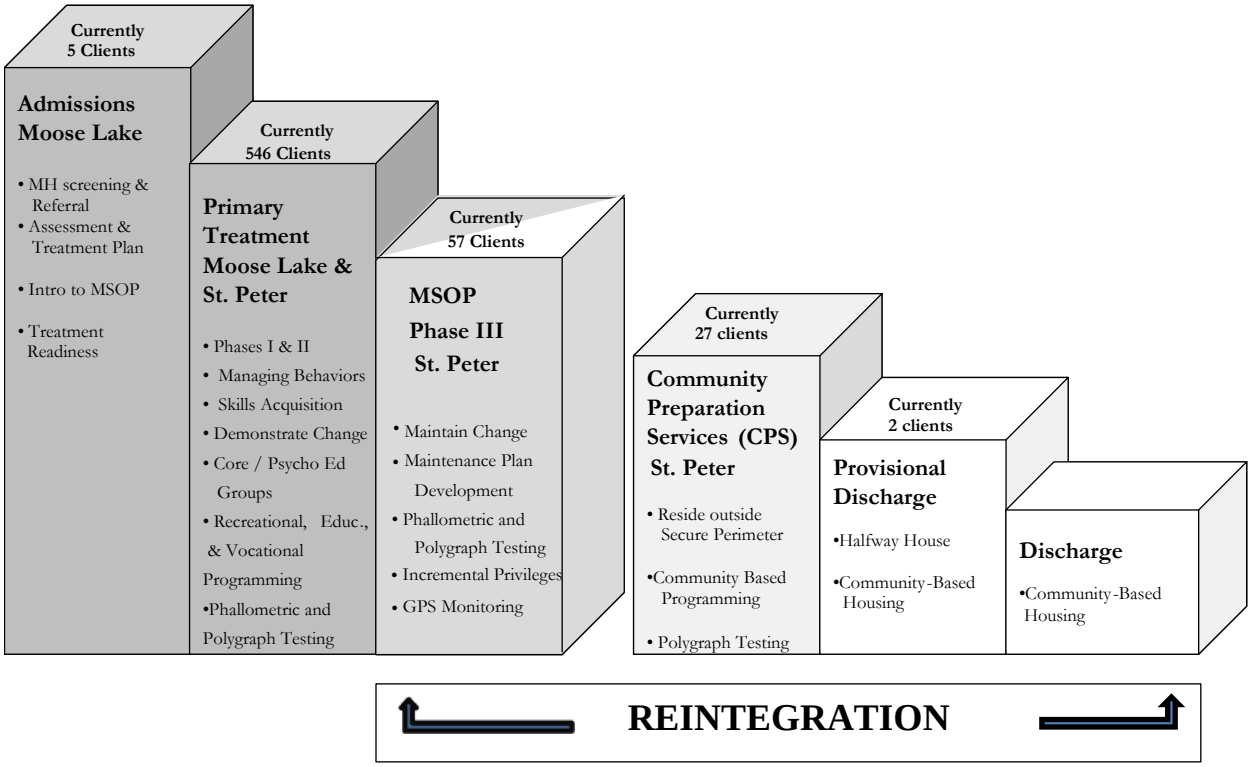
Therapeutic Concepts Unit (TCU): A former unit for clients refusing to actively participate in sex-offender-specific treatment programming. During the third quarter of 2012, those clients were integrated into the other living units alongside clients who are participating in treatment to provide added 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.

D. Treatment Progression

Clients progress through treatment by completing group module requirements and treatment assignments and by demonstrating they have changed their thinking and behaviors. Progress in treatment is assessed quarterly based on the Matrix Factors. These factors reflect criminogenic needs common among 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 with the observations and assessments of the client's primary therapist and treatment team. Individual treatment plans are modified accordingly.

MSOP Treatment Progression Model



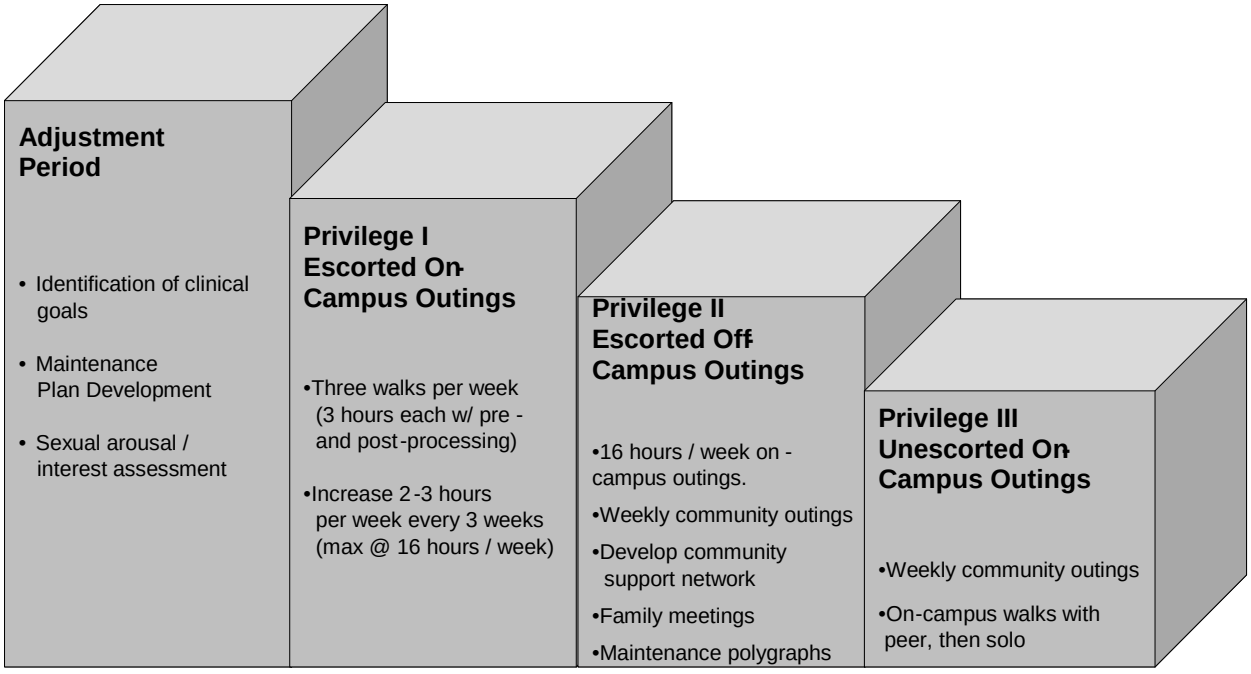
This chart does not reflect the clients who do not agree to participate in treatment after leaving the Admissions Unit (as of 12/31/14, 101 clients). Of the 27 clients in CPS, 24 are in Phase III, 2 are in Phase II and 1 is in Phase I.

E. Reintegration

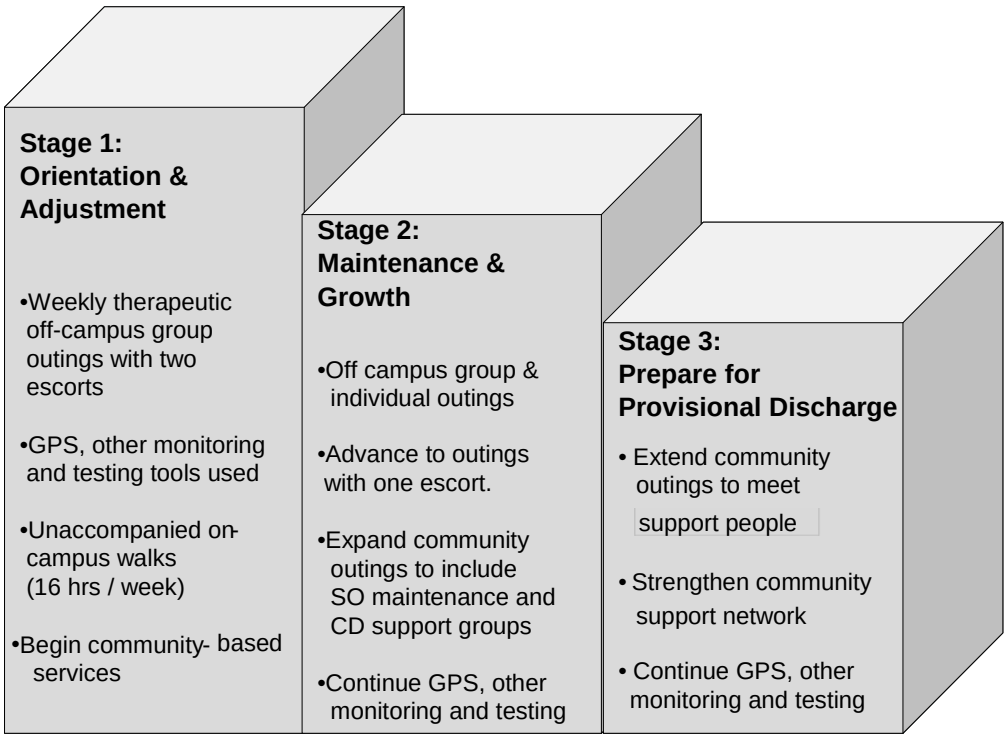
Reintegration is a transitional period designed to provide opportunities for clients to apply their acquired skills and to master increasing levels of privileges and responsibility while maintaining public safety. The focus of treatment during reintegration includes "decompression" from many years (often 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 first entering Phase III 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 living inside the secure perimeter and having these privileges wear Area Monitoring System (AMS) electronic monitoring bracelets at all times. Whenever leaving the facility for accompanied community outings, they also wear Global Positioning System (GPS) bracelets.



Community Preparation Services (CPS): When a client has demonstrated adequate self-management, cooperation with rules and supervision, and transparency with the treatment team to ensure a safe increase in liberties, and when it appears that an increase in liberties will allow for further advancement in treatment, that client may be encouraged to petition for a transfer to CPS. Such a transfer can only occur via the judicial appeal panel process. All CPS clients wear GPS monitoring at all times. 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 324 men who have been admitted to the MSOP-DOC program since 2001. As of January 7, 2015, there are currently 53 clients in the program. Of the 271 men who have been discharged from the program, 83 (31%) are in the DOC and 188 (69%) are not.

Commitment Status of Men Discharged from MSOP-DOC since 2001:
Of the 271 men discharged from the program:

→ 124 (46%) were civilly committed,

→ 15 (5%) were not referred to the county for review by the DOC (reside in the community or DOC),

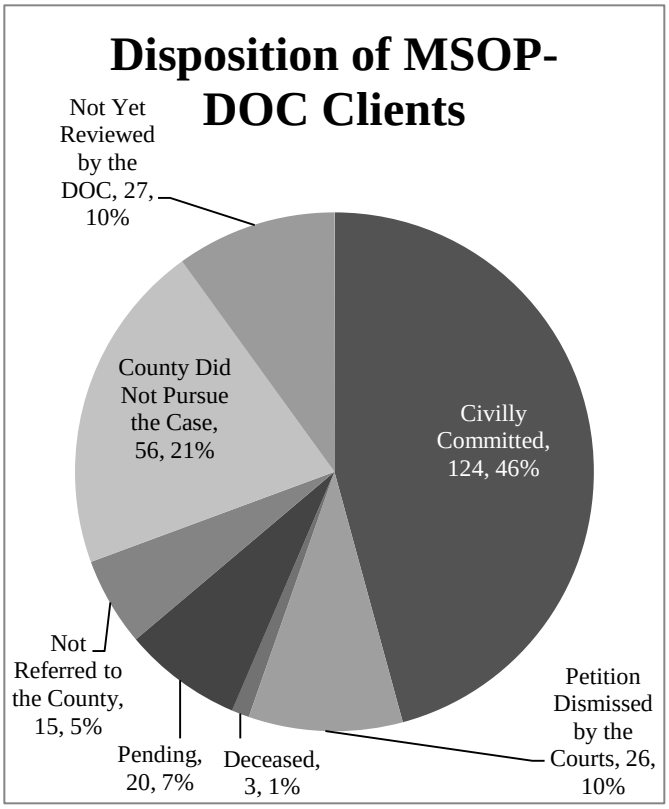
→ 56 (21%) the county did not pursue the commitment (reside in the community or DOC),

→ 26 (10%) the petition was pursued by the county and dismissed by the courts (reside in the community or DOC),

→ 20 (7%) DOC referred the petition to the county and it is pending,

→ 27 (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



In Q4 of 2014, the Research Department redesigned the report to reflect the status of participants in the program since 2009. This was done because the new clinical administration came to MSOP at that time and significant improvements and enhancements were made to MSOP's clinical services delivery, both within the MSOP facilities and at the DOC site. Therefore, the data below more accurately reflect statistical results from current program design (2009 to present). Please see the attached MSOP-DOC Site Visit Report in Appendix I.

There have been 122 men who have been admitted to the MSOP-DOC program since 2009. As of December 31, 2014, there are currently 53 clients in the program (of which 2 clients where admitted prior to 2009). Of the 69 men who have been discharged from the program, 47 (68%) are in the DOC and 22 (32%) are not.

Commitment Status of Men Discharged from MSOP-DOC since 2009:

Of the 69 men discharged from the program:

→ 5 (7%) were civilly committed,

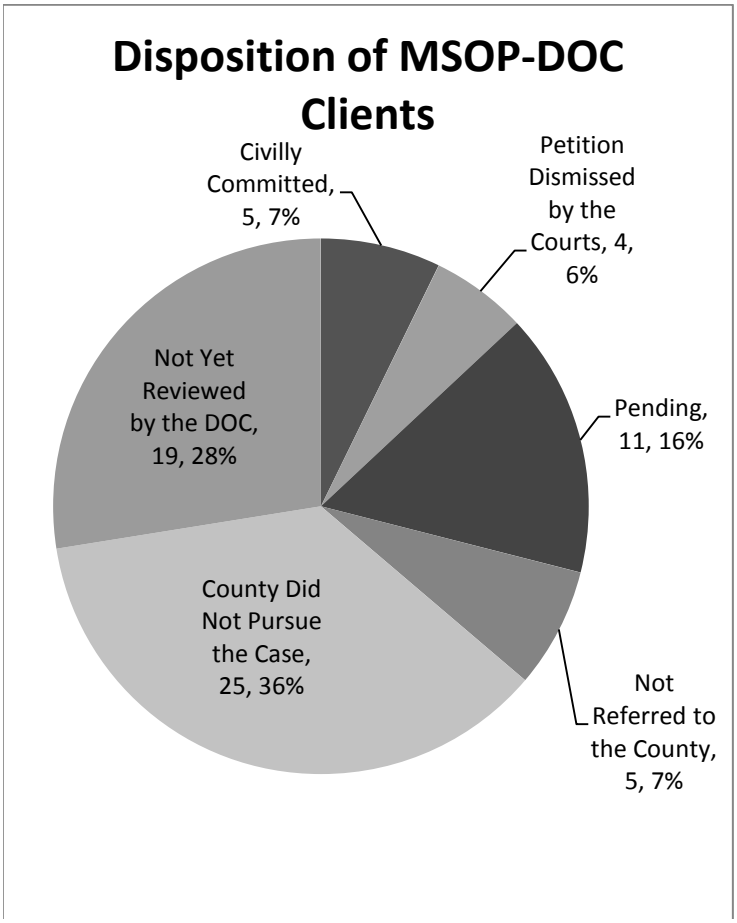
→ 5 (7%) were not referred to the county for review by the DOC (reside in the community or DOC),

→ 25 (36%) the county did not pursue the commitment (reside in the community or DOC),

→ 4 (6%) the petition was pursued by the county and dismissed by the courts (reside in the community or DOC),

→ 11 (16%) DOC referred the petition to the county and it is pending,

→ 19 (28%) have not yet been reviewed for referral by the DOC (reside in DOC not yet reviewed due to Scheduled Release Date)



VI. Program-Wide Per Diem and Fiscal Summary

Minnesota Sex Offender Program Fiscal Year 2014 & 2015 Per Diem

Description	FY 2014 Annual $$	Per Diem	FY 2015 Annual $$	Per Diem
Direct Costs				
Clinical	**16,645,130**	**61.71**	**19,409,579**	**73.35**
Healthcare and Medical Services	**5,302,238**	**19.66**	**5,864,159**	**22.16**
Security	**32,587,185**	**120.81**	**32,099,133**	**121.30**
CPS & Community Preparation	**1,033,828**	**3.83**	**2,149,160**	**8.12**
Dietary	**2,152,263**	**7.98**	**2,523,182**	**9.53**
Physical Plant & Warehouse	**8,540,536**	**31.66**	**7,519,922**	**28.42**
Program Support*	**10,507,821**	**38.96**	**11,356,866**	**42.92**
Total Direct Costs	**76,769,000**	**284.61**	**80,922,000**	**305.80**
Operating Per Diem		**285**		**306**
Indirect Costs				
Statewide Indirect**	**108,925**	**0.40**	**7,278**	**0.03**
Building Depreciation	**3,689,097**	**13.68**	**3,969,731**	**15.00**
Bond Interest	**5,065,200**	**18.78**	**5,359,200**	**20.25**
Capital Asset Depreciation	**119,324**	**0.44**	**101,897**	**0.39**
Total Indirect Costs	**8,982,546**	**33.30**	**9,438,106**	**34.99**
Total Costs	**85,751,546**	**317.91**	**90,360,106**	**341.46**
Projected Average Daily Client Count (ADC)	**739**		**725**	
Statutory Per Diem Rate		**318**		**341**

*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.

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

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 2015 is $341 and fiscal year 2014 was $318. The marginal per diem, which is the estimated additional costs for each new admission into MSOP, is currently $162.

VII. Annual Statistics

Current Program Statistics as of December 31, 2014

Total MSOP Clients	**709**
Clients by Location	
Moose Lake	457
St. Peter	252
Clients by Age	
18-25	12
26-35	140
36-45	178
46-55	195
56-65	114
Over 65	70
Average Age	**47**
Youngest	20
Oldest	92
Race	
American Indian/Alaskan Native	53
Black/African American	95
White Caucasian	530
Other/Unknown	31

Education	
0-8 Years	29
9-12 Years	64
High School Degree	321*
GED	220*
High School degree and GED	9
Some college or college degree	39*
Unknown	27
Civilly Committed Offenders by County	
Hennepin	144
Ramsey	70
Olmsted	32
Dakota	31
Anoka	28
St. Louis	18
Stearns	18
Beltrami	17
Other Counties	351
Metro Counties (7-County Area)	295
Non-Metro Counties	414

* 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, 2014, there were 9 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	3
Clients on judicial hold status in the DOC/jails	6
Total on judicial hold status	**9**

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 2014*	13
Clients previously committed whose cases were reviewed and finalized for commitment during 2014	1
Total civil commitments to the MSOP during 2014	**14**

**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 remanded to either a county jail or the DOC to serve a portion or all of their criminal sentences (14 clients in 2014). 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	191
Clients who are under civil commitment and in a DOC or federal prison	19
Total number of dually committed clients as of December 31, 2014	**210**

Clinical Statistics

Treatment Participation

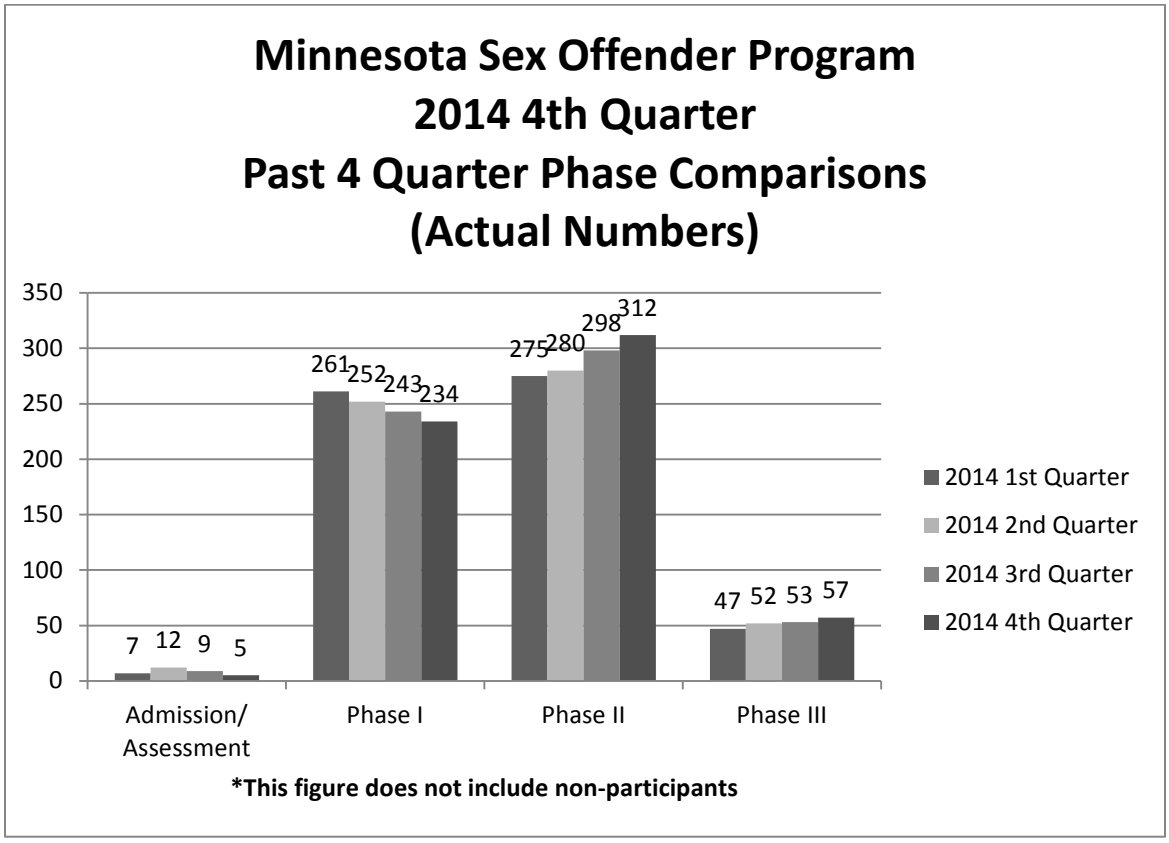
All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender-specific treatment, approximately 86 percent were participating at the end of 2014.

* 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

Treatment Progression

The phase progression data show how clients are progressing through the three treatment phases. The chart below represents the treatment progression of clients over the past calendar year.



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 36 percent of the clients residing on units that provide specialty programming while 63 percent reside on units providing Conventional Treatment. The remaining 1 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	Moose Lake	5	1%
Alternative Program Units	St. Peter	108	15%
Assisted Living Unit	Moose Lake	20	3%
Behavioral Therapy Unit	Moose Lake	11	2%
Community Preparation Services	St. Peter	27	4%
Conventional Program Units	Moose Lake and St. Peter	448	63%
Corrective Thinking Units	Moose Lake	56	8%
Mental Health Unit	Moose Lake	20	3%
Young Adult Treatment Unit	Moose Lake	14	2%
Total		709	

*Due to rounding, the total percentage is 101%

Note: Non-participants reside on various units. A program track can occur across various units.

Clinical Service Hours

Clinical Service hours at MSOP include both treatment hours and programming hours. All MSOP clients are scheduled for treatment hours based on their individual treatment needs and their Phase levels. The MSOP program design offers Phase I clients a minimum of eight hours of treatment hours each week. Clients in Phase II and Phase III are offered at minimum ten hours per week. Treatment hours are hours spent in Core Group, Psychological Education Modules, therapeutic community meetings, reintegration services, modified programming, individual therapy, progress reviews, and assessments.

In addition to weekly treatment hours, clients are offered the opportunity to participate in clinical programming. Programming hours are comprised of educational, therapeutic recreation, vocational, and volunteer services. The level of participation is determined by the client's treatment phase and motivation to participate in clinical programming activities. Total Clinical Service hours offered to clients equal the total hours of treatment and programming events available to each client per week.

2014 Clinical Service Hours Offered

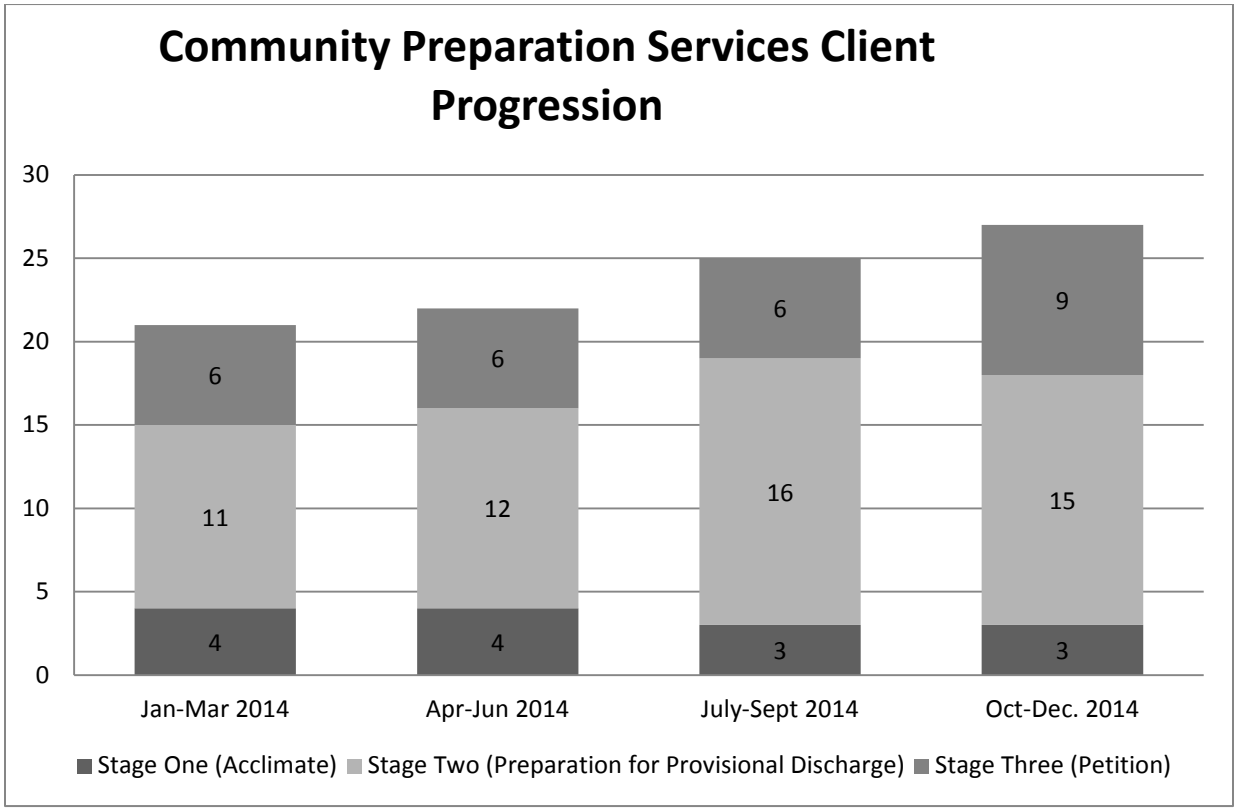
Hours Offered per client per week	Clinical Treatment	Clinical Programming	Total Clinical Service Hours
Phase I	8	5	13
Phase II	10	14	24
Phase III	10	15	25

Reintegration Statistics

As of December 31, 2014, the end of quarter four, 27 clients were residing in Community Preparation Services (CPS) at the Green Acres and Sunrise facilities.

At year end:

- Three 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);
- Fifteen 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
- Nine 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

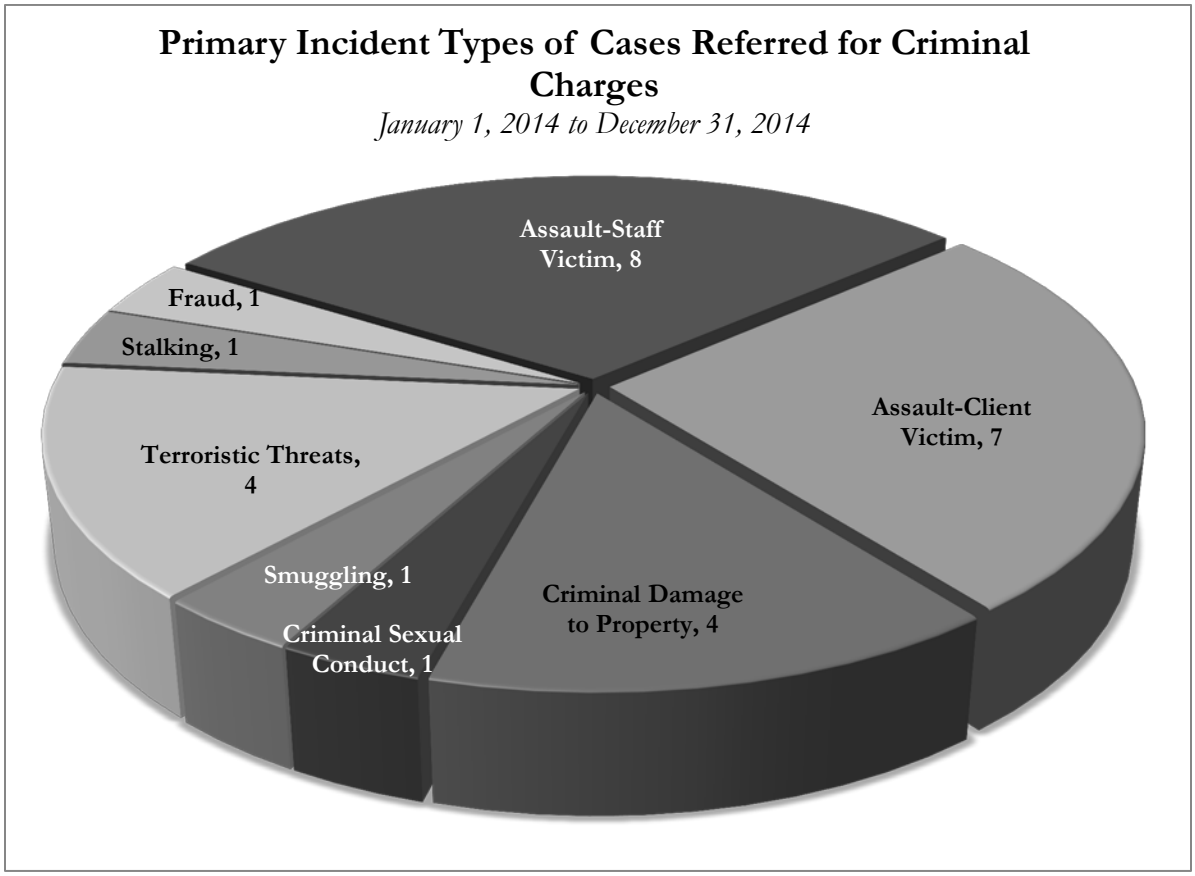
Staff accompanied CPS clients on 1,457 outings into the community in 2014, without incident. Clients participate in more than one activity on some of their outings, and this number includes trips with one or more clients.

Types of Outings	Jan-Mar 2014 Outings	Hours	April-June 2014 Outings	Hours	July-Sept. 2014 Outings	Hours	Oct-Dec. 2014 Outings	Hours
Programming Outings								
AA	80	154.75	92	252.75	90	243.5	91	244.5
SO Maintenance	21	62	27	63.25	22	73	22	73
Treatment Outings								
SO Treatment	21	76.75	42	86.5	35	86.25	13	40
Reintegration Outings								
Banking	14	4	8	3	12	5	14	5
Recreation	17	82	43	224.50	46	204.25	20	105.25
Volunteer	66	188.25	69	251	77	264.5	95	375.5
Library	7	9	4	4.75	8	15.5	10	20
Pro-Social Activity	130	439	98	533.5	136	575	179	650
Mentoring	0	0	0	0	0	0	0	0
Other	0	0	0	0	10	50	20	75

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 2014, OSI completed 193 investigations focusing on client misconduct (there were 372 in 2013). Twenty-seven of these cases were referred for criminal charges, with charges being filed in 25 cases (eight 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 2014, 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 in 2014 was 30 to 328 days, with 132 being the average.



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 2014, they visited the Moose Lake facility and the MSOP Treatment Program at the Minnesota Department of Corrections. The two reports generated as a result of these visits are contained within Appendix 1.

IX. Appendix 1: Minnesota Sex Offender Program Site Visit Reports 2014

Minnesota Sex Offender Program – Moose Lake Site Visit Report 2014

Site Visitors: James Haaven, Private Consultant
Portland, OR

Robert McGrath, McGrath Psychological Services Middlebury, VT

William Murphy, Department of Psychiatry University of Tennessee Health Science Center Memphis, TN

Location: Minnesota Sex Offender Program, Moose Lake

Dates of Visit: December 8-12, 2014

Date of Report: December 29, 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; December, 2012; December, 2013.

During the current review, we were requested to address two issues. The first goal was to conduct a program review of the MSOP-Department of Corrections site where the consultation team spent two days. The results of that component of the visit will be included in a separate report. The second goal was to evaluate the coordination of the operational and clinical services within the program. The findings concerning this second goal are detailed in this report.

MSOP is a complex organization with multiple sites and the Moose Lake facility itself is a complex facility with multiple units, a large number of operational staff, and a large number of clinical staff. The program has the task of maintaining the health and safety of residents and staff while at the same time providing effective clinical treatment. One key aspect of an effective therapeutic program is finding a balance between security and safety issues and clinical/therapeutic services.

The MSOP has separate parallel organizational structures for operations and clinical services. Operations is led by Mr. Kevin Moser, the Facilities Director. Mr. Mosher has responsibility for the overall management of the facility and security. He is assisted by an assistant director, , a director of security, a plants operational manager, program managers for the main building and complex, a program manager for special services, and on unit group supervisors, assistant group supervisors, and security counselors. On the clinical side, Mr. Peter Puffer serves as the Clinical Director of the Moose Lake site and reports to Jannine Hebert who serves as the Executive Clinical Director responsible for the clinical operations of all of the MSOP sites. Reporting to Mr. Puffer are two associate clinical directors (one part time), clinical supervisors, and clinicians. One associate clinical director position is vacant and when filled there will be two and a half associate directors.

Procedures

Because of the complex nature of MSOP-Moose Lake and limited time, the consultation team focused on two broad organization components. The first area was on information dissemination and committee functioning, especially those committees that jointly involve operational and clinical staff. The second focus was on the intersection of clinical and operational staff at the unit level, specifically on group supervisors and clinical supervisors. To accomplish this, the following activities were conducted:

Documents Reviewed

- Review of the MSOP Moose Lake Operations Department Organizational Chart
- Review of the Moose Lake Clinical Organizational Chart

Meetings Attended

- Morning Meeting
- Supervisor Meeting
- Moose Lake Client Placement Committee
- Behavioral Expectations Unit Hearing Panel
- One Clinical Team Meeting
- One Community Meeting
- Two Afternoon Shift Change Meetings

Staff Interviewed

- Peter Puffer, Clinical Director in multiple meetings
- Kathryn Lockie, Associate Clinical Director in multiple meetings
- Individual interviews with nine Clinical Supervisors
- Individual interviews with the four Group Supervisors
- Discussions with Scott Benoit, Program Manager, and Troy Basaraba, Security Program Manager following the Client Placement Committee and the Behavioral Expectations Unit Meeting
- Meeting with four clinicians to review their use of the Phoenix System
- On Unit Discussions with Security Counselors on four units
- Feedback meeting with Jannine Hebert, Executive Clinical Director
- Provided verbal feedback of our findings via video conference from MSOP to Nancy Johnson, Executive Director and senior MSOP representatives, clinical supervisors, and group supervisors.

The administrative and clinical staff provided site visitors with access to all documents requested, all areas of the facility requested, and all staff and clients the site visitors requested to interview. We express appreciation to staff for showing flexibility during this site visit, which took a somewhat different approach than previous site visits.

Findings and Areas for Consideration

This area of the report is organized into two sections: (1) information dissemination and committee processes, and (2) interaction at the unit level between group supervisors and security counselors.

1. Information Dissemination and Committee Processes

The site visitors were impressed with how the organization disseminates information. The information management system and committee meetings appear to serve the needs of the organization. Staff consistently reported they generally have the information they need to fulfill the responsibilities of their jobs.

The consultants found the Phoenix system to be an impressive information management system that provides a wealth of both operational and clinical information. The clinicians the consultants met with could easily navigate the system and could quickly find information related to security and clinical issues. The system maintains historical clinical information including past offense related data, past assessments, clinical progress notes, and information from vocational, educational and recreational therapy.

The Phoenix system also includes information related to security issues such as BER's. Clinicians also receive a morning email regarding all of their clients who may have received BER's during the previous day.

The site visitors focused on meetings that involved both clinical and operational staff and found these meetings to be well run, focusing on relevant issues with input from both clinical and operational staff. We observed cooperation and mutual respect between operational and clinical staff in the various committee meetings we attended.

Day-to-day operational information is first reviewed in the morning meeting with senior operational and clinical staff of both St. Peter and Moose Lake. The information from the meeting is then shared at a daily supervisors meeting which includes program managers and supervisors and managers from all areas of the facility who are responsible for communicating with relevant direct staff. Again, it appears that both clinical, security, and administration have input into these meetings.

It should also be noted that group supervisors and clinical supervisors are involved on policy committees and a system exists for them to provide input into policies that they are not involved in developing.

Areas for Consideration

Staff pointed out that at times there were delays in receiving responses from administration when they asked specific questions or made specific suggestions. They noted at times they had to send multiple reminders.

Some clinicians also communicated that at times they do not get timely information from clinical supervisors regarding decisions being made and at times the residents would have knowledge of certain decisions prior to their individual clinicians.

Staff were concerned that although they have information about decisions that are made, they at times would like more information regarding the rationale behind decisions both those in terms of policy and various restrictions.

One area where information is not readily available is from health services. The staff reported that at times they were not aware of medication changes.

Security staff, as they have raised in the past, have concerns that they are not able to read the residents' charts which they feel limits their having knowledge of the residents' overall history and functioning.

Because placement can be a significant issue it might be useful for the group supervisor to attend the Placement Committee meeting when a resident from their unit is being reviewed.

2. Unit Level Clinical-Operational Functioning

The site visit team observed that collaboration and cooperation within clinical teams seemed to be the best we have observed over the years. There were almost unanimous reports by group supervisors and clinical supervisors that the teams are functioning well. There is a good deal of mutual respect and communication between the clinical supervisors and the unit directors. We found this to be occurring even while the organization is under the significant stress of the lawsuit and some residents are showing significant disrespect to staff. In the face of these situations, it appears that "on the ground," both operations and clinical staff are working to maintain a therapeutic environment and focus on the mission of the organization.

The site visit team was impressed with the problem solving approaches being taken at the unit level. Where problems arise, program managers, clinical supervisors and group supervisors are working constructively together and avoiding adversarial relationships than can arise between security and clinical.

There were multiple staff comments on the importance of the institutional wide cross training that occurred in the last year, which was organized and conducted by Jannine Hebert, Executive Director. Staff felt this contributed to improved working relationships among staff and staff consistently reported that they hope cross training will be ongoing.

It was also noted by group supervisors that there is more consistency in that there is less turn over in clinical supervisor positions, which allows a better opportunity to develop mutual relationships.

Areas for Consideration

There continues to be some problems in clinical staff being able to attend the afternoon shift change meetings because they conflict with treatment groups. All staff recognized the importance of these meeting and the need for third watch staff to have interactions with clinical staff. The site visitors were impressed that a number of units have tried to be creative in having at least one clinical staff member at these meetings and the organization needs to explore ways of having a clinical presence during these staff meetings.

For a number of units, group supervisors are able to attend the clinical team meetings. However, this seems to be a struggle for some group supervisors with the barrier being their need to cover multiple units.

Because the number of group supervisors has been reduced over the years, there will continue to be barriers for increased involvement of the group supervisors in certain clinical activities. With the current staffing, it would be very difficult for group supervisors to be on a regular basis involved in quarterly and annual reviews. In addition, with the limited number of security counselors on some of the units, especially larger units, it would be difficult to have security counselors involved in such meetings. It is especially important for at least the group supervisors to participate in clinical team meetings. Administration will need to consider ways to increase clinical involvement of group supervisors and security counselors.

There was some staff who would like an opportunity for unit level cross training events, which would continue to improve unit level cooperation. In addition, such cross training would support the goal of increasing the operational staff involvement in clinical services.

Site Visit Report

Minnesota Sex Offender Program at the

Minnesota Department of Corrections

Minnesota Correctional Facility – Moose Lake 2014

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 – Department of Corrections Moose Lake, MN
Dates of Visit:	December 8-9, 2014
Date of Report:	December 23, 2014

Purpose

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program at the Department of Corrections, Minnesota Correctional Facility, Moose Lake, MN, hereafter referred to as the "MSOP-DOC" and the "program."

The consultation was a component of MSOP's quality improvement program. We spent two days at the program and reviewed and discussed our findings with the Executive Clinical Director in person and via videoconference from the MSOP at Moose Lake to Nancy Johnson, Executive Director and senior MSOP representatives.

Program Overview

The MSOP-DOC is 50-bed sex offender treatment program that operates under a cooperative arrangement between the Minnesota Department of Corrections (DOC) and the Minnesota Department of Human Services. The program is designed to be 3 to 5 years in duration and provide intensive sex offender treatment to offenders serving their correctional sentences under the care of the DOC. The DOC Risk Assessment Unit indentifies and refers to the program high risk sex offenders who are judged likely to be referred for civil commitment. Key program goals are to:

1. Help clients reduce their risk to sexually reoffend so that they are not civilly committed.

2. Help clients who are civilly committed move through the MSOP more quickly than if they had not enrolled in treatment at the MSOP-DOC.

The program started in 2001 and was revised in 2009 to be similar in scope and treatment design to Phases I, II, and III of treatment in the "conventional" program track at the MSOP. Since 2001, 319 men have been admitted to the program. Of these 319 men, 113 were admitted to the program since 2009 when the MSOP-DOC was revised to be consistent with the MSOP. On October 3, 2014, the program census was 53 men, and only two of these men were admitted to the program prior to 2009.

Based on the October 8, 2014 MSOP-DOC report entitled Commitment Status of Men Discharged from MSOP-DOC since 2001, the status of the 266 men who have been discharged from the program was: 47% (124) civilly committed, 21% (56) county did not pursue the case, 10% (26) petition dismissed by the courts, 8% (22) not yet reviewed by the DOC, 7% (20) DOC referred petition to the county and it is pending, 6% (15) not referred to the county, and 1% (3) deceased.

Since the program was modified in 2009, a higher percentage of men who enterd the MSOP-DOC have been diverted from civil commitment than in the past. Based on the December 9, 2014 MSOP-DOC report entitled Commitment Status of Men Discharged from MSOP-DOC since 2009, the status of the 62 men who have been discharged from the program was: 8% (5) civilly committed, 39% (24) county did not pursue the case, 6% (4) petition dismissed by the courts, 21% (13) not yet reviewed by the DOC, 18% (11) DOC referred petition to the county and it is pending, and 8% (5) not referred to the county.

Procedures

We reviewed the following written materials:

- MSOP Theory Manual (January 2013)
- MSOP Clinician's Guide (January 2013)
- MSOP-DOC Participant Handbook (updated 2014)
- MSOP-DOC program admission criteria
- Commitment Status of Men Discharged from MSOP-DOC Since 2001 (October 8, 2014)
- Commitment Status of Men Discharged from MSOP-DOC Since 2009 (December 9, 2014)
- Program Design Outline (7/15/14)
- Quality Assurance Plan (2014)
- Client satisfaction survey results from four quarters in 2014
- Packet of client handouts

During the site visit we engaged in the following activities:

- Met in individual and group meetings with Zachary Campbell, Clinical Supervisor, MSOP-DOC site
- Toured the facility
- Met with the following staff groups without their supervisors present:
    - clinicians (five individual meetings)
    - treatment psychologist (one individual meeting)

  - security officer (one individual meeting)
- Interviewed nine clients individually
- Attended two clinical team meetings
- Attended two core treatment groups
- Attended one community meeting
- Reviewed the clinical records of six clients
- Talked informally with staff and clients
- Provided verbal feedback of our findings to Jannine Hebert, Executive Clinical Director
- Provided verbal feedback of our findings via videoconference from the MSOP at Moose Lake to Nancy Johnson, Executive Director, and senior MSOP representatives.

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 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 13 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, empirically based model of change that describes how the program is intended to work.

The MSOP-DOC is similar in scope and treatment design to Phases I, II, and III in the "conventional" program track at the MSOP. As such it is guided by (1) the MSOP Program Theory Manual (January 2013) manual, which details the overall rationale, theory, structure, and empirical basis of the program, and (2) the MSOP Clinician's Guide (January 2013), which provides clinicians with direction about how to deliver clinical services. Additionally, the MSOP-DOC has its own Participant Handbook (2014), which is consistent with overall

MSOP policies and program design, but it has been adapted to account for the fact the program operates in a correctional facility.

The MSOP 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.

2. Selection of Clients

The program should specify the clients for whom the program is intended and the methods to select them.

The program is designed to provide treatment to sex offenders under the care of the Minnesota DOC who are assessed as being "high risk and most likely to be referred for civil commitment" and who meet the other following admission criteria:

- Minimum of 3 years, maximum of 5 years on their sentence
- Intellectual capacity to participate and complete in all levels of programming: reading, emotional processing, and social engagement
- Mental Health stability with instability needing to be under control or managed
- Medication compliance, as appropriate
- Met criteria for a Medium security facility
- Six months discipline free
- No major discipline or assaults for one year

These selection criteria are designed to serve two key program goals, which are to (1) help clients reduce their risk to sexually reoffend so that they are not civilly committed, and (2) help clients who are civilly committed move through the MSOP more quickly than if they had not enrolled in treatment at the MSOP-DOC.

Based on program statistics reported in the "Disposition of MSOP-DOC Clients" data sheet (see Program Overview), several clients who have participated in the program have not been civilly committed. It is unclear however how similar the characteristics of men accepted into the MSOP-DOC are to all men in Minnesota who are eventually civilly committed. The program should examine this issue to ensure that men who are assessed as needing the MSOP-DOC are truly "high risk and most likely to be referred for civil commitment." These analyses could include a comparison of the risk scores of men in the MSOP-DOC with those of men civilly committed in the MSOP on risk instruments used by DOC and the MSOP.

The MSOP-DOC has considerable opportunities to expand. The current program admission criteria, for example, exclude some client groups that include high risk sex offenders who are likely to be referred for civil commitment. These groups include individuals with significant intellectual disabilities and/or major mental illness, as well as high risk sex offenders who do not meet security clearance criteria for placement at the MSOP-DOC, which is housed in a medium security facility. If services are expanded to include individuals with significant intellectual disabilities and/or major mental illness, we recommend that these services be

provided in a program that meets the special needs of these clients and be separate from the current MSOP-DOC conventional program.

3. Risk and Intensity of Services

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

Because the MSOP-DOC is designed for high risk sex offenders who are likely to be referred for civil commitment, it should provide a relatively high level of treatment services. The program is 3 to 5 years in length and provides approximately 13 to 15 of hours of treatment per week, which includes core group, psycho-educational modules, individual treatment, and community meetings. We believe that this is an adequate dose and it is similar to that provided in other civil commitment programs, and it is consistent with Minnesota DOC program certification requirements.

4. 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."

Following the MSOP model, the MSOP-DOC 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. The Matrix indentifies the primary dynamic risk factors that are linked to sexual and other offending behavior.

Clinical staff and clients interviewed consistently reported that they understand the Matrix and its relationship to progressing through phases of the program. A strength of the program is that group co-facilitators score the Matrix collaboratively with input from other program staff and the clinical supervisor. As in previous MSOP reviews, we recommend the program continue to provide ongoing training on how to score the Matrix and conduct periodic reliability checks.

5. 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 is a "conventional" track program. It is not designed for individuals with significant intellectual disabilities or major mental illness, and these populations are screened out of the program.

Overall, clients appeared to be engaged in treatment process. They appear highly motivated to reduce their risk to sexually reoffend so that they are not civilly committed. Client satisfaction survey results from the four quarters in 2014 and our interviews with nine clients indicate that overall clients are quite positive about the treatment program, treatment staff, and therapeutic community.

We commend the program for developing a mentoring program for new arrivals, training conflict resolution mentors, and designating and supervising program tutors.

The program has trained staff in motivational interviewing (MI), and we observed staff using MI techniques effectively. Furthermore, clients were observed using these motivational and respectful communication strategies on a regular basis in treatment groups and community meetings with each other.

Several clients reported that group members who were more assertive received more group time for discussing issues and presenting homework than less assertive group members. We agree that learning assertiveness skills is an appropriate treatment target for some clients; however, we recommend that clinicians ensure that all clients receive relatively equal treatment time in groups. Several clients also reported concern that some treatment groups often started 5 to 15 minutes late. In particular, groups that were scheduled to begin immediately following the morning staff clinical team meeting often started late.

Another area for improvement concerns diversity issues. The majority of clients interviewed spontaneously reported concerns about racial tension within the program and these concerns were reflected in recent client satisfaction survey results as well. Additionally, several clients reported some staff were not sensitive to cultural and minority issues, although we were not able uncover detailed examples of these concerns. We support the program's plans to examine how the program can be more sensitive to cultural and minority issues.

6. Program Sequence

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

The overall MSOP program model sequences treatment is logical manner. The three-phase model is well detailed in program documents and appears to be responsive to clients' treatment needs and learning styles.

7. 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 MSOP has developed and implemented a series of structured treatment manuals for psycho-educational modules, many of which include role-play and skill practice, and the MSOP-DOC uses these modules. With respect to core groups, our review of treatment records, staff interviews, and group observation indicated that use of role-play, as a skill teaching and practice method, was infrequent. We have noted in previous reviews of the overall MSOP model that considerable emphasis in treatment is placed on insight and less on skill practice.

Clients in the program who evidence marked sexual arousal control problems in the areas sexual preoccupation, deviant sexual interests, and hypersexual behavior can and do receive medications to help them manage these problems. We support the program's current plans to expand the number of behavioral therapies available to target these problems.

The MSOP-DOC has incorporated a restorative justice component into the program, and it appears to be valued by clients and staff. It includes taking a Restorative Justice class developed by the DOC, making projects from yarn and donating them to the community, and structuring some assignments around making amends to the therapeutic community to address harm or wrongdoing clients have caused to others.

The program has employed a range of methods to assist clients who show poor treatment progress or break program rules. These include targeted assignments, including "success plans." In particular, we commend the program for using success plans, which for the most part focus on positive approach goals. In terms of focusing on approach goals, we note that the "Common Treatment Terms You Will Hear" client handout would benefit by including language that helps clients name and develop a positive identity (e.g., new me) versus overemphasizing a negative identity (e.g., perpetrator).

Several clients complained that time to present homework in core groups is limited because the majority of group time is spent on processing and talking about current issues. At least for clients in the first two phases of treatment, we argue that a considerable focus of treatment should be on homework designed to teach and practice new skills. As per the program model, clients in the third phase of treatment might present less formal homework in core group and focus more on skill application in the here and now.

The program provides one hour of weekly therapeutic recreation per week. Additionally, as time in the treatment schedule allows, clients have access to educational and vocational services offered in the institution.

8. Continuity of Care

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

The MSOP-DOC program design does not include a community integration component. MSOP-DOC clients who are civilly committed receive community integration services in the MSOP. MSOP-DOC clients who are not civilly committed receive community integration services through DOC. We did not review DOC community integration services.

9. 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 has in place processes for monitoring the ongoing daily functioning of the program, and these processes continue appear to be working well. These include clinical staff meetings, community meetings, and shift meetings, all of which occur several times a week.

Under Minnesota Department of Corrections Rules, Chapter 2965, the program is audited and must be certified to operate by the DOC every two years. These audits include record reviews, interviews with staff and clients, and compliance checks with several detailed program standards. The program continues to maintain its certificate to operate.

The program has yearly Quality Assurance Plans. The 2014 plan includes such goals as improving the therapeutic environment, ensuring program integrity, providing staff development activities, and networking with external organizations and the public.

10. Staff Training, Supervision, and Support

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

Zachary Campbell, M.A., L.P.C.C., has been the Clinical Supervisor of the MSOP-DOC for about one year, had worked as a clinician in the MSOP for about one year, and has worked for several years as a clinician and administrator in programs providing treatment services to correctional clients. He has the necessary skills and experience to fulfill the responsibilities of this position. The MSOP Clinical Director at Moose Lake, Peter Puffer, supervises Mr. Campbell and meets with him on a regular basis.

The seven clinical positions in the program are filled by an experienced and committed staff that appear to work quite well together. The program has two psychologist positions, one filled by a very experienced psychologist, and the other position has been vacant for several months. All of the clinicians have met sex offender therapist qualifications outlined in the Minnesota Department of Corrections Rules, Chapter 2965, per audits by Alan Listiak, Administrator of Sex Offender Program Certification.

Staff reported that Zachary Campbell, Clinical Supervisor, meets with each of them in individual supervision two to four times a month, is available additionally on an as needed basis, and co-leads groups with staff when a co-therapists is absent. The clinical team meets together several times a week for program planning, case consultation, and group supervision.

The program conducts some in-program training, but staff receive most of their training through the overall MSOP continuing education offerings, including annual training required for all MSOP employees in areas such as safety, security, and data management practices. Several staff attend the Minnesota ATSA (Association for the Treatment of Sexual Abusers) yearly meetings and a few staff attend the ATSA national conference each year. The program has brought in local and national experts for onsite training on a number of topics such DSM-5, attachment and trauma, psychotropic medication, team building, and sexual interest assessment. Clinical and security staff reported that recent departmental cross training was particularly useful for information sharing and team building. Providing continuing education training to staff is a particular strength of the program.

The program does not have or need its own full-time psychiatrist. The DOC provides psychiatric services to clients in the program.

11. Service Documentation

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

A limited review of six charts indicated that services are documented in an appropriate, thorough, and timely manner. Under Minnesota Rule Chapter 2965, the program undergoes and has passed rigorous file audits the DOC every two years.

12. Facility and Treatment Environment

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

The program is located in a correctional facility, which was previously a state hospital. Overall, based on our observations, client and staff interviews, and client program satisfaction surveys, staff interact respectfully with clients and resolve client concerns when possible. Overall, clients report that they feel safe in the program.

13. 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 MSOP-DOC operates under a cooperative arrangement between the Minnesota Department of Corrections (DOC) and the Minnesota Department of Human Services (MDHS) and the program appears to function well under this agreement. Clinical staff are employed by the MDHS and security staff are employed by the DOC.

Clinical and security staff do not have regularly scheduled meetings but appear to meet and communicate regularly to ensure the smooth function on the program. Such an informal structure would not likely work in a larger program, but it seems to work well in this 50-bed, one-unit program. As well, the current constellation of clinical and security staff seem have good working relationships.