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Minnesota Sex Offender Program Annual Performance Report 2015

Minnesota Sex Offender Program
February 2016

Legislative Report

Minnesota Department of **Human Services**

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I. Executive Summary

Considerable public attention has focused on the Karsjens class action lawsuit. Filed in 2011 by clients of the Minnesota Sex Offender Program (MSOP), it resulted in a trial occurring in February and March of 2015. Judge Donovan Frank issued a June 17 order finding the MSOP and civil commitment statute unconstitutional. No remedies were issued as part of the order. On August 10 Judge Frank held a conference with Department of Human Services (DHS) and MSOP representatives, plaintiff and defense attorneys, legislative stakeholders, and community stakeholders. Those attending discussed the schedule going forward and the remedies they felt were appropriate for resolution of the case. Following the conference, Judge Frank issued a new scheduling order for plaintiffs to submit their official remedy proposals by August 20 and DHS had until September 21 to file its response. The Court heard oral arguments from both sides on September 30.

On October 29, Judge Frank issued an order for remedies. The State appealed the order to the Eighth Circuit and requested a stay of the order from Judge Frank. Judge Frank denied the state's request of a stay. On December 2, the Eighth Circuit issued a temporary stay of Judge Frank's order and on December 15 the Eighth Circuit extended the stay until the Court hears oral argument on the State's appeal scheduled for April 12, 2016.

Meanwhile, the MSOP continues to provide comprehensive treatment in a safe and secure setting with 85% client participation rate. Clients continue to make changes and advance through treatment, as evidenced by the increasing numbers of clients in the later phases of treatment.

Clients who have been determined appropriate for a transfer to a less restrictive setting by the Supreme Court Appeal Panel (SCAP) move to Community Preparation Services (CPS) on the St. Peter campus. As in prior years, the population in CPS experienced significant growth from 27 clients at the close of 2014 to 51 clients at the close of 2015 with six more clients transferring to CPS in January of 2016. Current bonding work for a much needed 30 bed increase of CPS is underway for 2016, however, current rates of CPS transfers will likely outpace the building of living spaces for these SCAP transferred clients. Also, in 2015 the SCAP determined one client met statutory criteria for provisional discharge into the community making a total of three clients living in the community under the supervision of MSOP.

The increase in client progress through treatment phases and the SCAP's ordered transfers to CPS have created a shift in placement needs at both campuses. The Moose Lake facility housing and treating new admission and early treatment phase clients has experienced a reduction in population allowing the closure of two 25-bed living units. The St. Peter campus housing and treating later treatment phase clients and CPS has experienced an increase in population. This has created a shift in staffing needs for all aspects of the MSOP program including increased staffing resources to provide necessary reports and assessments to the Supreme Court Appeal Panel required for their determination of placement in CPS, provisional discharge, and discharge.

MSOP's interdisciplinary team continues to maintain a strong infrastructure for a therapeutic environment supportive of client change. The second annual St. Peter Family Support Day was held two separate days accommodating increased client participation in this critical treatment component ensuring clients have support networks for successful progress through treatment.

Commitment to staff safety is exemplified by the Minnesota Safety Council Meritorious Achievement Award in Occupational Safety awarded to the St. Peter program site for the third year in a row and the Moose Lake program site receiving its first award in 2015.

MSOP highlights for 2015 contained in this report reflect continued focus on its mission to promote public safety by providing comprehensive treatment and reintegration opportunities for civilly committed sexual abusers.

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. Due to this, 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. To avoid requests for deadline extensions in the future, MSOP will be pursuing a legislative change reflecting this practice in the 2016 session.

The statute specifies that this report include:

- Program descriptions, including strategic mission, goals, objectives and outcomes
- Calculation of program-wide per diem
- Annual statistics.

This program evaluation occurred in January 2016. It will be forwarded upon completion.

MSOP is one program, operating across two campuses. Admissions and the majority of primary treatment occur in Moose Lake. After clients demonstrate meaningful change and progress through the first two phases of treatment, they are considered for transfer to the St. Peter campus.

St. Peter is also the location for clients with compromised executive functioning due to learning disabilities, developmental disabilities, head injuries or trauma, or other issues that prevent them from being successful in conventional programming. These clients do all three phases of programming on the St. Peter campus.

The St. Peter campus has two missions: reintegration and programming for the 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 issues that prevent them from being successful in conventional programming. 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 to the MSOP.

MSOP operates treatment facilities in Moose Lake and Saint Peter[1]. Clients are civilly committed as Sexual Psychopathic Personalities (SPP), as Sexually Dangerous Persons (SDP) or as both SPP and SDP. The courts are responsible for determining if an individual meets the legal criteria for commitment. The courts are also responsible for determining when a client meets criteria to be provisional discharged and/or completely discharge for the MSOP program.

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 and individual sessions. Clients are provided opportunities to demonstrate meaningful change through their participation in rehabilitative services programming 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 five strategic goals. These strategic goals are organized under the following five program values:, Therapeutic Environment ,Program Integrity ,Learning Organization ,Employee Engagement ,and Responsibility to the Public

[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.

1. Therapeutic Environment:

Goal: Integrate treatment risk (matrix) factors into routine communications between staff and clients and between staff. Preserve and build upon the MSOP therapeutic environment.
Outcome: MSOP implemented annual staff training on the practical application of matrix factors in client daily living; due to an effective structured daily schedule with strong client compliance the need for ankle monitors on clients residing within the secure perimeter was discontinued; a multidisciplinary team was established to review and refine the existing therapeutic community with a focus on living rules application and due process; and the business requirements for an electronic communications log for the purposes of supporting an integrated therapeutic community communications system.

2. Program Integrity:

Goal: Continue centralizing data collection to ensure a robust and integrated data collection and analysis system within the MSOP Research Department
Outcome: Data collection templates for admission and departure were established, verification audits are in place to verify data in clinical treatment reports, business requirements were established for an electronic client file software to audit treatment phase data.

3. Learning Organization

Goal: Provide training that reflects treatment language and values.
Outcome: MSOP continues to provide training pertinent to the client population covering topics of mental health assessment, sexual deviance, and ensuring operational understanding of the application of treatment risk factors in the daily living within the therapeutic setting. The new employee orientation was restructured to better meet the needs of new employees in a more cost effective manner by decentralizing training to local facilities and utilizing more technology in the form of video conference to teach classes. The increased use of case conferences and incident debriefing are providing another vehicle for learning.

4. Employee Engagement

Goal: Empower staff to be agents of change using proactive interventions and to increase the overall culture of engagement.
Outcome: Each MSOP facility in Moose Lake and St. Peter established a multi-disciplinary committee to determine ways in which employees may become better engaged at their workplace. Ideas implemented have included peer initiated employee recognition activities, staff appreciation days, and building better connections with supervisory and managerial staff.

5. Responsibility to the Public:

Goal: Develop and implement strategies that promote transparency and education for stakeholders and the public regarding MSOP.
Outcome: MSOP continues to welcome opportunities to educate the public and stakeholders regarding the program and its role in the civil commitment process and sexual violence prevention.

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.

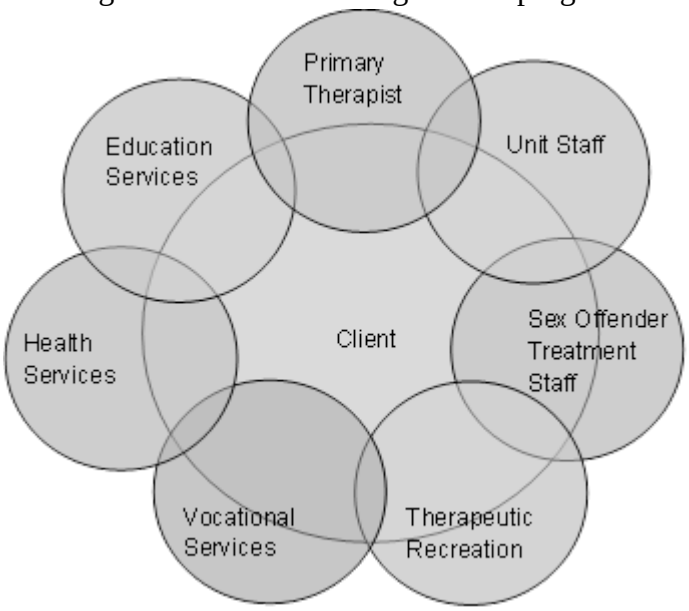
Each client participating in treatment is guided by an individualized treatment plan that defines measurable goals. These goals are updated as the client progresses through treatment.

Clients progress through three phases of treatment. In the initial treatment phase, clients acclimate to treatment and address treatment-interfering behaviors and attitudes. The next phase is the intermediate treatment phase with a focus on a client's 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.



Clients who participate in treatment have an Individualized Treatment Plan. 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 profiles. MSOP provides sex-offender-specific treatment to meet the needs of all clients.

C. MSOP Specialty 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.) our treatment in this unit is focused on returning clients to their previous treatment unit.

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

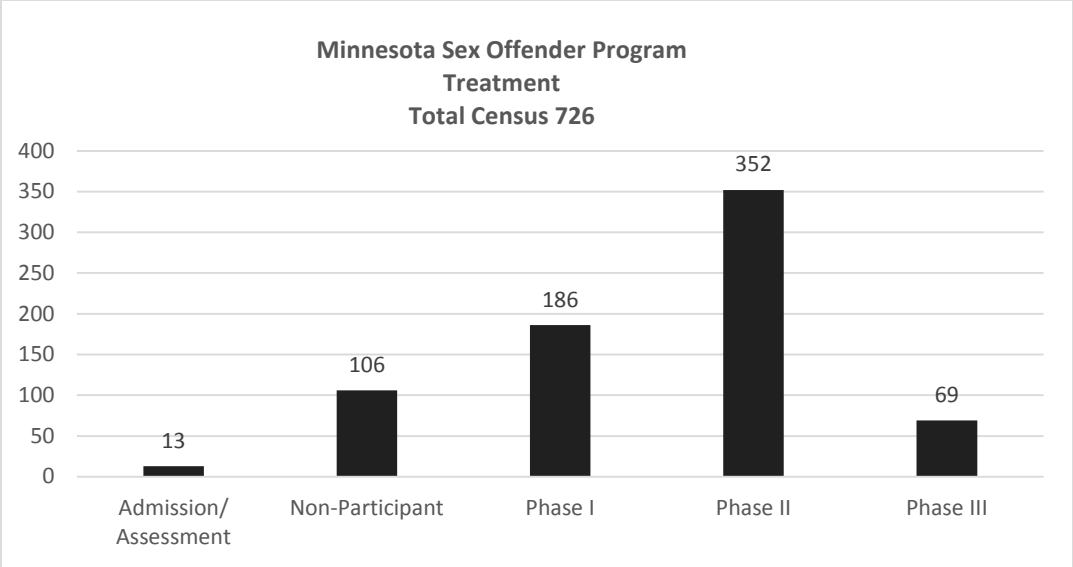
Mental Health Unit (MHU): Clients with significant mental health diagnoses including Axis I diagnoses that do not meet the requirements for a transfer to the Minnesota Security Hospital and/or significant personality disorders that result in persistent emotional instability and/or potential self-harm.

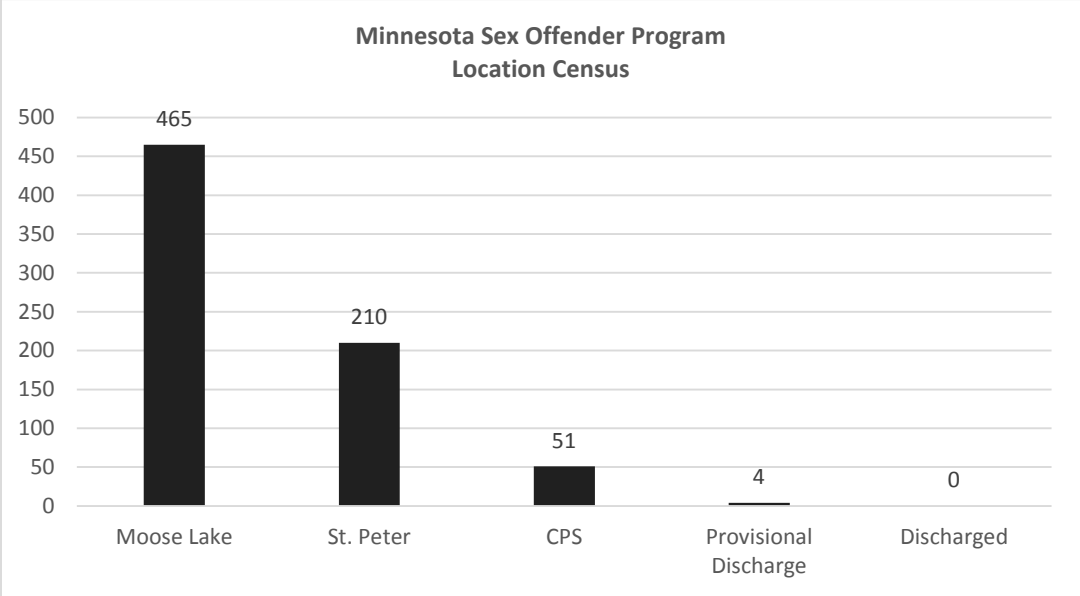
D. Treatment Progression

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 11 matrix factors. The treatment factors reflect criminogenic needs common among sexual offenders, are supported in the current professional literature, and are risk factors associated with recidivism. The matrix factors are:

- Group behaviors
- Attitude to change
- Self-monitoring
- Interpersonal skills
- Sexuality
- Cooperation with rules and supervision
- Healthy lifestyle
- Life enrichment
- Thinking errors
- Prosocial problem solving
- Emotional regulation.

On a quarterly basis, each client participating in treatment 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 and treatment targets are modified accordingly.





E. Reintegration

Reintegration is a transitional period designed to address deinstitutionalization and to provide opportunities for clients to apply their acquired skills and to master increasing levels of privileges and responsibility while maintaining public safety. Clients are provided opportunities at a gradual pace to demonstrate internalized treatment skills and consistent behavioral changes across settings.

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 adequately meet the client's needs -- the client is encouraged to

petition for less restrictive alternatives. The less restrictive alternatives available include reintegration through MSOP's Community Preparation Service (CPS), provisional discharge, or discharge.

The petition filed by the client is sent to the Special Review Board (SRB) which is established by the Commissioner pursuant to Minn. Stat. §253B.18 subd. 4(c). The SRB is made up of three individuals. One person experienced in the field of mental illness: a psychiatrist or doctoral level psychologist with forensic experience, an attorney, and a mental health professional.

Upon approval from the SRB the petition is sent to a Judicial Appeal Panel which is authorized by Minn. Stat. §253B.19. The Chief Justice of the Supreme Court of Minnesota appoints three district judges to the panel. This panel is sometime referred as the Supreme Court Appeal Panel (SCAP).

F. Reintegration Progression Model

The treatment progression stages within CPS are: Acclimation (stage 1), Preparation (stage 2), and Petition (stage 3).

Clients in the Acclimation Stage adjust to the new environment and develop clinical goals based on their individual needs. . Clients in the Preparation Stage broaden their experiences in the community through off-campus outings, building a support system outside of MSOP and volunteering. They also begin developing their plans for provisional discharge. Clients in the Preparation Stage strengthen their support systems and have initiate the legal process for a provisional discharge.

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 as the MSOP Moose Lake facility. Program participants are serving their correctional sentences and have histories that indicate they are likely to be referred for civil commitment.

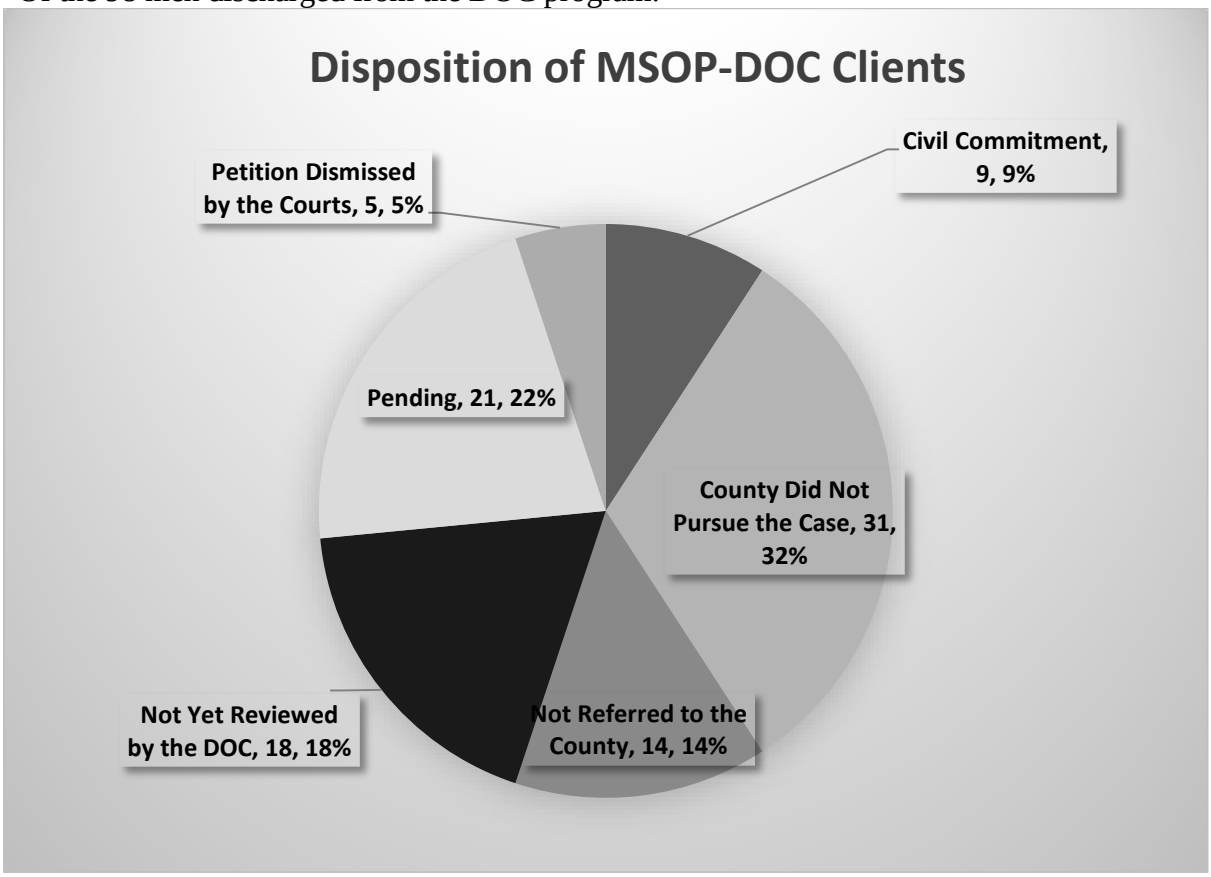
As a result of participating in this treatment prior to the end of their sentence in the Department of Corrections (DOC):

1. The county may not pursue commitment due to the client's significant progress toward management of risk factors.
2. The county pursues commitment, if the client is civilly committed to MSOP they are able to continue their treatment where they left off at DOC.

There have been 151 men who have been admitted to the MSOP-DOC program since 2009. As of December 31, 2015, there are currently 53 clients in the program and 98 men who have been discharged from the program.

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

Of the 98 men discharged from the DOC program:



VI. Program-Wide Per Diem and Fiscal Summary

Minnesota Sex Offender Program Fiscal Year 2015 & 2016 Per Diem

	FY 2015		FY 2016	
Description	**Annual $$**	**Per Diem**	**Annual $$**	**Per Diem**
Direct Costs				
Clinical	**19,409,579**	**73.35**	**18,313,539**	**67.71**
Healthcare and Medical	**5,864,159**	**22.16**	**6,565,885**	**24.28**
Security	**32,099,133**	**121.30**	**34,885,367**	**128.98**
CPS & Community	**2,149,160**	**8.12**	**2,246,967**	**8.31**
Dietary	**2,523,182**	**9.53**	**2,706,680**	**10.01**
Physical Plant & Warehouse	**7,519,922**	**28.42**	**7,295,628**	**26.97**
Program Support*	**11,356,866**	**42.92**	**11,671,933**	**43.15**
Total Direct Costs	**80,922,000**	**305.80**	**83,686,000**	**309.40**
Operating Per Diem		**306**		**309**
Indirect Costs				
Statewide Indirect**	**7,278**	**.03**	**39,099**	**.14**
Building Depreciation	**3,969,731**	**15.00**	**3,969,731**	**14.68**
Bond Interest	**5,359,200**	**20.25**	**5,359,200**	**19.81**
Capital Asset Depreciation	**101,897**	**0.39**	**101,897**	**.38**
Total Indirect Costs	**9,438,106**	**34.99**	**9,469,927**	**34.99**
Total Costs	**90,360,106**	**341.46**	**93,155,927**	**344.01**
Projected Average Daily Client Count (ADC)	**725**		**739**	
Statutory Per Diem Rate		**341**		**344**

*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 2016 is $344 and fiscal year 2015 was $341. 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, 2015

Total MSOP Clients	**726**
Clients by Location	
Moose Lake	465
St. Peter	261
Clients by Age	
18-25	7
26-35	142
36-45	177
46-55	203
56-65	137
Over 65	60
Average Age	**48**
Youngest	21
Oldest	93
Race	
American Indian/Alaskan Native	53
Black/African American	102
White Caucasian	537
Other/Unknown	34

Education		
0-8 Years	27	
9-12 Years	63	
High School Degree	327	
GED	226	
High School degree and GED	9	
Some college or college degree	47	
Unknown	27	
Metro Counties (7-County Area)	300	
Non-Metro Counties	426	

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.

Clients Pending Civil Commitment:

Clients on judicial hold status in the MSOP	8
Clients on judicial hold status in the DOC/jails	3
Total on judicial hold status	**11**

The civil commitment process in Minnesota is started by a county attorney, in the area the crime occurred, by filing a petition for commitment. During the commitment hearing, the county court will determine if the individual meets the statutory criteria for civil commitment. If this burden is met the individual's committed and transferred to MSOP (if the client was not already admitted).

Clients Civilly Committed to the MSOP:

Clients who have been initially and finally committed during 2015*	13
Clients previously committed whose cases were reviewed and finalized for commitment during 2015	1
Total civil commitments to the MSOP during 2015	**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.

Dually-Committed Clients:

Clients who are under civil and DOC commitment in the MSOP	190
Clients who are under civil commitment and in a DOC or federal prison	8
Total number of dually committed clients as of December 31, 2015	198

Clinical Statistics

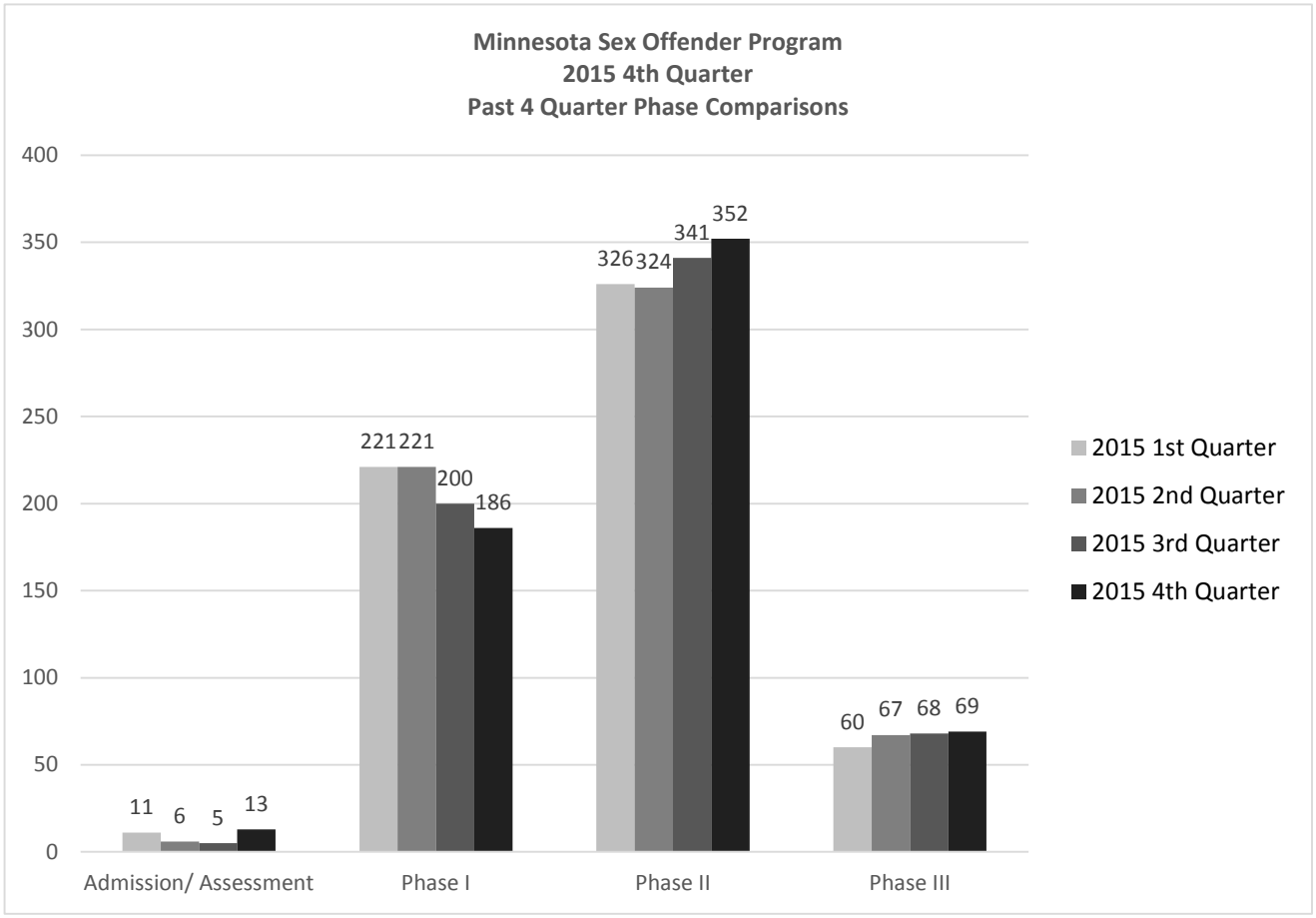
Treatment Participation

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 2015.

Once the civil commitment process is finalized, an individual is encouraged to participate in treatment. Should they choose to engage in treatment, a sex offender assessment is completed and an individualized treatment plan is developed to address their unique needs.

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.



The following chart illustrates the 2015 distribution of clients across the treatment units. The MSOP population is diverse with 24 percent of the clients residing on units that provide specialty programming while 74 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.

	Location	Total Clients	Percentage
Admissions	Moose Lake	13	2%
Alternative Program Units	St. Peter	111	15%
Assisted Living Unit	Moose Lake	18	2%
Behavioral Therapy Unit	Moose Lake	25	4%
Conventional Program Units	Moose Lake and St. Peter	536	74%
Mental Health Unit	Moose Lake	23	3%
Total		726	

Clinical Service Hours

Clinical Service hours at MSOP include both treatment hours and programming hours. Clients participating in treatment are scheduled for treatment hours based on their individual treatment needs and their treatment Phase. The MSOP program design offers Phase I clients a minimum of eight hours of treatment each week. Clients in Phase II and Phase III are offered at minimum nine hours per week. The number of treatment hours offered at MSOP is consistent with similar civil commitment programs across the country.

Treatment hours are spent in Core Group, Psychoeducational 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. Assignment to programming is determined by the client's treatment phase and individual needs.

2015 Clinical Service Hours Offered Weekly

Hours Offered per client per week

	Clinical Treatment	Clinical Programming	Total Clincal Service Hours
Phase I	9	4	13
Phase II	7	13	20
Phase III	9	24	33

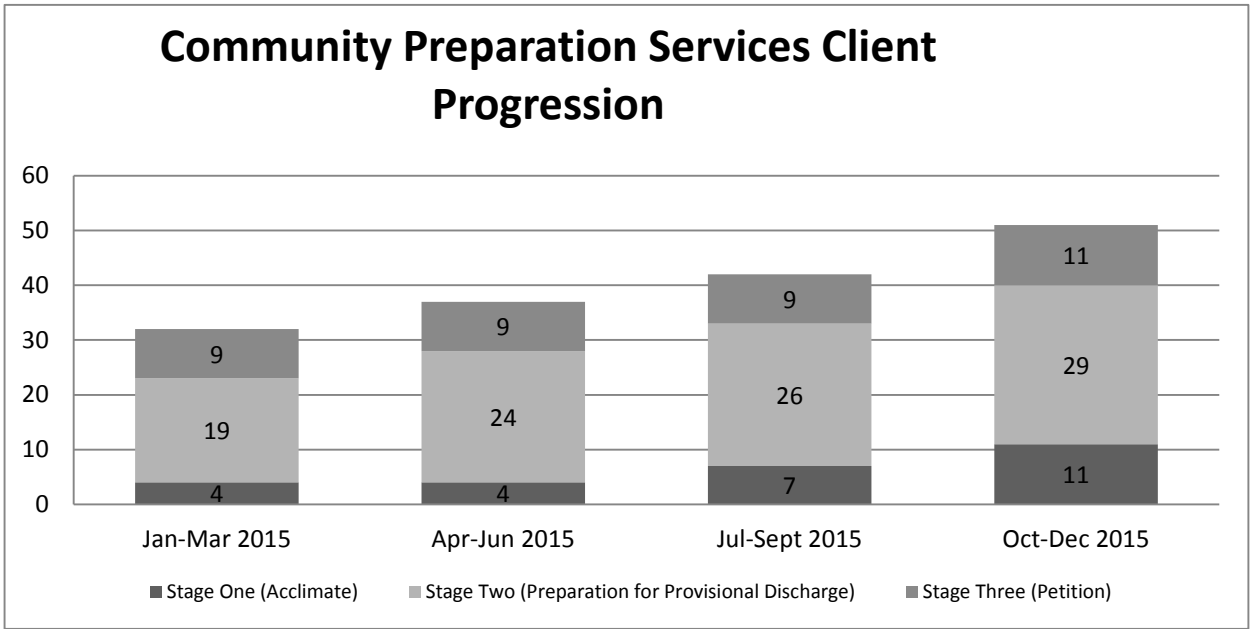
Reintegration Statistics

Community Preparation Services (CPS) continues to experience significant growth. The total client population at the close of 2015 was 51. A bonding request was approved during the 2014 legislative session to expand bed capacity at CPS and that project is approximately 50% finished. During 2016 the remaining portions will be completed, adding 30 additional beds.

The number of provisionally discharged clients has also grown, albeit as a slower pace. In August of 2015, the third MSOP client (one was provisionally discharged in 2000, and subsequently returned to the facility and is not included in the numbers here) was provisionally discharged by the courts to the community. He is slated to live at an adult foster care home, but is currently waiting for a bed to become available. In September 2015, a fourth MSOP client was provisionally discharged by the courts to the community. This client is residing in an adult foster home and transitioning well. An additional order for provisional discharge was granted by the courts in August 2015 and is currently being appealed. In summary, there are three Provisionally Discharged MSOP clients in community placements, one client waiting for housing, and one case under appeal.

As of December 31, 2015, 51 clients were residing in Community Preparation Services (CPS) at the Green Acres facility.

- Eleven clients are 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);
- Twenty-nine clients were in Stage 2 (Preparation for Provisional Discharge) To progress, clients must 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.
- Eleven clients were in Stage 3 (Petition) Here, clients finalize their provisional discharge plans and petition the court for Provisional Discharge. .
- Four clients have been provisionally discharged. Three are residing in the community.



CPS Client Outings

Clients in phase III who have attained privileges are provided opportunities for staff escorted therapeutic outings into the community. Staff accompanied CPS clients with privileges on 1,836 therapeutic outings into the community in 2015, without incident. Clients participate in more than one activity on some of their outings, and this number includes trips with one or more clients.

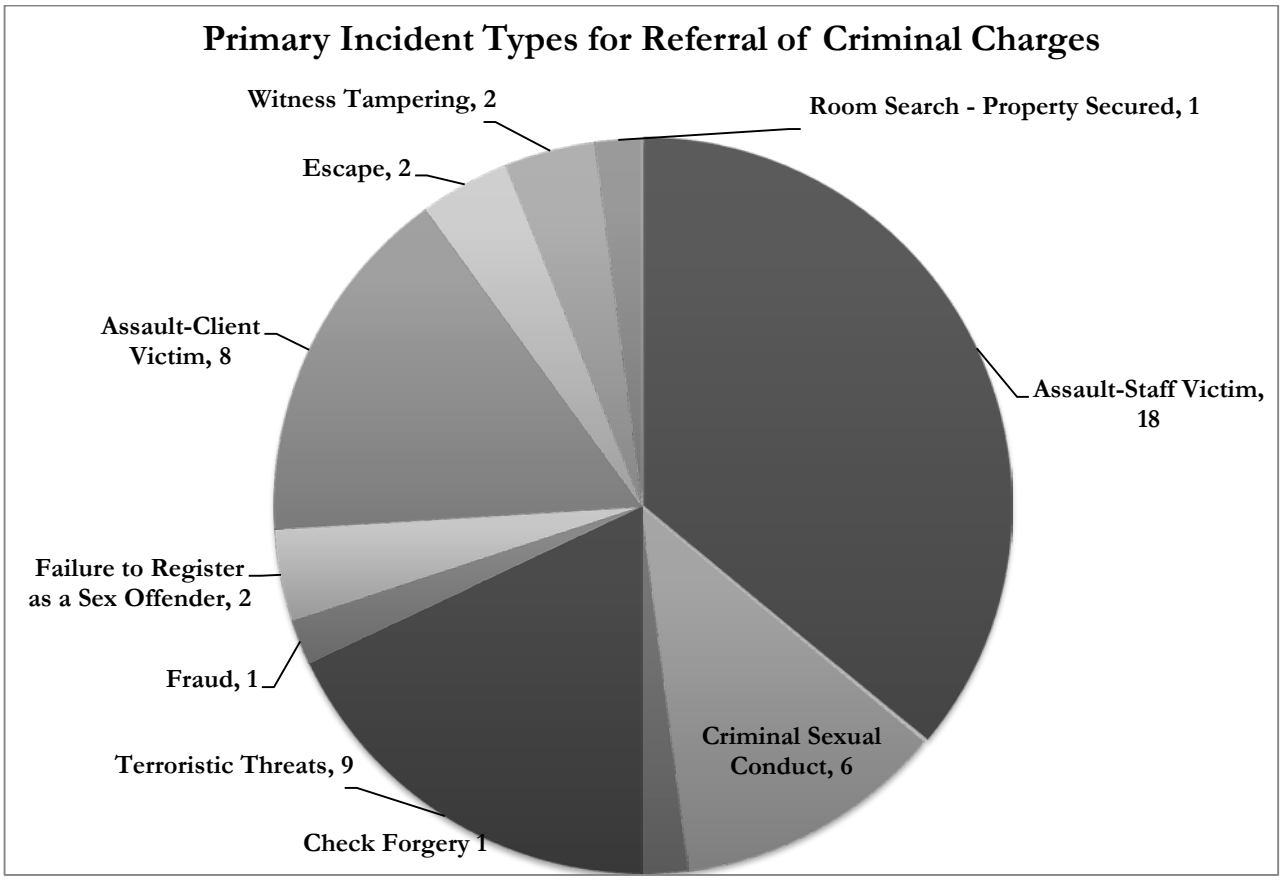
CPS Types of Client Outings
2015 Outings Hours
January to March/ April to June/ July to September/ October to December

Treatment/Programming Outings								
Off-Campus CD Support Groups	65	136	120	331	114	342	92	249
Off-Campus SO Support Groups	47	210	39	209	33	179	37	191
Off-Campus CD Treatment	24	74	24	74	10	30	6	18
Off-Campus SO Treatment	15	113	17	130	14	108.5	16	122
Therapeutic Reintegration Outings								
Off-Campus Vocational Programming	0	0	29	108	55	220	0*	0*
Off-Campus Reintegration Outing	212	594.70	152	470.17	183	651.50	167	562
Off-Campus Volunteering	96	306	80	257	90	299.25	99	318.42
On-Campus Therapeutic Reintegration Outing	1090	1,477.83	800	1,606	1,281	1,754.58	1,308.25	1,747.38

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.

From January 1, 2015 to December 31, 2015, OSI has investigated 104 MSOP cases focusing on client misconduct (there were 136 investigations in 2014). Fifty of these cases were referred for criminal charges, with charges being filed in 23 cases (six referrals were carried over from 2014.) OSI also provides information to the Department of Corrections (DOC) regarding non-compliant clients who are on conditional release from the DOC. In 2015, eight 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 2015 was 210 to 355 days, with 276 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 contracts 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.

Minnesota Sex Offender Program Site Visit Report 2015

Site Visitors:	Bud Ballinger, Private Consultant, Hamilton, New York Robert McGrath, McGrath Psychological Services, Middlebury, Vermont William Murphy, University of TN Health Science Center, Memphis, Tennessee
Location:	Minnesota Sex Offender Program, Moose Lake, MN Minnesota Sex Offender Program, St. Peter, MN
Dates of Visits:	January 11-15, 2016
Date of Report:	January 25, 2016

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 (McGrath and Murphy) previous program reviews in February 2006, October 2007, April 2009, October 2010, December 2011, December 2012, December 2013, and December 2014.

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 Shelby Richardson, MSOP Executive Director; James Berg, Deputy Director; Jannine Hebert, MSOP Executive Clinical Director; and senior managers at both sites via video conference from St. Peter.

Evaluation Requests

During the current site visits, the MSOP requested that we address different evaluation issues at the Moose Lake and St. Peter sites. At the Moose Lake site, the requests were to evaluate program's therapeutic culture, effectiveness of administration efforts to be supportive of the staff, and clinical staff's training needs. At the St. Peter site, the request was to evaluate the functioning of the Community Preparation Services (CPS) program.

Procedures

We reviewed the following written materials:

- Organizational Charts
    - MSOP Sex Offender Executive Operations

  - Moose Lake Clinical Organization
  - Treatment Assessment Unit
  - St. Peter Operational Department
  - St. Peter Clinical Department
  - St. Peter Rehabilitation Therapy Program
  - St. Peter Reintegration Services
- Community Preparation Services program client census 2009 to 2016
- Moose Lake Security Statistics for selected quarters between FY13 to FY15
- Moose Lake memos related to unit restructuring in 2015
- Moose Lake memo regarding Treatment Assignments and Extended Case Reviews dated August 24, 2015
- Moose Lake memo regarding Treatment Assignments 1st Quarter 2016 dated December 31, 2016
- MSOP Quarterly Reports statistics, 3rd quarter 2015
- Table of treatment hours offered and accepted per quarter in 2015
- SRB Petitions vs. Hearings (2012-2015).

During the site visit at Moose Lake we engaged in the following activities:

- Met in individual and group meetings with senior management, including:
  - James Berg, MSOP Deputy Director
  - Jannine Hebert, MSOP Executive Clinical Director
  - Kevin Moser, Facility Director at Moose Lake
  - Terry Kneisel, Assistant Director at Moose Lake
  - Peter Puffer, Clinical Director at Moose Lake
  - Jerry Fjerkenstad, Associate Clinical Director at Moose Lake
  - Kathryn Lockie, Associate Clinical Director at Moose Lake
  - Chad Mesojedec, Education and Rehabilitations Service Director
- Toured the facilities, with particular attention to the following:
  - 1D Unit at Moose Lake
- Met with the following staff groups without their supervisors present:
  - clinical supervisors (3 individual meetings)
  - clinicians (6 individual meetings)
  - psychologists (3 individual meetings)
  - rehabilitative services director
  - program manager (1 individual meeting)
  - unit directors (1 meeting with 2 directors)
- Attended a client placement meeting
- Attended client meetings:
  - Unit Representatives
  - informal client interviews during unit visits and group treatment sessions
- Attended the following treatment groups:
  - one core treatment groups
  - two psycho-education module groups
- Provided preliminary verbal feedback of our findings to Peter Puffer, Clinical Director at Moose Lake

During the site visit at St. Peter we engaged in the following activities:

- Met in individual and group meetings with senior management, including:
  - Elizabeth Barbo, Reintegration Director
  - Christopher Schiffer, Clinical Director at St. Peter
  - Brenda Todd-Bense, Clinical Supervisor at St. Peter
  - Michelle Sexe, Reintegration Program Manager at St. Peter
  - Pat Quigley, Unit Director at St. Peter
- Toured the Community Preparation Services (CPS) facility
- Met with the following staff groups without their supervisors present:
  - clinicians (3 individual meetings)
  - security counselors in informal meetings
  - Reintegration Specialist (1) at St. Peter
- Met in individual meetings with 10 clients
- Attended two core treatment groups
- Attended a therapeutic community meeting at Green Acres West

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, Hong Kong, and the United Kingdom, the Association for the Treatment of Sexual Abusers (ATSA) Practice 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

Two events during the last year have had a significant impact on the MSOP. By way of introduction, they are noted here and detailed further in subsequent sections of this report. First, U.S. District Judge Donovan Frank ruled that MSOP violates constitutional safeguards. The Minnesota Attorney General is appealing this ruling. Second, the MSOP was under a hiring freeze from October 2014 through June 2015.

Findings concerning the Moose Lake site are addressed first followed by those for the St. Peter site. Recommendations for continued development are detailed for each site.

I. Moose Lake

The referral requests at the Moose Lake site were to evaluate the program's therapeutic culture, level of staff support, and clinical staff's training needs.

A. Therapeutic Culture

Moose Lake staff are a dedicated and committed group of professionals who have worked hard during the last year to maintain a positive therapeutic culture under difficult circumstances. Challenges to maintaining a positive therapeutic culture have included a decrease in client engagement in treatment, some of which can be tied to clients' reactions to the lawsuit, and an increase in staff vacancies.

Regarding staffing vacancies, of 54 budgeted clinical positions, 20 positions are now vacant. Of these vacant clinical positions, six of the eight treatment psychologist positions are vacant as are two of the five assessment psychologist positions. The program has historically found it difficult to keep Moose Lake clinical positions filled and the program has been chronically understaffed. However, in recent years MSOP had implemented a variety of recruitment and retention strategies that resulted in almost full clinical staffing levels in 2014. Current low staffing levels appear largely attributable to the eight-month hiring freeze and the concomitant elimination of staff hiring bonuses, a loan repayment program, and staff finder fees. Of 180 budgeted security staff positions, 18 remain unfilled, which has resulted in an increased use of overtime to cover shifts necessary to maintain security within the facility.

To compensate for the reduced level of clinical staffing, the program has reduced the amount of clinical services offered. Phase II clients are now offered two instead of three core groups per week and no psychoeducational modules instead of one to two per week.

Regarding client treatment engagement, although approximately 85% of clients are participating in at least some treatment, the actual attendance level in treatment groups is markedly down compared to recent years. Overall, during the last year, the number of clients attending groups is roughly half or less of those enrolled in the treatment sessions offered by the program. A common pattern is that a few clients will attend groups regularly and a significant proportion of clients will attend group intermittently to very sporadically. Poor group attendance can undermine group cohesion and a positive therapeutic climate.

Several staff and clients told us that poor group attendance is partly attributable to an increase in client's' lack of confidence that active treatment participation is the best route to discharge from the program. This lack of confidence in the program appears to have been exacerbated by the recent court ruling that MSOP violates constitutional safeguards. Some clients believe engaging in treatment is not worthwhile because they hold the view that the court will simply close the program and release them, while others believe that they will be assessed as not meeting commitment criteria. However, some clients noted that movement through the program is now faster and that this has increased their hope for eventual release.

Similarly, several staff and clients reported that in the lead up to and immediately after the court ruling a significant minority of clients became more outwardly negative towards the program and

Staff. Although a review of facility reports does not show an increased number of disciplinary incidents over the past year, we heard multiple reports of an increase in clients being verbally hostile and disrespectful towards staff, often citing the court ruling and court testimony criticizing the program. This has made working conditions for staff more stressful. Nonetheless, we were impressed that, as a group, staff recognize clients' legitimate frustrations about slow movement through the program, and staff appear to be responding in empathic manner to clients. Our meeting with the client unit representative group and other clients indicated that a notable proportion of clients believe that the clinicians are competent, respectful, and are working in clients' best interests.

Nonetheless, the unit representative's client group and other clients reported several concerns that have had a negative impact on the therapeutic culture of the program. As during past site visits, clients complained that low staffing levels and high staff turnover results in frequent changes in primary therapists assignment. The process of new primary therapists becoming familiar with their new clients slows down clients' treatment progress. As well, clients complained that the program (see memos dated August 24, 2015 and December 31, 2016) directed every client in the program to complete the same set of treatment assignments and review them in their core group. The assignments included writing out a sexual offense history, sexual history, and timeline of one's life. Complaints were that most clients had completed these or similar versions of these assignments one or more times in the past, that the assignments were not individualized to the needs of a particular client, and redoing earlier assignments held clients up from moving forward in the program. A frequently expressed client concern that was corroborated in interviews with several of the staff was a lack of consistency in clinicians' scoring of Matrix factors.

The program has developed several initiatives to make improvements in the therapeutic culture of the program. For example, in September 2015 the program reconfigured the makeup of the residents on the 1D Unit. For this Unit, the program identified and placed 65 clients who have special intellectual or mental health needs that were not being adequately addressed in conventional programming, but whose level of functioning was not low enough to qualify for alternative programming. These difficulties contributed to particularly slow movement in the program. The 1D Unit is focusing on developing a specialized therapeutic milieu, providing more individualized treatment, and enlisting the services of an advanced Phase II client who lives on the unit and serves as a mentor to clients. We were informed that the review of clients for the 1D unit was the first step in developing a formal policy of regularly reviewing clients who were not progressing in phases.

The Community Living Project is another initiative to improve the therapeutic culture of the program. A multidisciplinary committee is developing an alternative to the current privilege and disciplinary system. The new system aims to be more therapeutic and positively focused rather than punishment focused. The plan includes developing unit community councils that would be involved in developing therapeutic unit cultures by giving their peers feedback about their behavior and encouraging them to maintain appropriate standards of behavior. The community councils would be trained in peer mediation and attempt to resolve conflicts at the lowest possible level. Client privileges within the program would be based on behavior not treatment level. The reliance on Behavior Expectations Reports (BER) to manage behavior would be reduced and there would be increased recognition and reinforcement of prosocial behaviors. Staff from multiple disciplines support and are very committed to this new system.

There is also a plan to introduce and regularly use the Group Climate Scale to evaluate the therapeutic climate in group. Research has shown a relationship between a positive group climate and positive changes in dynamic risk factors.

The therapeutic culture of the facility continues to be enhanced by the Rehabilitation Services department, which includes recreational therapy, education, and vocational services. These programs continue to have a relatively high level of client participation and add significantly to the positive therapeutic culture of the program. Rehabilitation Services recognizes clients on a quarterly basis for positive achievements. In the last year, Rehabilitation Services organized recreational and community-building events for the facility. Staff and clients alike described these events as having fostered very positive staff and client interactions.

Lastly, there have been some changes regarding security procedures within the facility that have improved the therapeutic climate of the facility. Staff reported that the ankle monitoring system (AMS) was quite challenging to manage, and clients did not typically like it. It has now been discontinued and security staff have implemented new facility movement policies that support reasonably free movement within the facility while maintaining good security.

Areas for Continued Development

1. Regarding staff vacancies, we support previously successful strategies to recruit and retain staff. These include reinstituting staff hiring bonuses, a loan repayment program, and staff finder fees.

2. Although redoing some assignments can be beneficial for some clients in some circumstances, we question the August 24, 2015 and December 31, 2016 directives for all clients in the program to complete the same set of treatment assignments and review them in their core group. We view these assignments, which included writing out a sexual offense history, a general sexual history, and timeline of one's life, to be related to problem identification interventions, which primarily are designed to identify relevant treatment targets. Once clinical staff have identified relevant treatment targets, future interventions should focus primarily on addressing these treatment targets.

3. As in the past, we support plans that would allow trained Bachelors level staff to facilitate some psycho-education modules. Using Bachelors level staff would increase the hiring pool and may make filling positions easier.

4. Staff turnover is a problem in most mental health settings, especially large civil commitment centers that are located in rural areas. Client complaints about the negative impact of having frequent changes in their primary therapist are clearly justified. We recommend the program develop a formal process for transferring clients to a new therapist. Ideally, this would include a meeting with the previous therapist, the clinical supervisor, and the new therapist. This meeting should review the client's progress, current dynamic risk factors being addressed, and the client's scores on the matrix. The new therapist should also be given time to review the client's clinical record.

5.

6. Despite the fact that progression through the program is slower than staff and clients would like, the program has improved the rate of progress through the program and there has been a dramatic increase in the number of clients who have progressed to the CPS program at St. Peter. The program should consider developing an educational program for residents that highlights the benefits of participating in treatment. This could include showing charts that detail recent positive changes in the rate of progress through the program.

7. Client and staff should have confidence that clients' Matrix scores are fair and accurate. Such confidence should contribute to a positive therapeutic environment. Recommendations for improving consistency between clinicians in scoring the Matrix are detailed in the "Staff Training" section that follows.

B. Staff Support

Overall, clinical staff report feeling supported by their supervisors and the program. The MSOP provides clinical staff with frequent clinical supervision. Clinicians typically receive one hour of individual clinical supervision per week and attend one treatment team per week, which provides group supervision. Additionally, the program holds a meeting for all clinical staff once a month.

The MSOP offers Employee Assistance Program (EAP) services to employees. During the last year, the program increased access to the EAP by providing some services onsite. As well, the program has arranged for the same counselor to provide most of the EAP services at Moose Lake. This has helped the counselor learn about the special issues staff face working at the facility and provides continuity of services.

Areas for Continued Development

1. As in past years, supervisors rarely conduct direct observation of staff leading groups. Direct observation allows supervisors to provide clinical staff immediate feedback and direction for improving skills. When supervisors observe groups, the program could improve the quality of this supervision by developing a group therapist rating scale that sets key group therapist performance expectations and guides clinicians in delivering services as intended.

C. Training Needs

As in the past, all new clinical staff complete an initial 40-hour training focused on a general orientation the program and facility. Additionally, during the past year all clinical staff that had been employed in the program for approximately three years or less completed a 40-hour training focused on MSOP sex offender assessment and treatment approaches.

Several clinical staff noted that funding for attending off-site trainings, including the Minnesota Association for the Treatment of Sexual Abusers (ATSA) conference and the national ATSA conference, were limited this year due to budget constraints. Clinical supervisors reported that

newer clinicians sometimes have had difficulty managing more disruptive clients. As previously noted, there has been an increase in clients being verbally hostile and disrespectful towards staff during the past year.

Consistent with client complaints, several staff noted that more training about how to score the Matrix would be beneficial.

Areas for Continued Development

1. We support the program's plan to provide enhanced training about how to mange disruptive client behaviors in treatment groups, as well as schedule a series of trainings on general group therapy skills that is to be provided by an outside consultant.

2. We support staff attending off-site trainings, including the Minnesota Association for the Treatment of Sexual Abusers (ATSA) conference and the national ATSA conference. Attendance at regional and national conferences not only help staff improve clinical work and remain current with standards of care, but can also improve staff morale.

3. There is a continuing need to train clinicians on how to score clients accurately on the Goal Matrix for Phases I, II and III. Accurate Matrix scores are critically important as they are used to identify treatment needs, to measure treatment progress, and as benchmark criteria for moving between phases of the program. We continue to support the program's use of the Matrix to make these decisions, provided that it is more consistently scored so that the decisions are fair and based on accurate information. The Matrix provides a common language to describe dynamic risk factors that is well integrated into the thinking of staff in multiple departments within the program. However, as we have noted in past reviews, the program needs to more precisely define the anchors for each Matrix item. The program needs to develop a training protocol that includes practice scoring sample cases and a process of regular reliability checks to ensure scoring accuracy and minimize scoring drift.

II. St. Peter

The referral request at the St. Peter site was to evaluate the functioning of the Community Preparation Services (CPS) program.

A. Community Preparation Services (CPS)

Overall, the CPS program is well designed to gradually "step-down" clients in preparation for supervised community release.

During the last year, similar to the Moose Lake site, the CPS program has been impacted by the lawsuit and hiring freeze. Additionally, two other issues have impacted the ability of the CPS program to deliver services as intended.

First, as detailed in Table 1, the CPS client census has increased dramatically in recent years, and it is projected to increase at a similar or higher rate in the near future. On the one hand, this is a positive development as it represents increased movement of clients through the program. On the other hand, staffing levels have not kept up with the increased need for services. The number of staff who are assigned to prepare clients for community reintegration and supervise clients on community reintegration outings has remained about the same over approximately the last two years. To address this staffing shortage, only those clients who are judged to be close to provisional release are assigned to work with a reintegration specialist, and the number of community outings per client per month has been reduced, on average, by about half. Consequently, clients are not receiving the intended and appropriate level of reintegration services in the CPS program.

Table 1. CPS Census from 2009 to 2016

2009 June	2010 June	2011 June	2012 June	2013 June	2014 June	2015 June	2016 January
3	5	7	9	12	22	38	51

The CPS program is currently licensed for 59 beds. At a current census of 51 clients, it is near capacity. There are now at least six clients with orders to transfer to CPS in January 2016. Several Phase III clients that the program deemed ready or close to ready for placement in the CPS continue to live within the MSOP St. Peter secure perimeter. Expansion of the program is needed, and there is a plan to increase the number of CPS beds.

The second major challenge CPS faces is that the courts are now placing some Phase II and III clients in the program. These are clients that the court has judged can be safely managed in the "less restrictive environment" provided in the CPS program, as opposed to a more restrictive placement within the secure perimeter in the other MSOP programs. A challenge for the program is that the programming needs for Phase I and II clients are different than those for Phase III clients. The treatment focus for Phase III CPS clients is to prepare for and practice community reintegration skills, whereas the goals of Phase I and II clients are focused on behavior management, problem identification, and skill development and practice.

Other observations are that the CPS clinical, reintegration, and security staff are dedicated and competent. There is good program leadership. The therapeutic culture within groups and on the units is very positive. Overall, clients express hope about being provisionally discharged from the program, albeit at a slower rate than the program design outlines and the clients expect. At the time of the present site visit, four MSOP clients were living in the community on provisional discharge, one client has a provisional discharge date set, and the program is currently supporting the provisional discharge of approximately five other clients.

With respect to the CPS administrative structure, clinical staff report to the Associate Clinical Director and reintegration and security staff report to the Reintegration Director. Several staff reported some tension in the working relationships between reintegration and clinical staff and

some role confusion regarding each disciplines' responsibilities and the chain of command. These problems were evident to a lesser degree during a previous review and may be more notable now due to the rapid expansion of the program.

Areas for Continued Development

1. CPS staffing levels should be increased to meet the demand of an increasing client population.

2. As has been noted, an increasing number of Phase I and II clients are being placed in the CPS program, and the programming needs of these clients are different than those of Phase III clients. We recommend that MSOP consider having two programs for clients placed outside the secure perimeter at the St. Peter site. One would be consistent with the original intent of the CPS program for Phase III clients who are preparing for transition into the community in the near future. A second program would be developed to meet the needs of Phase I and II clients. Ideally, clients in the two programs would live in separate units and attend different treatment groups. We support efforts that the program has already initiated to move in this direction.

3. For Phase III clients that are actively preparing for transition, the number of clinical treatment hours per week could be decreased. Currently, these clients typically attend three core groups and one psycho-education module per week. We recommend that the program consider reducing the number of group sessions to approximately one core group per week, which would be more consistent with what clients would receive when they transition to the community and receive services in an outpatient program. This decrease in treatment groups would ideally be paired with an increase in reintegration services that would target such areas as job interview skills, development of community support systems, nutrition, independent living skills, and budgeting.

4. Some Phase III clients reported that they were being held back in treatment because the results of a polygraph exam yielded a finding of inconclusive or deception. Although almost all sex offender civil commitment programs use the polygraph, we believe it is important to ensure that treatment decisions are not based solely on the basis of polygraph tests. We support the program's recent work to ensure that polygraph questions are appropriately constructed.

5. Several Phase III clients have treatment plans focused on arousal management and to a lesser degree on trauma work. In general, these are treatment targets that should be addressed in earlier phases of treatment. Similarly, it is common practice for CPS therapists to have clients begin core group check-ins by reporting current sexual thoughts and behaviors. We opine that these types of check-ins may be appropriate in some earlier stages of treatment, but not uniformly for clients who have advanced to Phase III clients.

6. Staff and client interviews and group observation indicated that use of skill teaching and practice, such as role plays, in CPS core groups was relatively infrequent and should be increased.