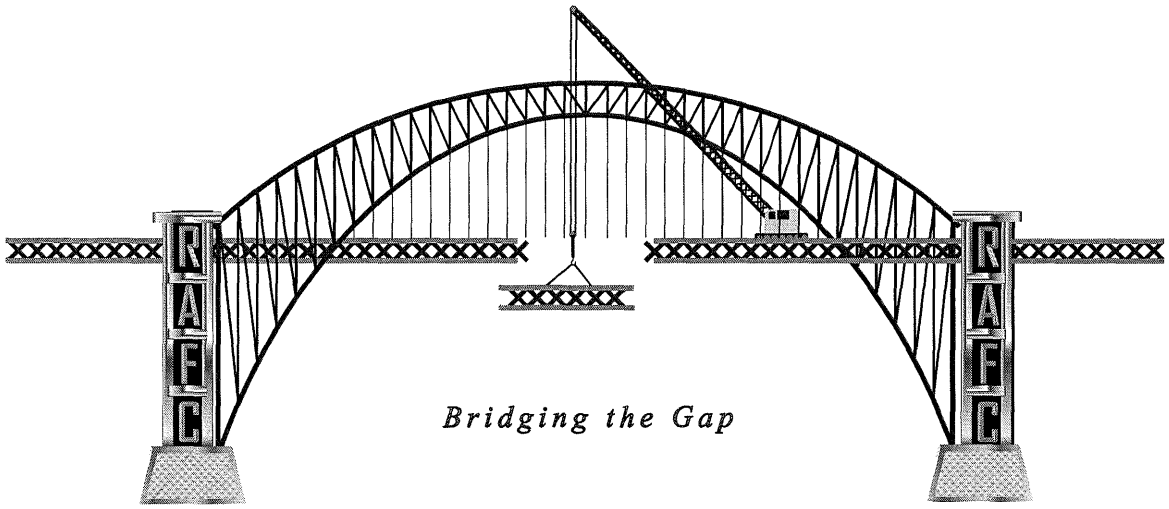
May 2016

16 - 0557

Resident Advisory & Family Council



REPLY TO Minnesota Sex Offender Program Annual Performance Report 2015

Legislative Report

Introduction

The Resident Advisory and Family Council organization ("RAFC") is a statutorily mandated entity charged with advising those committed to the Minnesota Sex Offender Program ("MSOP") of their rights and takes an active role in protecting those rights and advocating for all rights of those thus committed.

In this role, RAFC has closely studied the "*Minnesota Sex Offender Program Annual Performance Report 2015*" (hereinafter, "*MSOP Annual Performance Report 2015*") prepared by MSOP itself for submission to the Minnesota Legislature.

RAFC delegates have noted numerous instances within that *MSOP Annual Performance Report 2015* of inaccurate and misleading statements and implications. A substantial part of the purpose of this *Reply* to that *Report* is to correct such misstatements and incorrect implications.

The other purpose of this *Reply* is to set forth certain fundamental failings and problems of MSOP, both as an assessment and treatment program and as a living environment for all who reside within it.

These two purposes are served by the following two respective Parts of this *Reply*.

- -

However, first, an especially important clarification: We are not "prisoners." In every legal sense, we are not here for punishment -- or as punishment -- for any past crimes, or for anyone's hysterical imaginings, speculations, or collective attributions of supposed past unreported crimes.

Because we are not prisoners, we are entitled – just the same as any other citizen of this state and our country -- to dignity, respect, privacy, unrestrained communication and access to public media and information, due process, equal protection of law, and petition for redress of grievances, as well as all other constitutional and human rights accorded to anyone else.

It is also inaccurate and nothing more than an incendiary, propagandistic act of labeling to call us "sex offenders" or to apply to us any other, more inflammatory terms based on conceptualization of such past crimes, real or projected. The literature uses that term so uniformly that we are compelled in this report to echo it. However, we decline to apply it to ourselves because of its inaccuracy to who we are now and because we rightly refuse to buy into the condemnation unfairly heaped upon us now.

The image of serial commission of sex crimes upon numerous stranger victims applies to very few in MSOP. Most committed to MSOP engaged in only one, two, or three episodes of sex misconduct, usually with those either related to them or who knew them well. Almost everyone

in MSOP regrets those incidents and wishes that time travel were possible, so as to be able to return to the past and refrain from such misconduct on those occasions. Of course, that is simply not possible.

However, any sex crime or crimes committed by those present within MSOP occurred no more recently than several years ago – most well more than a decade ago, and some two decades ago or more distant than that in the past. Some confined in MSOP do not have a past sex crime at all. Others committed their only sex crime as a juvenile. Therefore, to label someone in MSOP as a "sex offender," implying a present intent to commit sex crimes, is simply incorrect.

Worse, it is grievously unfair to each of us to apply such collective labels to us as manipulation of the emotions of the constituency. To do so simply again stirs the public tendency to extreme fears and hatreds of those so mislabeled.

We ask all legislators, other politicians, and the media to stop this exploitation of our plight. It is the human thing to do, and it is absolutely necessary if Minnesota is ever to solve the problem that MSOP presents to state governance. Government should not be reduced to a never-ending hate-fest of disguised retribution, deterrence, and preventive detention beyond criminal sentencing, all disguised as claimed-but-unreal-treatment-toward-release, but in reality as nothing more than government-as-a-preventative-and-punitive-state. There are far more effective ways to spend the tax dollars of the State than to reach such a miserable, ignoble end. More importantly, the vast majority of sex crimes are committed by those never previously convicted of any sex crime. Therefore, such an official aim of further post-imprisonment (disguised) incarceration could never eliminate or seriously staunch the rate of sex crimes in the state.

At various times, MSOP has referred to those within its confinement facilities as "patients," "residents," and "clients." None of these terms are accurate in any meaningful sense.

With only rare exception, none of us is "mentally ill"; therefore we are not "patients," any more than MSOP's facilities can be called "hospitals." (Most assuredly, they are no such thing, they are detention facilities, simply with some so-called 'treatment' slathered on top for appearances sake.)

We are not "residents – a term that inherently implies a matter of choice. We are detained by order of the State of Minnesota. Were it not for such involuntary detention, almost none of us would remain here.

Lastly, to call us clients is as laughable as to suggest that concentration camp inmates of World War II were "guests" of the SS.

MSOP simply must stop manipulating the language to cast a more acceptable, but utterly false public image of its role. MSOP is our captor, and we are its detainees. Accordingly, we use the

term "detainees" throughout this document instead where needed for clarity and uniformity of reference. At other points, we refer to ourselves as what we are: "individuals" and "people."

Part 1

Numerous Inaccurate and Misleading Statements Render the MSOP Annual Performance Report 2015 an Incorrect Picture of MSOP Overall

This Part will address the various objectionable statements in the *MSOP Annual Performance Report 2015* in the order they appear in that *Report*.

1. CPS is broken, in that it fails to serve MSOP detainees as a means of exit from confinement.

On page 5, the Report states that the Community Preparation Services ("CPS") program within MSOP-St. Peter ("SP") has expanded from 27 detainees in 2014 to 51 detainees currently, and that an additional 30-bed expansion project is currently in the bonding process. The implication is that this increase in CPS capacity portends a massive increase in releases to provisional discharge status in the near future. However, no evidence actually supports that opinion. In fact, as will be discussed in Part 2, all real indicators strongly suggest that no significant numbers of releases – even just to the extraordinarily restrictive "provisional discharge" status – can reasonably be expected anytime in the foreseeable future. Instead, it appears that CPS will serve as an exit-less, politically-mandated repository of those who have been provided as much treatment as MSOP has to offer.

2. Also on page 5, MSOP cites its closure of "two 25-bed living units" at MSOP-Moose Lake ("ML"). This statement fails to mention, however, that the two units closed were used to house those in the last portion of Phase 2 of MSOP treatment.

These two units are located in the "main" building at MSOP-ML and consisted of rooms for single-detainee-occupancy. In closing these units, a determination was made by MSOP "Clinical" employees regarding which of the residents of those units were currently ready for

transfer to Phase 3 (and hence to MSOP-SP) and which were not. Those thought ready were sent to MSOP-SP, where they began Phase 3 of treatment. In contrast, all other residents of those units were transferred to empty beds in the so-called "complex" building in MSOP-ML, and the two units, now emptied, were closed purely as a cost-saving move when falling MSOP staff levels could not keep those two units open.

Previously, those assigned to that latter portion of Phase 2 were assigned to those two units as a means to allow them a quiet, undisturbed environment conducive to focus upon their treatment. Now, those detainees not transferred to MSOP-SP from those closed units co-occupy general-purpose housing units within the Complex building. These units house a general mix of detainees, some of which are in Phase 1 of treatment or are not in treatment at all. Those Complex units are much larger, each resembling a maximum-security prison "K-Building" unit. Each of these units houses from 68 to 98 detainees. Due to their size and the lack of treatment engagement among Phase 1 detainees and of course, treatment nonparticipants, these living units tend to be comparatively loud, full of distracting activity.

The fact that the 25-bed units in the main building were not kept open and re-filled with Phase 2 detainees strongly suggests that no Phase 2 detainees left in MSOP-ML are now deemed to be in the latter phases of Phase 2 treatment, and hence that no further mass transfers of detainees to Phase 3 in MSOP-SP are contemplated at this time. In turn, this strongly suggests that those transferred to MSOP-SP are thought by staff to be likely to remain in Phase 3 there for quite some time, such that no MSOP-SP beds will be opened anytime soon.

In sum, this recent mass transfer was just a 'show transfer,' and that it does not mean any true increase in the nearly imperceptible, creeping pace of treatment advancement experienced by all MSOP detainees. Collectively, RAFC believes that this show is simply aimed at the media and the Legislature, to deflect longstanding criticism of MSOP.

3. Page 5 also states, "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." Although "family support" sounds helpful, this statement implicitly points up two enormous failings in MSOP treatment philosophy.

To understand this in its true context, it is necessary to grasp certain fundamental facts about committed people in MSOP. Most committed their first sex crime at young ages and received a prison sentence for it. Most MSOP detainees committed a second sex crime after prison release and endured a very long 'repeater' prison sentence for that crime before their commitment. Typically, commitment to MSOP occurred upon their prison release, thwarting that release.

Therefore, the reality is that relatively few MSOP detainees were ever married, and fewer still had marriages that produced any children. Moreover, according to the Report itself, at p. 17,

the average age of all MSOP detainees is 48 years of age. This includes those who have only recently arrived and those otherwise not yet in treatment at all, plus numerous detainees in Phase 1 of treatment.

In MSOP, advancement to Phase 3 takes at least ten years after commencement of treatment, on average. This means that an MSOP detainee is in his late-50s, on average. (However, see post for the truth that, currently less than 20 detainees are actually in Phase 3.) From that age on forward, the death rate for parents of detainees is high. Hence, many if not most MSOP detainees no longer have parents living when they advance to Phase 3.

Further, except for MSOP detainees with unusually devoted wives and exceptionally close children (by then, adults), the phenomenon of "family support" for MSOP detainees who are in Phase 3 approaches a rarity. With these facts in mind, we discuss these two failings of MSOP treatment and release philosophy:

(a) MSOP embraces the myth that only an incest offender can be released from confinement – even merely onto the extraordinarily restrictive status of "provisional discharge" – with a certainty of public safety, and then only if the releasee is in a marital relationship and has additional "support" (for which read monitoring, surveillance, and reporting to authorities) by adult relatives; and

(b) MSOP seeks to avoid release of any of its detainees who do not meet this paradigm of such relationships and support and uses its own declaration of a purported fundamental importance of such relationships and support as an excuse not to endorse release of every detainee who does not have such relationship and such additional familial "support." This includes refusing to endorse the release of even elderly MSOP detainees, as to whom there is simply no statistical likelihood of sexual re-offense at all.

MSOP believes – or claims to believe – that all who have been committed to it currently are highly compulsive sex criminals who would certainly commit another sex crime if released and if able to find an opportunity to do so. This is simply tacitly clinging to the old false myth that sex offenders are "100% recidivists." In truth, sex offenders tie with murderers for the very lowest rate of recidivism.

Currently, that average recidivism rate for the first five years after release is a mere 3% (all offender ages at release combined). Recent research from the parallel commitment facility in Florida has shown that the recidivism rate by sex offenders released from commitment approximates this same 3% rate. This reveals the falsity of claims that those meeting statutory commitment criteria (roughly the same between Florida and Minnesota) are supposedly exceptionally likely to commit another sex crime.

Separate research has also established that sex offenders at age 60 (the nearest age cohort to the average age at projected MSOP release on average, if MSOP were to engage in more than trivial numbers of releases) is only about one-sixth of that overall recidivism rate. *R. Karl Hanson*, The Validity of Static-99 with Older Sexual Offenders, 2005-01 (*Public Safety and Emergency Preparedness Canada*), at p. 10; *R.A. Prentky, E.Janus, H. Barbaree, B.K. Schwartz & M.P. Kafka*, "Sexually Violent Predators in the Courtroom: Science on Trial," 12 *Psychology,*

Public Policy & Law 357, 377-78 (2006), *Richard Wollert*, "Low Base-Rates Limit Expert Certainty When Current Actuarials Are Used...," 12 *Psychology, Public Policy and Law* 56, at 61 et seq (2006); *Daniel Montaldi*, "A Study Of The Efficacy Of The Sexually Violent Predator Act In Florida," 41 *Wm. Mitchell L. Rev.* 780, 845 (2015).

Applied to that modern, general 3% rate, this means that a 60-year-old MSOP detainee has a probability of sexual re-offense in that same first five-year period of only 0.5% (one-half of one percent, or: 1 out of 200). Even those with extensive criminal records of sex crimes in their past (and even within the most recent decade) are so subject to this natural (indeed biologically inevitable) desistance pattern that the highest adjusted estimate for such former serial recidivists remains no higher than about 2.5% at age 60. By time sex offenders reach age 70, there is no detectable recidivism at all (i.e., zero percent).

MSOP and other sex offender commitment programs elsewhere insist that those committed by reason of sex crimes in the past are somehow special, such that these percentages do not apply to them. However, the Florida research unequivocally demonstrates that these figures do indeed apply to committed sex offenders. Indeed, the Florida research could not find a single recidivistic sex crime by any commitment releasee at or above age 60.

Therefore, in sum, MSOP is simply in error in claiming that only a family support structure can render released sex offenders safe to the public after release from commitment. The related MSOP claim that such a support structure is indispensable to successful treatment is simply an attempt to excuse not releasing anyone lacking such a support structure – even senior citizen releases. In reality, this demand for a nonexistent support structure as the price of exit (even just to extremely monitored and surveilled "provisional discharge") is simply a subterfuge for MSOP obedience to political direction not to release any detainees for whom any excuse can be trumped up.

4. The chart data shown on page 12 of the *MSOP Report*, when read together with other passages, states or implies certain important revelations about CPS.

First, the "Total Census 726" chart declares that 69 detainees are in Phase 3 of treatment. Since this 69 detainees is part of the numbers otherwise shown in that chart – all of which total to the total number of MSOP detainees (at both facilities combined), it logically follows that the 51 detainees currently assigned to CPS are within this "Phase 3" total of 69. Conversely then, the total number of Phase 3 detainees in MSOP not in CPS is a mere 18. This belies MSOP's implicit claims of an active and full Phase 3. In reality, this tiny number (2.5% of MSOP clients) shows to the contrary that the Phase 3 treatment level is so nearly empty as to be close to nonexistent.

This in turn necessarily implies that it will be a considerable amount of time into the future before any significant additional number of MSOP detainees will be ready for assignment to

CPS, given MSOP's sluggish treatment advancement policies. Accordingly, MSOP's seemingly urgent appeal for legislative approval for the expansion of CPS to an 89-bed capacity appears in hindsight to be extremely disingenuous.

Currently, the licensed bed capacity of CPS is 59 (2016 *Site Visitors' Report*, page 9). In addition to the 51 detainees currently in CPS (at the time of the *MSOP Report*), another six were slated to be transferred to CPS after the start of 2016 (and may already have been transferred). This would bring the CPS total to 57 – still within that licensed capacity. Apparently, MSOP staff or officials told the Site Visitors that "several" additional Phase 3 detainees are "ready or close to ready" for CPS transfer. (*Site Visitors' Report*, p. 9) However, if so, this will deplete the aforesaid already-thin ranks of Phase 3 detainees almost to nonexistence.

Meanwhile, the Site Visitors complain that the CPS census has recently increased dramatically, and is projected to continue to do so (ibid.), while releases in the same period of years since 2009 have been limited to just 3 (approximately 1 out of each 240 MSOP detainees). This matches the number of detainees in CPS in 2009. Effectively then, it is fair to conceptualize CPS as having only freed the three detainees already assigned to it seven years ago. At best, this is a release function in abject failure.

Frankly, more likely it bespeaks a tacit political dictate not to actually release anyone, or at most, not more than a few 'token releasees' as a pattern of 'show releases' to deflect criticism of MSOP for lack of an earnest aim to release anyone. This would appear to be confirmed by MSOP's own citation of CPS "staffing shortages" brought about by MSOP failure to add on CPS staff to keep up with the rapid rise in CPS detainees between 2013 and the present.

> "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 [while CPS detainee population increased by an extra 132%]. 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." (ibid.)

This picture is congruent to concessions in the *MSOP Report* itself, at p. 21, that, of the 51 CPS detainees, only 11 are in the final stage of CPS. This has only increased by two over comparable figures from the start of 2015. Because reintegration work, community outings, and this final stage are necessary prior to release, it appears that, by 'squeezing the tap shut' at this point through apparently deliberate understaffing and squandering those same monetary resources on expanding CPS bed capacity, MSOP leadership has demonstrated that it still remains not serious about effecting releases onto provisional discharge.

This also appears to be buttressed by the recent placement of Phase 2 and Phase 3 detainees into CPS – not for release preparation, but simply because they have been determined 'safe' to be assigned to a "less restrictive alternative" to MSOP detention. In particular, Phase 2 detainees in this status are claimed by MSOP to continue to have treatment needs. In effect, this amount to

blaming the courts for enforcing the statutory and constitutional rights of detainees who courts deem to be safe to release, and MSOP is thereby implying that it refuses to let them go (to provisional release status) -- only because MSOP thinks they 'need' further treatment, despite that court ruling as to each.

This is confirmed by the *Site Visitors' Report*, p. 10, which recommends that "MSOP consider having two separate programs for clients placed outside of the secure perimeter at the St. Peter site. One would be consistent with the original intent of the CPS program for Phase 3 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 1 and 2 clients. Ideally, clients in the two programs would live in separate units and attend different treatment groups."

Of course, given MSOP insistence that no one be released until he has completed the entire treatment program successfully (through Phase 3), all such detainees in CPS who have not done so will not be released; they will simply occupy a CPS bed indefinitely for quite a long time. Conversely, since these separate units and treatment groups require staff of their own, the understaffing problem is thus exacerbated. This means that those in CPS as preparation for release will be forced to stay in CPS even longer to accomplish the CPS tasks for reintegration preparation. This will impeded releases from MSOP confinement collectively.

5. On the contrary to page 13 of the Report, participants in the prison-based "MSOP-DOC Site" treatment program, if committed, do not pick up in post-commitment treatment "where they left off at DOC"; instead, they are forced to begin treatment all over again, as if never in the treatment program.

These detainees are generally not advanced in treatment at any rate faster than the glacial pace applied to all others who get committed. Numerous instances exist of specific MSOP detainees who have been relegated to this 'start over' fate. The MSOP generalization to the contrary is simply untrue.

6. Also, the appearance from the pie chart on page 14 of the Report is completely misleading; the reality is that MSOP-DOC Site is purely a commitment facilitation device.

This pie chart purports to set forth the outcome of 98 individuals who participated in treatment in MSOP-DOC Site. At first glance, it would appear to represent that only 9% of such participants wound up committed. However, this ignores the additional category of those as to

whom commitment petitions remained pending when the table was prepared (22%), plus those whose participation was terminated before the end of their prison terms, probably for alleged "treatment failure." As to this last additional 18%, the Department of Corrections had not yet reviewed them for referral for commitment. However, because of such claimed treatment failure, their referral for commitment consideration is highly likely. Thus, in total, 49% of MSOP-DOC Site treatment participants either have been, or could still be committed, in part based on their record in that program.

More significantly, this chart clearly shows that only 14% of MSOP-DOC Site prison detainees were not referred to county prosecutors for commitment petition consideration. Conversely, this implicitly means that the other 86% of such participants were in fact so referred. Since MSOP-DOC Site makes its own decisions as to all of its participating prison detainees, this implies that MSOP-DOC Site staff recommended that this 86% of its participants be considered for commitment. This is not a commitment avoidance device, but instead, a commitment advocating device that gathers a dossier of information about each participant to build a commitment case against him.

7. The MSOP claim (Report, p. 16) that a "marginal per diem" of only $162 applies to "new admissions" to MSOP is simply false.

At page 15, MSOP concedes that the "Statutory Per Diem Rate" per detainee is $344. As an initial matter, this per diem figure includes an unbelievably low figure of $3.9 million in building depreciation, and a "capital asset depreciation" figure of a mere $101.9K. These figures do not include the cost of construction of the buildings at MSOP-ML or of necessary renovations and refitting of existing buildings at MSOP-SP to allow their use for MSOP occupancy/use.

Indeed, except for an entry for "bond interest" on that funding for such costs, there does not appear to be any accounting for that cost of construction. Therefore, it is first submitted that the true total per diem rate of MSOP per detainee is far higher – perhaps in the range around $600/day.

Second, it is completely fallacious to imply, as does the aforesaid statement on page 18, that a "marginal" per diem figure would apply to any and all "new admissions" to MSOP. Even the so-called "direct" costs in the table of per diem calculation on page 17 reflect a "direct" per diem cost of $309 per detainee. This reflects an apportioning of such costs among all 726 current MSOP detainees.

Thus, addition of one more detainee would only alter the per diem calculation by division of the per diem rate by 727, rather than by 726. In effect, this would reduce the per diem rate by only one divided by 727, even if we assume that the 727th detainee would add no additional costs at all to the program (itself a false assumption).

In sum, this effort to understate the per diem through misleading accounting should be ignored. Operation of MSOP inherently involves staggering annual costs. This cannot be blinked away.

8. As shown on page 17 of the Report, the fact that only 90 (12.3%) of the 726 MSOP detainees do not possess a high school diploma or a GED means that MSOP's exclusive educational efforts at achieving such GEDs effectively ignore the educational needs of the 87.7% of MSOP detainees by failing to provide them with college-level educational and vocational training that can equip them for jobs with a reasonable income expectation in the community upon release. This choice to ignore those needs bespeaks the true, tacit MSOP intent to never release any substantial portion of its detainee population.

9. Calculation of "treatment hours" as explained on page 20 of the Report is incorrect.

On page 20, MSOP's calculation of "treatment" hours includes more than clinical matters. Such clinical matters obviously include "Core Group, Psychoeducational Modules," and "individual therapy". The first two of these categories occur weekly. "Individual therapy" is actually occurs only once every two weeks for a half-hour per detainee, thus contributing only 15 minutes to the quantum of total clinical hours per week.

"Progress reviews" typically happen only quarterly, and hence add only a few minutes per week if so allocated. "Modified programming" also occurs only once per quarter (for one week) and, apart from recreational activities, comprises only a written treatment assignment that is most often either given short shrift in response or is simply ignored. Hence, it effectively adds almost nothing to the weekly allocation of treatment hours. "Assessments" happen only rarely, and thus do not add any weekly time addition to the quantum of treatment. Likewise, "reintegration services" involves only those in CPS and hence add nothing to treatment hours in any of the three phases of treatment.

The so-called "therapeutic community meetings" are simply meetings to discuss matters of living unit concern. The claim by MSOP clinical staff that polite and cooperative conduct of these meetings is somehow "therapeutic" is patently ridiculous, in that such matters of social cooperation and etiquette have nothing to do with propensity to commit sex crimes. Bluntly, the world is full of abrasive, irritating people – who never commit a sex crime.

Clinical staff at MSOP also claim that other activities are involved in "clinical programming." However, in reality, these activities are simply efforts by MSOP detainees to better their general lot in life. Thus, for instance, educational efforts simply lead to better vocational prospects and otherwise provide a greater awareness of matters relating to generally useful or enlightening personal knowledge.

"Therapeutic recreation" simply refers to exercise, sports, and games. This amounts to diversion and perhaps to some degree of physical fitness. However, it has no significant relationship to psychological treatment of any kind, except as a physical outlet for stress built up from treatment. (In what world is treatment resulting in infliction of stress actually therapeutic?)

The "vocational" programming in MSOP simply refers to jobs held by detainees. These include cleaning crews, kitchen work, and work supporting the industry program in MSOP. All of these positions are simply jobs that would otherwise be performed by workers hired from the surrounding area in the vicinity of the respective facilities. Hence, the main function of holding these jobs out to MSOP detainees at a net wage of half the federally required minimum wage is to save MSOP a substantial amount on its costs of operation.

Finally, "volunteer services" merely refers to religious representatives and representatives of addiction-combatting entities such as Alcoholics Anonymous and Narcotics Anonymous. Again, the religious portion of this has nothing to do with psychological treatment. The argument can always be made that struggling against chemical dependency is part of any psychological treatment when it is needed. However, in MSOP, attendance at such meetings is purely optional, and such meetings are completely uncoordinated with treatment, and such attendance and the content of such meetings are unrecorded in any records of MSOP sex offender treatment.

In sum, none of these activities can reasonably be said to comprise part of sex offender treatment. Hence, clinical staff have no rationale for taking credit for any of these activities chosen by MSOP detainees.

10. On page 23 the pie chart "Primary Incident Types for Referral of Criminal Charges" sets forth a revealing picture about what serious misconduct by MSOP detainees is, and equally importantly, what it is not.

Text on page 23 states that, of 104 investigations by OSI in 2015, only 50 incidents were referred for criminal charges. The pie chart on that page visually divides such incidents down by type. The great majority of these incidents involved violent assaults or confrontations, totaling 41 of the 50 incidents.

Of these, 18 were violent assaults of staff, 8 were violent assaults on detainees, 6 were sexual assaults or other sexual misconduct, and 9 involved only terroristic threats of violence. Apart from these 41 incidents, the other 9 of the 50 involved less severe charges without violence or sex: 1 of fraud; 1 of check forgery; 2 of failure to register as sex offender; 2 of witness tampering; 1 of drug contraband; and 2 of escape actions.

The assaults on staff victims depicts detainee frustrations with and anger against staff over rules, interpretations of rules, and staff actions perceived as unfair, needlessly overly restrictive, hyper-technical, personally directed, or retaliatory, among other things. The rule structure in

MSOP closely resembles that in force in Minnesota's high-security prisons. Conceptually, this is completely inconsistent with MSOP's insistence that it is purely "therapeutic" and not punitive.

Further, MSOP adheres to a "behavioral" form of treatment. At many points, that treatment modality includes extensive prohibitions and restrictions upon those subjected to such treatment, as well as demands for certain actions by detainees in treatment. Since satisfactory completion of treatment is a requirement for release, in perceived effect, compliance with such prohibitions, restrictions, and demands are seen as the equivalent of ransom demands, failing which compliance, release will be denied.

Given the extreme length of MSOP treatment in confinement and given the elaborate list of such dictates and prohibitions and their inherent conflict in many instances with human nature and barring conduct unprohibited outside of MSOP, chafing over such rules and staff actions appears to be frequent and seems to have grown more intense in recent times. An examination of the MSOP structure of such prohibitions, restrictions, and demands upon detainees would appear to be in order to determine which are absolutely essential, and which in contrast are simply needlessly punitive or excessive.

Of special note, none of these referrals for criminal charges include any pornography or any use of computers for misconduct. This latter point also implies no unauthorized Internet access and no cell phone possession. MSOP detainees are to be praised for their self-restraint on these fronts.

Nonetheless, in the current era of ubiquitous and indispensable Internet usage and cell phone communication, the total ban on MSOP detainee use of these technologies and means of communication and information access is comparable to ancient imprisonment practices of barring visitors and mail to detainees. Comparatively, in the federal court system, even as to child pornography possessors, prohibitions on Internet access and cell phone usage have been struck down as an unconstitutional denial of freedom of communication and access to information. Particularly in light of the aforementioned record of good conduct by MSOP detainees in refraining from pornography usage and other forms of computing misconduct as well as prohibited cell phone possession, there is simply no rationale that justifies such an extreme, total ban on use of these technologies.

In sum, it is suggested that MSOP earnestly examine and revamp its rule structure, to eliminate all but the truly essential prohibitions and, wherever possible, to transition from total bans to reasonable regulation of all matters not presenting a true threat to institutional security.

11. Notions of "therapeutic culture" and of "therapeutic alliance" are self-delusions when there is no prospect of treatment completion and release within any reasonable time.

On page 4 of the *Site Visitors' Report* appended to and incorporated within the *MSOP Report*, MSOP complains of "a decrease in client engagement in treatment," including serious

reductions in actual attendance by MSOP detainees in core groups and psychoeducational modules in which they are nominally enrolled. MSOP states that "[p]oor group attendance can undermine group cohesion and a positive therapeutic climate." MSOP blames "clients' reactions to the [*Karsjens*] lawsuit, and an increase in staff vacancies. This amounts to blaming the actions on the cart rather than the horse.

In reality, disengagement by MSOP detainees in treatment is entirely due to their realization at long last that release does not follow treatment after any reasonable period. Consider again the facts that: (a) MSOP treatment continues on interminably over a period that even MSOP itself concedes requires, at a minimum, 9-10 years. In fact, however, the average period of treatment to declared "completion" is closer to 20 years. (b) There is no linear path in treatment; many treatment participants find themselves demoted to a lower phase or held back from advancement to a higher phase for trivial reasons or based on claims denied by the detainee. (c) Even those who ultimately complete such insanely over-length treatment are then relegated to a post-treatment program (CPS) with no reliable exit to release from confinement in any knowable, reasonably brief period, merely witnessing the rare, isolated few 'show releases' mentioned above, intended to fool judges, legislators, the media and the public – but fooling no one among MSOP detainees. This combination of deliberate design features ensures both a sense of hopelessness of release through treatment and an unquenchable resentment against those who, at every step, have barred the way and filled it with stumbling blocks.

Parenthetically, we note that MSOP cites "client unit representatives" who claim to embrace the notion of clinicians working in the best interest of MSOP detainees. MSOP fails to explain in this connection that these so-called "representatives" are hand-picked by clinical staff themselves as the only detainees eligible to take seats on such "representation" councils. Therefore, this is merely the utterances of 'trained seals' who seek to curry personal favor from staff by saying whatever will please staff. ONLY the Resident Advisory and Family Council (RAFC) is immune from this, since by virtue of our bylaws, anyone is eligible to be elected to the RAFC. Only RAFC can and will speak fearlessly and accurately. This document is evidence of such fearlessness.

In all types of treatment other than sex offender 'treatment,' therapy only lasts for periods of six months or less. Indeed, it is widely recognized that if a goal cannot be achieved through a regimen of therapy over such a short term, it simply cannot be accomplished regardless of how much longer therapy is administered.

Worse, it is equally universally acknowledged that longer periods of attempted therapy very quickly begin to have deleterious effects upon the patient. Periods of therapy that have experimentally been lengthened to two or three years have been observed to have profoundly adverse effects, including a complete undoing of all aims initially thought mostly achieved, and indeed such reversals that patients in such overly long treatment often wind up worse than they were at the outset as to the specific cognitive/emotional/behavioral problem sought to be remedied or palliated through treatment in the first place.

In the case of sex offender treatment, no treatment program outside of prison or commitment settings lasts longer than two years. There is no reason in psychological theory why treatment in confinement would require longer periods than this; the object remains the same. Even prison-based treatment programs are designed to conclude as to any given sex offender within no more than 3-4 years. Even most commitment programs as to sex offenders are based on treatment regimens intended to be completed by their detainees in not much longer periods than that.

Editorially, this lengthening to such multi-year periods in confinement environments appears to be solely for twofold goals: (1) to satisfy political masters who wish to impose the harshest, longest, and least endurable conditions of confinement and delayed release; and (2) an attempt to completely 're-create' each sex offender to be entirely someone else – a totally different persona – by the end of treatment.

The first of these goals will only instill extreme frustration and rage in the hearts and minds of those subjected to such inhumane programs against the creators and political patrons of them.

The second goal is a fool's pursuit. It is impossible to do so. There is no means to entirely eradicate one's persona and replace it with another persona. In the past, efforts at 'brainwashing' and regimens of massive doses of psychoactive drugs have only resulted in grave psychological damage, often requiring lifetime institutionalization due to resulting total debilitation of one's ability to meaningfully function. Attempts to achieve such impossible goals, repeated over extremely long periods, can only stir extreme resentments and ire on the part of involuntary treatment participants. In MSOP, by virtue of the parole requirement for treatment participation in MSOP, all MSOP detainees still on parole are, by definition, involuntary treatment participants under coercion.

The *Karsjens* lawsuit and other current federal lawsuits by MSOP detainees primarily aim to remediate these problems, or simply to end the MSOP program, as being incapable of change to any positive concept of equipping its detainees for reasonably quick release under a theory of acceptable level of unlikelihood of sexual re-offense. Thus, blaming the *Karsjens* lawsuit for the MSOP mis-design and outrageously endless duration of treatment (patently intended as a cover for permanent preventive detention) is contemptible garbage. It is an insult to the intelligence of MSOP detainees, of legislators, and of the public for the creators of this problem to make such an accusation.

Likewise, MSOP's problems due not arise from staff shortages. MSOP's inability to recruit and to retain clinical staff arise from this mis-conceptualization of what sex offender treatment should be, and mis-design of the treatment program, most especially its interminable length and lack of any relationship to exit from confinement within any reasonable period. We submit that recruitment and retention difficulties are due to awareness by psychologists and other clinicians of the unprofessional character of both "assessment" and treatment in MSOP. Unless and until this conceptual and design problem is cured, MSOP will always have this staffing problem, as ethical clinicians understandably refuse to have anything to do with MSOP's utter abomination unto forensic and clinical psychology.

12. Recent demands that MSOP detainees participating in treatment re-do old assignments are simply a means to get those detainees to provide concessions of 'deviance' and of lack of attempted control or lack of successful control (in the sense of declining to entertain deviant fantasies).

On page 5, the *Site Visitors' Report* states that in late 2015 every participant in the MSOP treatment program was directed to complete a set of assignments that had originally been assigned earlier (and which many participants filled out at that time). "The assignments included writing out a sexual offense history, one's "sexual history" otherwise, and a timeline of one's life," as well as various inquiries about one's family. This assignment was criticized by detainees on grounds that it was repetitious and because it was not individualized to any detainee.

However, more fundamentally, there has never been any explanation as to why yet another set of responses to these questions was now needed by clinical staff. Frankly, answers to such questions inherently involve discussion of any "deviant" sexual orientations one may have. Questions in this questionnaire require essay-like responses to questions discussing whether one feels that the respondent has tried to suppress such deviant orientations and, if so, whether any such efforts have been successful.

Of course, all sexual orientations are just that – orientations. By their very nature, they are not subject to eradication or to change, nor are they subject to conscious efforts at suppression. Yet merely for answering such a question with these immutable facts of human nature, one would provide claimed 'evidence' of 'dangerousness.'

The fallacy of such claimed dangerousness (apart from the infinitesimal recidivism rate for sex offenders discussed above) is that a surprisingly large portion of the human male population has experienced at least some level of attraction to prepubescent children of one or the other gender or both genders. Yet very few such males actually ever commit any sex crime with any child. Therefore, deviance simply does not equate to criminal "dangerousness."

Moreover, the concept of "lack of control," properly understood, does not refer to one's claimed ability to suppress any such deviant attraction. Instead, it alludes to whether, at the moment when presented with the unplanned opportunity to immediately commit a sex crime, one feels compelled to commit that crime on the spot, with no ability to engage in any process of rational decision-making as to whether or not to commit that crime. Only those who feel this state of compulsion and are forced internally to immediately act upon it can be said to lack "volitional control" in the psychological sense.

In reality, almost no MSOP detainees experience such a compulsive loss of self-control in the moment. Yet because of the misleading, far broader use of the term self-control by MSOP staff, MSOP detainees are likely to answer such questions in that broader sense of attempts to suppress that deviant sexual attraction altogether, and will admit the impossibility of doing so.

Ultimately, such answers -- about past sexual history, including past sex crimes; other relevant concessions about (1) one's childhood and later life, (2) the shortcomings of one's parents, and/or (3) one's failed past relationships with spouses, lovers, and others; odd paraphilic acts that one may have engaged in at any point; the fact and details of one's deviant sexual orientations and fantasies; and such statements about "control" (even though misunderstood by the responding detainee) -- will all be proffered to opponents of that detainee's release to use in that opposition. In effect, such an assignment is an insistence that one act as a witness against oneself in a court proceeding to try to gain release.

It should not escape note that this demand to re-do that assignment came with the threat that refusal to do so would be deemed grounds for treatment demotion and even as constituting refusal to participate in treatment (recall: a ground for revocation of one's correctional parole). Hence, these answers were given under coercion. Yet because a request for release from MSOP is not deemed a criminal proceeding in court, this self-incrimination under threat will probably not bar the use of such responsive statements by the detainee in question.

13. The so-called "Community Living Project" (based on the "STEP Program" in Canada) will result in conditioning one's right to one's property and one's existing rights on pleasing clinical staff, and thereby will further result in loss to many MSOP detainees of both property and current rights, and will be applied by decisions by certain appointed 'lap-dog' detainees, who will act out of personal spite and a motivation to please their clinical-staff masters.

The *Site Visitors' Report*, at page 5, introduces a "Community Living Project" in MSOP. This is described as an "alternative to the current privilege and disciplinary systems." In fact, it is a nightmare on rails for MSOP detainees.

This explanation declares that "client privileges within the program would be based on behavior not treatment level." While disciplinary BERs would not be entirely eliminated, under this project MSOP detainees picked by Clinical staff would decide what property and privilege reductions would be applied to an detainee guilty of some minor rule infraction.

Yet currently, most matters concerning allowable property are uniform for participants in all treatment phases. Certainly this is true as to all MSOP-ML detainees. So the change as to property is that an MSOP detainee's right to possess certain property that he already possesses will be curtailed if staff is displeased with his "behavior," or alternatively, if some panel of staff-fawning detainees decide that he is guilty of some minor rule violation and use that as an excuse to inflict punishment him by removing some item(s) of property from him. Having detainees decide these rule violation cases and additionally dispensing with the rights to a hearing and to an appeal about such violations, is the rankest violation of procedural due process imaginable, especially considering that property is at stake.

It is very difficult to believe that clinicians who should know full well that former prison inmates will not take kindly to making decisions about their property and levels of "privileges" (really, rights) did not realize the strife between detainees this so-called "project" is likely to engender. Previously, disciplinary decisions were made by security staff. Now they will be effectively ruled upon by Clinical staff, who also will decide what property and privileges one receives and can keep, on a purely *ad hoc* basis with no due process. This is a recipe for fulminating anger. It is an extremely dangerous idea, and it may in fact be a deliberate provocation to detainees.

14. The Site Visitors' proposal to allow "Bachelors' level staff to facilitate some psycho-education modules" is anachronistic; B.A. level personnel already facilitate both such modules and also core groups.

Right now, core group facilitators typically have no master's or doctorate degree in psychology. Any advanced degree in other disciplines is simply irrelevant. This is also true of almost all module facilitators. This is an outrage that has been in effect since the commencement of MSOP. This 'proposal' would appear to simply legitimize this arrangement. It is ill-advised. It is utter hogwash to assert that a non-professional with only a bachelor's degree can suffice in this clinical role.

15. The Matrix is unscientific and unworkable and must go.

The Matrix is a failed and unworkable hugely-over-complex and vague set of treatment concepts. It is a hodgepodge of intuition-originated ideas with no basis in science at all taken from many different sources. Clinicians are constantly uncertain how to score it, and almost invariably produce scores inconsistent with other clinicians as to the same detainee's group behaviors in the same session. This is why, after numerous training regimens in the Matrix, clinicians continue to ask for more training as to the Matrix.

Moreover, the fact that the Matrix has so many aspects, each requiring instruction and then behavioral practice, is the single most impactful factor causing MSOP treatment to be endless. Regardless of all posings at claimed intent to accelerate treatment, as long as the Matrix governs and guides MSOP treatment, such treatment will remain interminable and will be unable to complete satisfactorily. The Matrix simply must be jettisoned.

16. The Site Visitors' claim of "improved progress through the [MSOP] program" is irrelevant; a totally new, extremely abbreviated treatment program is required instead.

The *Site Visitors' Report*, at page 7, claims that the rate of progress through the phases of treatment in MSOP has increased. This has already been addressed above, concluding that the only true increase in such phase progression has been to fill beds in CPS. The fact remains that there is still no evidence that treatment is intended to achieve release for any detainee in any reasonable period of time after arrival in MSOP (that is, in 1-2 years, as opposed to the minimum 15-20 years that currently appears to be a de facto minimum period.

A totally different treatment program is needed to replace this unworkable program dependent on fulfillment of each of a series of 34 "matrix" goals that mostly appear to be about living something close to someone's idea of an 'ideal life.' Effectively, MSOP clinicians are merely playing an unrealistic game with detainees as 'Ken dolls' who can be pushed around at whim of the juvenile players. Freedom should not depend on satisfying someone else's views on living an ideal life. Refraining from committing sex crimes does not require any such artificial and arbitrary 'perfection', according to anyone's personal view.

A very abbreviated replacement treatment program is needed, focusing on education/indoctrination as to the immorality of sex crimes and the consequential psychic harms wreaked thereby, and secondly, on the unceasing array of law enforcement tools and expert personnel who will surveil and investigate each sex offender constantly once released, thereby preventing any intended sex crimes, and jailing the releasee for merely taking the very first step of preparation for such sexual misconduct. See Part 2 on this suggestion.

Part 2

The True Overall Picture of MSOP as a Failed Assessment and Treatment Program for Sex Offenders and as a Program for Deliberate Denial to Those Committed to MSOP of Their Constitutional Rights

1. The General Facts of MSOP's Long-Unremediated Circumstances and Practices Demonstrate beyond Question That MSOP 'Treatment' Is Not Aimed at Release at Any Reasonable Time.

Most therapists employed by MSOP lack advanced degrees in psychology, and thus are unqualified to provide treatment to sex offenders.

Other specifics of this illusory façade of purported treatment-toward-release include:

- deliberately sluggish treatment[1];
- 'patient' hold-backs and demotions;
- frequent treatment regimen replacements, requiring patient 'start-overs';
- the inherent impossibility of extinguishing deviant attractions;
- ill-conceived, failed attempts at 'brainwashing';
- refusal to acknowledge any "meaningful change" despite successful treatment completion;
- lack of more than a few 'show' releases through treatment (4 of 780 currently, including deceased detainees);
- duration of confinement through old-age to death; and
- insistence on an unattainable 'zero-percent recidivism risk' "public safety guarantee" before granting release,

all present an undeniable overall revelation of a commitment scheme intent on natural-life preventive detention, with only the sheerest gossamer veil of claimed treatment, in reality not in earnest or even merely good faith. Unquestionably, that sole realistic goal of preventive detention shows the undeniably punitive aim and function of SPP/SDP commitment.

As shown through these facts, the reality of MSOP operation is:

(a) to sluggishly conduct over the course of a decade or more treatment that could be accomplished within one year;

(b) to invent excuses to demote those in treatment to a lower level of treatment attainment and to alternatively retain those in treatment in the treatment phase or module already completed;

(c) to disqualify from treatment (and thereby from release) all those who deny the commission of a given alleged sex crime; and

(d) periodically (but before any appreciable number of committed sex offenders can complete the prescribed regimen of treatment) completely replace that regimen with a different regime as discussed above), thereby forcing all treatment participants to start over in that next decade-long replacement treatment regimen.

---

[1] In its January 2011 report to the Minnesota Legislature: "Options for Managing the Growth and Cost of [MSOP]: Facility Study" (hereinafter, the "MSOP Report") MSOP boasts that it offers "the longest treatment durations," apparently as a goal in and of itself. (Id., p. 9). This supports the inference that, as its goal and that of the legislature to which it addressed that statement, MSOP intends to keep its detainees confined for as long as possible.

2. MSOP 'Therapy' Includes Numerous Counterproductive Practices.

MSOP 'therapy' includes, and often is based on numerous counterproductive treatment practices by therapists. These practices confuse treatment participants and interfere with their progress through the "phases" of such treatment. These practices also have psychologically harmful/'toxic' impacts upon the minds of such treatment participants. Among these practices are the following, as described in *Terence Campbell & Demosthenes Lorandos, Cross-Examining Experts in the Behavioral Sciences*:

- The 'Blame-and Change' Maneuver[2]
- Victims, Villains, and Saviors[3]
- Strengths vs. Deficits[4]
- Long Term Therapy or the 'Clinician's Illusion'[5]

3. MSOP Engages in Experimentation Rather Than Scientifically-Based Treatment.

MSOP detainees are not given treatment, but instead merely a never-ending series of experiments without informed consent, or even merely notification. These experiments, in turn, are not based on any valid scientific understanding of the nature of sexual orientations and of sexual desire, but to the contrary, such experiments are founded only on *a priori* concepts declared by sheer *fiat*. This has gone on for the entire existence of MSOP. Each new experiment replaces its failed predecessors and results in each participating detainee being ordered to start the new regimen from scratch, in some cases even after 20 years of such repeated experiments. This course of repetitive regimen replacement has prevented MSOP detainees from ever being able to complete treatment 'successfully' and to show thereby that their recidivism risk has been reduced to the 'very low levels' demanded by MSOP staff.

---

[2] Therapists suggest to clients that treatment must 'blame your family' in order to 'change you.'

[3] Clients frequently come into treatment expressing allegations and complaints about people close to them. These allegations and. Seeking the client's loyalty, therapists often Therapists endorse clients' complaints directed at spouses, siblings, or parents, causing the client to begin to think of these people with whom the client is disaffected, to some degree, as villains. This often leads to the client assuming the role of a beleaguered victim; and the therapist evolves as an altruistic savior, assisting the client to contend with the villains of a 'toxic family.'

[4] Therapists 'prime' their clients for analyses of their supposed deficits in great depth and detail. Therapists exercise priming effects via leading questions and other suggestive influences. Therapists lead clients into biased searches for their deficits and shortcomings. Simultaneously, therapists overlook their clients' strengths and resources. These biased searches then leave clients more discouraged and pessimistic via mood-congruent memory effects influencing how clients think about themselves and their life situations.

[5] Treating therapists characteristically view clinical disorders as more severe than they actually are. Their views in this regard lead them into overestimating the duration of treatment necessary to assist clients. Relevant research demonstrates that treatment of longer duration is not associated with better outcome.

4. MSOP Intends to Never Release Any Significant Number of Its Detainees.

In 2011, MSOP administrators declared that no releases were anticipated for the foreseeable future. MSOP's projected number of detainees in 2020 is based solely on current rates of commitment, with no deduction for any projected releases. In the absence of any projection or anticipation of releases in any of the next seven years, it is clear that MSOP is utterly disingenuous about treatment in MSOP as a path to release.

5. MSOP's Attempts to De-Condition Deviant Sexual Arousal Are Inherently Doomed in the Long-Term to Failure and Further, Have Nothing to Do with Recidivism Probability.

M. Hamilton, 'Adjudicating Sex Crimes as Mental Disease,' 33 *Pace L. Rev.* 536-599, 546), succinctly summarizes: "...[P]araphilias generally appear in early adolescence, are relatively stable, and are considered rather immutable – paraphilia conditions as evidently incurable, ...that would not go away with time."

In reality, regardless how socially feared and loathed a sexual attraction pedophilia is, for example, it is simply a sexual orientation. As such, it cannot be dispelled or converted to adult heterosexuality or homosexuality. Hence, it is more intellectually honest to refer to it as "pedosexuality." No "treatment," regardless of length or intensity – not even brainwashing, can ever extinguish heterosexuality or homosexuality, or convert one to the other.

Why then would anyone expect otherwise of pedosexuality? Treatment cannot convert sexual interests; therapy to redirect sexual attraction away from children toward adults has fared no better with pedophilia than it has with same-sex attraction. *M. Seto*, *Pedophilia and Sexual Offending Against Children* (2008), at 175-76; *Alice Dreger*, "What Can Be Done about Pedophilia?", *The Atlantic* (Aug 26, 2013, 9:42 AM), http://www.theatlantic.com/health/archive/2013/08/what-can-be-done-about-pedophilia/279024/ ("We have not yet found a way to convert pedophiles into non-pedophiles that is any more effective than the many failed attempts to convert gay men and lesbians into heterosexuals."). Thus, there is no 'cure' for pedosexuality, nor any instances to date of such 'cure' – anywhere. In this sense, it is not a 'treatable' personality/emotional/sexual malady. See *Margo Kaplan*, "Taking Pedophilia Seriously," 72 *Wash. & Lee L. Rev.* 75, 104-105 (Winter 2015); and *Thomas K. Zander*, "Civil Commitment without Psychosis: The Law's Reliance on the Weakest Links in Psychodiagnosis," 1 *Jour. Of Sexual Offender Civil Commitment: Science and the Law* 17, at 37-38 [2005]) on this point. Yet the "Deviant Sexual Interests"/"Sexually Deviant Interests" targets in the MSOP treatment "Matrix" (*MSOP Report*, Appendix C, p. 31) necessarily imply that a pedophile would have to prove that he no longer has pedosexual attractions, in order to show "meaningful change" to qualify for release.

6. MSOP's Demand for 'Admission' of Denied Adjudicated and Unadjudicated and Merely Generally Suspected Offenses Thwarts Treatment and Is Used to Deliberately Prevent Release.

"Treatment" within MSOP, in which those committed under said *Act* are detained, requires that a given committed sex offender "admit" each sex crime which MSOP officials believe that the offender committed. This requirement is enforced: (1) as a condition to further participation in such treatment and to advance through the respective "phases" and "modules" of that treatment regimen; and (2) by means of demotion of that sex offender to a less-advanced phase or module as punishment for declining to make such admission. This applies to hearsay and to uncharged accusations and to mere general suspicions of non-reported additional crimes categorically, as well as to convictions of each offender.

The scientific reality is that "...Contrary to what is commonly assumed, those sexual offenders who denied their offenses were no higher risk [of sexual re-offense] than other offenders." *R. Karl Hanson,* Predictors of Sexual Offender Recidivism: A Meta-Analysis, 1996-04 (*Public Safety and Emergency Preparedness Canada*), p. 12. Therefore, this insistence upon admission by MSOP is scientifically baseless. Worse, it turns the therapeutic relationship into one of interrogator versus suspect. Moreover, because refusal to admit such additional charged, uncharged, or unknown claimed instances of sexual crimes is used by MSOP as a ground for denial of treatment advancement, and even for treatment demotion, such refusal leads to extension of the time needed to complete treatment, in turn preventing release from MSOP.

7. MSOP's Misuse of Polygraphy and of Penile Plethysmography Thwarts Treatment and Deliberately Prevents Release.

Howard Zonana, et al., *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association* (1999), at p. 156, flatly declares, "There are three objective means of determining sexual interest in sex offenders: penile plethysmography, visual reaction time assessment, and polygraphs.... None of the three methods provides a level of validity that meets any of the prevailing standards required for admissibility in court as scientific evidence." Note that each of these three methods is in use in MSOP. Analysis of each of these methods follows.

a. Reliance upon the Junk-Science Tool of Polygraphy of Proven Unreliability at Measuring Deception.

MSOP refers a given 'treatment' participant under consideration for either phase advancement or demotion to a visiting polygraphist. Any detainee declared to be deceptive in any regard by the outcome of that polygraph examination will be subjected to adverse action (whether denying advancement or imposing a demotion to a lower treatment phase).

This type of polygraph testing is almost invariably "multiple-issue" utility testing," which the American Polygraph Association regards as an unprofessional misuse of polygraphy. According to leading experts in polygraphy, this 'dragnet' method of polygraph misuse is no more accurate than pure chance, and actually invites errors.[6]

Where release from commitment and treatment advancement and demotion decisions inherently effect the course of the rest of the detainee's life, such unscientific reliance on such unreliable testing is unconscionable as nothing more than a modern-day 'witch-finder's tool.'

Treatment staff place implicit trust in polygraph results despite its gross inaccuracy, especially as to false positives.

As to the progression to Phase 3, a "full disclosure polygraph" must also be taken "to verify an agreed-upon sexual history." (*MSOP Clinician's Guide*, p. 15).

However, as to both maintenance and full-disclosure polygraph tests in MSOP, the polygraph result must indicate no deception as to each relevant question. Even an "inconclusive" outcome on any such polygraph is not sufficient and is taken as a sign of deception in answering. In the *Karsjens* trial, Dr. Elsen testified that, to her knowledge, no treatment participant has ever been advanced from Phase II to Phase III who had not passed the full disclosure polygraph. (Trial Tr., v. 7, p. 1349). Note that, in the case of detainees in the "alternate" treatment program are subject to "a determination by the polygraphers whether or not a client is able cognitively to take a polygraph exam." In the event that a given alternate program participant cannot do so, no polygraph is given, and the given alternate participant cannot progress to Phase 3. While the *MSOP Clinician's Guide* permits advancement in exceptional situations where the requirements (including polygraph passage) are not met, Dr. Elsen testified that this had never been done with any treatment participants under her supervision. (Elsen testimony, Trial Tr., v. 7, p. 1375-76).

Close attention should be paid to the notorious "false positive" inaccuracy of polygraph testing generally. Many MSOP treatment participants who have taken such polygraph tests complain that the claimed deceptive outcome is incorrect. It appears that such polygraph 'tests' are mere ruses for interrogation purposes, with no actual 'result' being derived through

[6] Noted polygraph expert Kenneth Blackstone, in "BNA Insights, Sex Offenders: Post-Adjudication Polygraph: A Discussion of the Science and the Law," 90 Criminal Law Reporter, No. 9, pp. 306-08 (2012), declares that the 'dragnet' manner of such polygraph misuse is no more accurate than pure chance (50-50%).Thus, a sex offender can easily be mis-assessed as lying, when in fact he is telling the truth.

professional analysis of the polygraph charts.[7] Despite this shocking failure of polygraphy in the nervous-reaction context of sex offender treatment, Dr. Pascucci admitted that such polygraph results are considered in assessment as to provisional discharge (Trial Tr., v. 8., p. 1657).

The most common method of polygraph testing sex offenders in sex offender treatment is this 'dragnet' use of multiple relevant questions. Extensive research has consistently found that this kind of polygraph testing achieves only a chance level of accuracy (55%) among innocent subjects. In other words, in the sex-offender treatment-in-commitment context, over half of the time this test falsely indicates deception where there was none. This wrongly causes the examinee to suffer consequences that commonly include treatment level demotion or refusal to promote to the next level, with delayed release implicit. This figure was derived from dry experimentation outside that context. Hence, this does not include the error-compounding factors of intense nervousness (common among sex offenders in such tests), 'outside issues' contamination (also very common in that specific context), and examiner 'contamination bias' and 'confirmation bias' (ib*id.*).

Both 'maintenance' and 'monitoring' exams involve broad questions (at least, at first), to serve as a vague 'dragnet ' as to any crimes or rule or treatment violations. (*Id.* p. 15)

Additionally, a 'Stimulation Test' and a 'Silent Answer Test' are also frequently performed by polygraphers in sex offender commitment contexts. (*Id.* p. 6) These are used as pure interrogation devices. In the first, the examinee is subjected to a range of assertions about a past fact. This test betrays a significant psychophysiological response when a choice among those assertions is mentioned that reflects a guilty truth. (Example: "Did you commit any act of sexual abuse of a child in – 2005? – 2006? – 2007? - 2008?", etc.) This is self-incrimination by an unintentionally communicative bodily response – a phenomenon parallel to interrogation under sodium pentothal stupefaction. The Silent Answer Test works on the same 'recognition' principle, effectively acting to the same degree of accuracy (or claimed accuracy) as if the examinee had verbally answered the "relevant question" asked. Thus, effectively, one cannot avoid 'answering' polygraph test questions by remaining silent. Both of these types of polygraph test therefore have extremely troubling implications as to deprivation of one's right to remain silent, both under the First and Fifth Amendment.

The observations of *Dr. Berlin*, in his *Report to Schiff Hardin & Waite* (etc.), at pp. 13-15, as to polygraphy misuse in sex offender treatment, particularly in the commitment-confinement context, are both astute and specifically applicable to such misuse in MSOP:

---

[7] For instance, *Dennis M. Doren, Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond* (Sage Publns., 2002) explains at p. 47: "The actual utility of polygraph assessments for civil commitment is ...in the contents of the pre- and post-testing interviews of the subjects. It is during those interviews that many subjects disclose information not otherwise recorded." NYS DPCA *Research Bulletin 3: The Use of the Polygraph*, at p. 3, candidly admits that post-test questioning is 'crucial' 'because it offers the offender the chance to explain deception or confess to behavior that heretofore had not been disclosed.' Faced with an assertion (whether true or false) by the examiner that the test result indicates deception, many tested sex offenders make self-incriminating admissions at this point. Page 12 includes the boast that obtaining such admissions ("truth facilitation") is a core purpose of such testing, as is providing information from such test responses to the supervising agent (in the case of probation or parole), where such agents can decide to seek parole revocation based thereon, for instance – an obviously criminal-case application, regardless that it may arise in a sex offender commitment context.

"...[O]ne cannot complete the second phase of treatment without first passing a polygraph examination. In order to pass, the results cannot ordinarily be either equivocal or suggestive of deception. Thus, failure to 'pass' the polygraph can represent a potential permanent roadblock to the successful completion of treatment.

"...[U]se of the polygraph can also run the risk of contributing to a 'we versus they' mentality between patients and their treatment providers, potentially undermining the development of a positive doctor/patient relationship.

"...Some patients may falsely admit to prior offenses if they feel that they 'need to play that game' by falsely disclosing significant numbers of past bad acts, because they have begun to believe that that is the only way that they will be able to progress through treatment. ...[A] recent review of the polygraph by the prestigious National Research Council cautioned that use of that technology is far from infallible. As with any technology, there can be both false positives (in the case of the polygraph, the appearance of lying when none is present), and false negatives (the appearance of a truthful response in the face of deception). I know of no evidence that shows that polygraph testing, when used as an ancillary tool in the treatment of sex offenders, has been shown to lower the subsequent rate of future recidivism,....

"...For the program to attribute to [polygraphy] sufficient weight that it can act, in effect, as a potential permanent roadblock to progression through ...treatment, in my professional opinion, represents a substantial departure from accepted practice, judgment, and/or standards in the field of inpatient mental health treatment.

"Finally, ...it is important to note that treatment should not be turned into an ongoing debate about past guilt or innocence Such matters are often best resolved in a court of law, rather than through a therapy session. Occasionally persons are falsely convicted Sometimes the observations of past victims, or past hearsay, may not be entirely accurate. Polygraph testing can sometimes be suggestive of deception when none is present. The primary purpose of therapy is to try to ensure that there will be no future bad acts. ..[I]t is not always necessary, or perhaps even possible, to try to establish 'guilt or innocence' regarding each and every alleged prior bad act in order to successfully treat sexual offenders. The thrust of treatment needs to focus instead on what each treated individual must do in order to safeguard both the future interests of society, as well as his own future success. In my professional opinion, debating, perhaps indefinitely, potentially irreconcilable accusations and denials, does not represent a form of good, or even psychiatrically acceptable, treatment. To the extent that that may be how certain aspects of therapy are being conducted, in my professional opinion that represents a substantial departure from accepted practice, judgment, and/or standards in the field of inpatient mental health care."

Again, these observations fit the current situation in MSOP precisely. Treatment advancement is arrested, and a phased demotion often imposed, simply because a polygraph result for the treatment participant in question indicates deception or is inconclusive. Thus, even such inconclusive results are effectively treated as indications of deception. In either case, such results are treated as an irrebuttable presumption of the truth of the adverse information inquired about, whether as to some past alleged crime or some current type of misconduct merely part of a 'checklist' without any previous reason for suspicion. As Dr. Berlin conveys, neither the particulars of one's former criminal record nor whether one is in compliance with every

institutional rule have anything to do in reality with success in treatment or with one's ability and motivation to live a law-abiding lifestyle upon release.

The unwillingness of MSOP administration to authorize a polygraph exam for those detainees who deny their current offense and request one, even though (for litigation show-purpose only) the MSOP rule on polygraphy appears to authorize such exams, shows that MSOP staff and administration themselves do not actually believe in the scientific accuracy of polygraphy. This makes their claimed reliance on polygraph outcomes in such treatment advancement-denials and such demotions knowingly baseless, and hence blatantly sadistic.

Maas, *supra*, at pp. 1261-62, explains this application of polygraphy by MSOP:

> "The questionable validity of polygraphy has been known for decades and polygraphs have never been widely accepted among scientists. Their use by clinicians in SPP/SDP retention decisions is therefore curious.
>
> "Even if polygraph reports are to be believed, they are not so reliable that they can be validated. For example, even if collateral information conflicts with the polygraph results, failure of a polygraph is still an absolute block to discharge. The practice of requiring such an exam serves no purpose other than creating another reason for preventing discharge."

b. MSOP Misuses Penile Plethysmography and 'Abel Testing' Without Scientific Basis and in Defiance of the Inescapable Fact of Immutability of Sexual Orientation to Thwart Treatment Progress and to Prevent Release.

When Phase 2 is completed, "a PPG or Abel/ABID assessment" must be taken, and the results of these tests must be "address[ed] ...in treatment." Like the polygraph outcome, a satisfactory result on the PPG/Abel assessment, reflecting no deviant arousal or at most only very low deviant arousal, is required to advance to Phase 3. Also unstated here, the PPG is the test primarily relied upon, with the Abel/ABID test being administered only when a failing outcome is reported from the PPG.

Howard Zonana, et al., *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association* (1999), at p. 58, bluntly explains:

> "...[L]aboratory responses cannot be used to predict or validate behaviors outside the laboratory. Each of us, at times, has arousal that, if we acted on it, could be quite problematic. Having arousal, be it paraphilic or non-paraphilic, does not mean that we necessarily act on that arousal. Plethysmography results are frequently used inappropriately in making judgments regarding the veracity of an individual's claim that he did or did not participate in paraphilic behavior outside the laboratory. However, irrespective of the desires of plaintiffs and defendants in such cases, plethysmography cannot provide definitive answers to such complex questions. As a result, it is considered inappropriate to use plethysmography measures to argue the issue of the veracity of an individual's statement regarding his previous behavior."

As it happens, the test scorers of the PPG test claim a substantial portion of test subjects show such sexual arousal, casting such test scoring into serious doubt. Once again, many current and former treatment participants report that the claimed failure result of the PPG test is incorrect, based on the fact that no penile arousal actually occurred during the test, but was the claimed basis for alleged failure.

MSOP makes considerable use of plethysmography and of the Abel assessment of sexual interest. Each of these tests also has accuracy/reliability problems and is subject to operator manipulation of test results. Beyond this, even were results of these tests accurate and reliable, they focus on the wrong thing. Basically, for instance, a committed pedosexual/pedophile whose test results reflect that orientation will never be released by MSOP because that sexual orientation is permanent. That is not treatment; it is permanent condemnation. The real question, for public safety purposes, obviously ignored by, and unanswerable by such testing, is whether, if released, a given pedosexual/pedophile will or will not commit further sex crimes.[8]

The Abel/ABID 'test' merely shows the test subject images and asks that each be rated as to its sexually arousing effect on the subject. Because nothing prevents the subject from lying, this test is scored subjectively, with the test scorer simply deciding whether these answers strike the scorer as consistent with other evidence, including the polygraph result. Thus, this is simply a subterfuge for again relying on the polygraph result without overtly so admitting. As a separate point, many who have taken the Abel/ABID 'test' complain that such subjective opinions are only that, and have most often been as utterly incorrect as a sheer guess.

In sum, the prevailing opinion among MSOP treatment participants in Phases 2 and 3 is that clinical staff simply privately decide *a priori* whom they wish to promote from Phase 2 to Phase 3, and then set about amassing falsified 'evidence' to support that decision either way.

Howard Zonana, et al., Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association (1999), at p. 156, concludes that, of penile plethysmography, visual reaction time assessment, and polygraphs, none of them provides a level of validity that meets any of the prevailing standards required for admissibility in court as scientific evidence.

Beyond this, even were results of these tests accurate and reliable, they focus on the wrong thing. Basically, for instance, a committed pedosexual/pedophile whose test results reflect that orientation will never be released by MSOP because that sexual orientation is permanent. The real question for public safety purposes, obviously unanswerable by such testing, is, as Dr. Berlin suggests, whether if released, a given pedosexual/pedophile will or will not commit further sex crimes. Since a pedosexual will always retain that orientation, he is forever preordained by MSOP to fail treatment. That is not treatment; it is permanent condemnation. All pedophiles will remain confined in MSOP until death, if MSOP continues to decide the issue of release. This is the very heart of preventive detention.

---

[8] In United States v. McLaurin, 731 F.3d. 258, 264 (2d Cir, 2013), a release condition of plethysmography was struck down, the Second Circuit declaring that "the [penile] plethysmographic condition does not bear adequate relation to the statutory goals of sentencing to outweigh the harm it inflicts, that it involves a greater deprivation of liberty than is reasonably necessary to serve any of those statutory goals, and that it may not, consistent with substantive due process, be imposed on [the defendant]."

8. MSOP Employs Undefined, Unspecific "Matrix" Standards to Justify Overly Conservative, Subjective Evaluation by Clinicians That Deliberately Thwart Treatment Advancement and Prevent Release.

Since 2009, MSOP has relied on a 'treatment Matrix' to purportedly assess detainees' needs and progress in treatment. Before that they were not used in MSOP. No other sex offender commitment or treatment program uses this 'Matrix.' (*Karsjens* Tr. 2745: 22-25, PA 894; Tr. 1026: 4-9, PA 743; Tr. 2221: 12-14, PA 870; Tr. 2747: 21-24, P.A. 895.) For years, outside experts have warned MSOP executives and staff that there was confusion over how to apply the Matrix factors, inconsistent application of those factors, subjective application among evaluators (exacerbated by staff turnover), and that the required Matrix factor scores for phase progression were too high. (*Karsjens* Doc. 658 at 37-38; PX 184 at 75, PEXB 195; PX 46 at 5, PEXB37; PX 43 at 2, PEXB21; PX 184 at 4-5, PEXB47-48.) Because the Matrix factors constitute the fundamental basis of the MSOP's treatment and are an essential component in phase progression (Doc. 658 at 31; PEXB423-424), all Plaintiffs suffered injury resulting from the inconsistent, misapplied matrix factors because MSOP requires that Plaintiffs reach Phase III before it will support a Plaintiff's reduction-in-custody petition (Tr. 1210: 6-14; PA 749). Yet treatment 'Matrix' standards are undefined or ill-defined, lack specific examples of application, and are highly subjective. Many therapists report that the Matrix is not being uniformly applied and that standards for interpreting the matrix are lacking, allowing a wide range, from impossible-perfection standards to very lenient standards, from one therapist to the next.

A mere glance at some of the factors used in various 'behavioral areas' of the Matrix confirms this subjective vagueness: "negative social influences," "poor self-regulation," "general hostility," and "antisocial attitudes and behavior."

The undefined, unspecific Matrix standards used by MSOP ostensibly to judge treatment progress "allow for overly subjective evaluation by clinicians" in MSOP. (*OLA Report*). In most cases, these Matrix standards have been employed to thwart treatment progress, rather than to promote it.

In its Findings of Fact, Conclusions of Law and Order dated June 15, 2015 in *Karsjens et al. v. Jesson [now Piper] et al.*,, the federal Court has already rejected the scientific validity of the so-called "Matrix Factors" in use in MSOP, observing that they "are not used by any other civil commitment program in the country" In this connection, Judge Frank concluded that:

> "The Court has already concluded that the MSOP "treatment program's structure has been an institutional failure and there is no meaningful relationship between the treatment program and an end to indefinite detention." (*Karsjens et al. v. Jesson et al.*, Conclusion of Law 35).

Again, although this conclusion by the Court sounds definitive, its effectiveness in practice is weighted down by the fanatical adherence by MSOP administrators and clinical

supervisors to the unspoken concept that treatment of committed sex offenders 'should' take a long time, on the tacit belief that, to render any MSOP detainee "safe" for release, he must utterly be 're-made' as a different persona than his own. It is this belief, never laid bare, that is behind the decades-long detention and treatment of MSOP's detainees, compelling them to satisfy the Herculean requirements of a practically endless series of "Matrix" "goals" before administrators will consider an individual's release. This is the vehicle by which each treatment-participating MSOP detainee is denied "completion" of treatment over countless years, until they simply give up. It is deliberate and cruel.

Finding 82 by Judge Frank in *Karsjens* elegantly observes that "[t]he Matrix factors are not used by any other civil commitment program in the country." (Confirmed by Dr. Freeman's testimony, *Trial Tr.*, v. 5, p. 1026; accord: Ms. Hébert's testimony, *Trial Tr.*, v. 17, p. 3922). MSOP's use of these Matrix factors as it does has never been validated on a sex offender population. *Id.*, v. 5, p. 1026. Accord: Darci Lewis testimony, *Trial Tr.*, v. 7, p. 1448.

Note also Dr. Miner's testimony as to the Matrix:

> "Q. Let's talk about the Matrix factors. Do you take any issue with the Matrix factors scoring guide?
>
> "A. Yes.
>
> "Q. And tell me about that.
>
> "A. Well, the Matrix factors scoring guide doesn't meet minimal requirement for a psychological test as promulgated by the joint APA-AERA Guidelines for Psychological and Educational Testing. It doesn't include a lot of information that would be required in a guide or in a manual....
>
> "It's been criticized for being unreliable..." (*Trial Tr.*, v. 6, pp. 1183-84).

More pragmatically, Dr. Cauley testified that the Matrix factors at MSOP are:

> "...sort of an in-house tool that was developed by members of the -- employees at the facility. It serves a purpose perhaps of simply being – I wouldn't say treatment progress, but it's almost like a checklist of really how somebody is participating in treatment. Okay? So it's a lot of 1 to 5 ratings of things like attending groups, participating in group, that kind of thing. But it's unique to the Minnesota program. It's not used anywhere else. And it doesn't serve a larger purpose of assessing risk." (*Trial Tr.*, v. 10, p. 2221).
>
> "[The Matrix is] not tied to the initial risk. It's used for everyone in the same way and it doesn't start its hinging on likelihood of re-offending or risk for future sexual violence. It's just simply a checklist where you score 1 to 5 on the items. The items tend to be subjective and vague. And through my record review, that awareness has been going on for a long, long time, that there are concerns with the item, there's concerns about the reliability of scoring the Matrix, there's concerns about staff training related to the matrix that have been going on for at least six years. And there's been a continued offer to resolve it through new training and then the next year the same problem arises.
>
> "Q. ...[W]hat studies have been done of the Matrix factors system?
>
> "A. There haven't. Matrix is unique to this program. It was developed by this program." (*Id.*, pp. 2224-25).

MSOP Executive Clinical Director Jannine Hébert testified that, with respect to the way MSOP uses them, "there's no best practices with regard to the matrix factors specifically." (*Trial*

Tr., v. 12, p. 2767). Effectively, this means that any way that MSOP chooses to use Matrix factor scoring is deemed by MSOP clinical leadership as perfectly acceptable despite the utter lack of any scientifically accepted protocol for such use.

At *id.*, p. 2768, Ms. Hébert admitted the lack of research into Matrix factor scoring:

"...It's not designed as a tool to be researched.

"Q. My question is yes or no. Have you done any research about whether the matrix factors that you use at MSOP effectively measure treatment change?

"A. Could you define research in that question?

"Q. Sure. Have you done any studies?

"A. Studies? No.

"Q. Okay. Have you done any analysis of a statistical nature?

"A. It doesn't lend itself for that kind of research, no.

"Q. So the answer is no?

"A. No.

"Q. Have you done any interrater reliability studies with respect to how the Matrix factors are scored?

"A. No.

"Q. Are you aware of anyone who has done any interrater reliability studies with respect to the Matrix factors?

"A. I don't know who else uses the Matrix factors, so no. (*Trial Tr.*, v. 12, p. 2768).

Hébert admitted in testimony that MSOP's Matrix factors and their usage are under "extreme criticism":

"Q. Under extreme criticism from whom?

"A. To the extent that they were -- they have been part of the 706 comments and previous auditors' reports. I don't know specifically what extreme criticism was referring to, but it was pretty public that people were having opinions about Matrix factors.

"Q. Well, this is before the 706 report, so it can't be them, right?

"A. Oh, then it isn't.

"Q. Right, so it has to --

"A. It was in previous auditor's reports for sure, yes.

"Q. Sure. It was in previous auditor's reports several times years before, right?

"A. In different forms, yes.

"Q. Sure. "Extreme criticism" is what you call it here right?

"A. That is what I say here, yes." (*Id.*, pp. 2768-69).

In Findings 83-86, the Court determined that MSOP clinical staff has experienced substantial confusion and inconsistencies in the use and application of the Matrix factors, with Matrix factors scores fluctuating at changes in clinical staffing, such that a lack of inter-rater reliability is presented. (D. McCulloch testimony, *Trial Tr.* v. 1, pp. 82-83.) Dr. Vietanen put it more bluntly: "...[T]here isn't any inter-rater reliability in Matrix scoring." (*Trial Tr.*, v. 10, p. 2327). Dr. Nicole Elsen conceded that scoring of the Matrix factors is somewhat subjective. (*Trial Tr.* v. 7, pp. 1347). Dr. Elsen also admitted that she had, at various times, directed the clinicians under her supervision in MSOP to lower a given treatment participant's Matrix scores,

and that such scores were in fact lowered at her direction. (*Id.*, pp. 1347-48.) Yet Dr. Elsen has never approved phase advancement of any MSOP detainee who has not met the Matrix goal requirements for such advancement. (*Id.*, p. 1348).

"Haaven, et al., 2012 and an expert panel that reviewed MSOP client records in February 2013 that included Haaven, et al., and additional experts noted problems with the reliability of clinicians' ratings of the Matrix used by MSOP...." (*706 Experts' Report*, p. 33, quoted at *Trial Tr.*, v. 3, p. 535.) Dr. Vietanen agreed that there is "no apparent interrater reliability" as to use of Matrix factors. (*Trial Tr.*, v. 10, p. 2303).

Ms. Todd-Bense, at MSOP--St. Peter, stated in an email that a lack of consistency exists as to Matrix scoring, particularly between treatment staff at St. Peter, compared to at Moose Lake. (Hébert testimony, *Trial Tr.*, v. 12, pp. 2789-90).

Yet despite such observations and critical reports by external reviewers, MSOP has not investigated how clinicians are scoring the Matrix factors or what, if any, level of consistency exists in scoring Matrix factors. [*Trial Tr.* v. 1, pp. 90-92] Until 2014, MSOP did not provide training to all staff on the Matrix factors and their scoring. Not stated in these findings is whether such training has had any impact on accuracy and consistency of such scoring. Inconsistent scoring on Matrix factors can slow treatment progression.

Dr. Wilson, *Trial Tr.*, v.3, . 536, concludes: "...[U]ltimately, we also need to have some sense of just exactly whether or not this tool [i.e., the Matrix] is telling us or doing what it's intended to do. And this speaks to the actual validity of the tool, and I'm not aware of any scientific investigation that's been done on this tool to establish what its reliability is or its validity. And unless you know those two things, how do you know what the tool is doing?" The Matrix "was just implemented without really knowing exactly what it was that it was measuring, or whether or not that was being measured consistently. This is a serious problem with respect to the psychometric ability of the tool." (*Id.*, p. 537). The Matrix factors and the related scoring manual were developed by the MSOP or by someone under contract to the MSOP. (*Ibid.*).

9. MSOP's Misuse of "Dynamic Risk" Is Simply Excuse-Making to Commit and to Keep Detained.

Conceding that the 'static' actuarial approaches of ARA had proven inaccurate, the the January 2011 report to the Minnesota Legislature: "*Options for Managing the Growth and Cost of [MSOP]: Facility Study*" (hereinafter, the "*MSOP Report*"), trumpets a more recent emphasis on "dynamic risk" assessment techniques. However, this discussion ignores all of the aforementioned "protective factors that reduce recidivism likelihood." Instead, it only refers (at p. 10) to negative "dynamic risk factors" that "are associated with risk for reoffending," redefining such factors as being comprised of "psychological vulnerabilities or mechanics" that "significantly increase risk for reoffending." This contravenes the actual forensic literature,

which describes "dynamic" risk factors as all things, whether internal or external, or whether deliberately altered by an individual offender or instead simply either spontaneous or inexorable (such as the effects of middle- or old-age on libido).

It appears that the *MSOP Report*'s emphasis on this distorted mis-definition of "dynamic risk factors" as being an individual's purported "criminogenic needs" is a desperate attempt to redefine the overall rationale for sex offender commitment. MSOP thus spins dynamic factors as being evils particular to each sex offender, such that something terrible and ominous can be said against each one both in commitment cases and in petitions by any committed sex offender for release/discharge.

The sole dynamic risk tool used by MSOP, the Stable-2007, is widely criticized for its subjective and open-ended criteria judgment standards. Dynamic risk factor application in general is open to a vast sea of differing interpretations. Further, the statistics behind use of each specific dynamic risk factor are notoriously unstable; different researchers have reached opposing results about almost all such dynamic factors. Dr. Pascucci conceded: "...[T]here's some qualitative assessment, so I guess some subjectivity." (*Karsjens* Trial Tr., v. 8. p. 1676).

Among the vague and subjectively assessed factors in the Stable-2007 are these: lack of concern for others, impulsivity, poor problem solving, hostility towards women, and negative emotionality. (*Id.*, p. 1677). *State v. Michael Regan*, Opinion, No. 10-E-64, 2011 N.H. Super. LEXIS 110 (New Hampshire Superior Court, N. Dist. Of Hillsborough County, Apr. 12, 2011), at p. 12, adds mention of these additional factors on the Stable-2007: absence of significant social influences, a lack of capacity for relationship stability, emotional identification with children, feelings of general social rejection, sex drive/preoccupation, sex as a coping device, deviant sexual preference, and the extent of cooperation with supervision. In addition to the uncertainty as to the presence of each of these factors, just what, if any, relationship exists between most of them and sexual offending is utterly unclear and completely unproven. It is simply a list of 'guesses' at recidivism factors. While some might apply to rapists of adult women, it seems intuitively clear that those same factors (e.g., hostility toward women) have nothing to do with sexual recidivism as to pedophiles. Dr. Pascucci admitted that the Department of Human Services had never conducted a study of application of the Stable-2007 as to inter-rater reliability. (*Id.*, p. 1678).

Moreover, this list is open-ended, and other matters may be imported into the instrument by the rater on an *ad hoc* basis in any given case. In *Regan*, for instance, the court observed: "...Because Dr. Jensen merely borrowed factors and employed them out of context, the value that Stable-2007 would ascribe to the factors is not considered. The result is the items are used in an idiosyncratic manner and without empirical support."

In *Regan* (*ibid.*), Dr. Abbott also questioned whether the items overlap or are redundant with items on the actuarials used by the MDT. For example, "Capacity for Relationship Stability" on the Stable-2007 appears to duplicate the "Intimacy Deficits" factor on the Static-99R....

> "The result is that it is unclear whether applying the Stable-2007 risk items in this manner creates an artificial increase in the risk of recidivism through the use of

duplicative or invalid factors. Accordingly, testimony regarding the Stable-2007 dynamic risk factors is inadmissible." (*Ibid.*)

"The Stable-2007 as an instrument has only been standardized on community samples, meaning that use of this tool in an institutional setting will require some modification along with a degree of caution and interpretation. This is not currently happening at MSOP." (*Karsjens* 706 Experts' Report, p. 40, quoted at Trial Tr., pp. 542-43; accord: Dr. Pascucci, Trial Tr., v. 8, 1679: the Stable 2007 hasn't been validated on an institutionalized population). On this, Dr. Caldwell testified that "The Stable-2007 was developed and normed with community samples. And many of the items have to do with the selection of peers, an association of other individuals, things that are essentially meaningless in a confined setting where the individual is only allowed to interact with certain individuals under certain limited circumstances. And so, that is really not an appropriate scoring risk scale for an individual that has been confined. It's really not an appropriate scale to be using. I would not expect those -- I don't think there is any basis to expect that those scores would be valid." (*Karsjens* Trial Tr., v. 11, p. 2508).

Despite this fundamental criticism, Dr. Wilson observed that MSOP uses the Stable-2007 "as part of the treatment progress review. I think it's also used if there is an evaluation for the SRB. So if someone is going forward to the SRB -- and actually, that's where we observed it most. We had the opportunity to observe two or three SRB hearings, and in those, there was reference to the Stable-2007." *Karsjens* Trial Tr., v. 3, pp. 548-49). Dr. Freeman stated flatly that MSOP use of the Stable-2007 "is not appropriate for an inpatient population." (*Id.* v. 4, p. 769). See also: *Gregory DeClue*, "Avoiding Garbage 2: Assessment of Risk for Sexual Violence after Long-Term Treatment," 33 *J. Psychiatry & L.* 179, 198 (2005) (advising caution in the use of dynamic risk factors in determining whether offenders continue to meet commitment criteria).

Dr. Herbert testified that other actuarial tools may be used by her assessment staff as well. This includes the VRS-SO. She testified that this tool creates a lot of subjective decision-making by the assessor. Obviously, such subjectivity is the cause of grave inaccuracy, just as it is in so-called clinical-judgment-based assessment. (Trial Tr., v. 24, p. 5209).

Some evaluators of sex offender recidivism have striven to "adjust" (almost invariably upward) scores derived from a given RAI on "clinical" considerations. This is just an attempt to resurrect the "CRA" approach despite its extreme inaccuracy. To justify this, such clinical evaluators will cite certain facts that they claim are beyond the factors examined by the RAI that such evaluators claim need to be reckoned into the probability of the subject sex offender's likelihood of future re-offense. However, the range of such supposedly extraneous matters proposed by clinically oriented evaluators as further factors, upon which to justify inflating the RAI-derived recidivism probability is endless. *Dennis M. Doren*, *Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond* (Sage Publ'ns. 2002), at pp. 167-68, cites these, for instance, as among such matters lacking in scientific confirmation:

> "insulting, teasing, and obnoxious verbal behaviors; lack of consideration of others; unconventional attitudes; criminal attitudes; shallow affect, superficiality; tension; medication noncompliance; problems with housekeeping or cooking; poor self-care and personal hygiene; substance abuse; physical self-abuse; suggestible and easily led;

problems with money management; ...firestarting; criminal associates; inappropriate dependency).... excitement, anxiety, mania, anger, ...depression, guilt feelings.... poor use of leisure time, unpopular, social withdrawal, inactivity, excessive shyness, ...poor assertion, lack of family support).... violent lifestyle, criminal personality, ...weapon use, substance abuse...."

Dr. Vietanen explained the impact of this procedure:

"Q. What would a higher score on the Stable mean?

"A. A higher scoring increases risk. So I can give you an example.

"Q. Please.

"A. On the Stable, these are dynamic risk factors. I may read someone's finding of fact and not see impulsivity, for instance, in their offending pattern. So I may have scored it a 1 in the middle, because they are getting a 0, 1 or a 2. So until we get to know them better, we don't know, are they a 0, you know, with really not an impulsivity problem, or are they a 2 with a huge impulsivity problem and I just didn't see it? And Dr. Allen explained to me that until we get to know them better, we will assume it is higher. So there were multiple times that they went to 2s when I would have scored them 1s until we got a better handle on the client." (*Trial Tr.*, Id., pp. 2299-2300). Dr. Vietanen stated that this happened "regularly." (*Id.*,, p. 2364).

Thus, in essence, Dr. Vietanen was being told by her superiors to err on the side of assuming greater danger than any known facts would warrant, and often contrary to known facts (such as those in the findings of fact in her example), and to continue to do so until some contrary information disproved the factor in question.

Even more troubling, Dr. Vietanen testified that group therapy notes are sometimes written in deliberately adverse ways in an effort to thwart a given treatment participant's progress in treatment simply because he is disliked, citing this example:

"...[T]he staff was told to document every single thing Mr. *Karsjens* did in group. That seemed inappropriate. Part of what Mr. *Karsjens* was asking was how are we supposed to feel safe in a treatment group when we have persons who were security personnel now in our treatment group? And that was a real sticking point for him. My question to our clinical supervisor on the unit was, are you asking us to target Mr. *Karsjens* in documentation for his behavior more than anybody else? I didn't get a response. I got a look." (*Id.*, p. 2308).

Lawyer X, Deviant Justice: The American Gulag, (*In Depth Media*, 2014, avail.: www.amazon.com), at pp. 83-84, adds these further "dynamic factors": "poor social support, antisocial peers, antisocial/impulsive lifestyles, ...hostility, ...anxiety, poor coping mechanisms, substance abuse, intimacy deficits, ...unemployment, ...poor grooming." Many of these are "acute," that is, varying greatly from one period to the next (e.g., daily, weekly, or monthly variation). All of these matters are amorphous and subject to extremely subjective judgment. Moreover, none of them has any clearly demonstrated causal or indicative relationship to sex crime commission.

Lawyer X, supra, at 90-91, cites *Prentky, Janus, et al*, "Sexually Violent Predators....", supra, at 12 *Psychol., Pub. Pol'y & Law* 378 as explaining that use of these claimed factors is

done in an adverse, 'cherry-picking' manner, seeking to confirm an a priori opinion that the offender remains dangerous. In other words, merely any criticism whatsoever that can be laid against a given sex offender, regardless how far removed from sex offending, can be claimed, with no scientific accountability, to justify increasing the asserted level of sex-crime recidivism probability. This is the end of science.

Lawyer X, ibid., states that the aforementioned *MSOP Report* admits use of such "negative dynamic risk factors," but redefining them even more amorphously as "psychological vulnerabilities or mechanics" that "significantly increase risk of reoffending." This contravenes the actual forensic literature, which describes dynamic risk factors as "all things, whether external or internal, or whether deliberately altered by an individual offender or instead simply either spontaneous or inexorable (such as the effects of middle age on libido).

It appears that the *MSOP Report*'s emphasis on this mis-definition of "dynamic risk factors" as being on an individual's purported "criminogenic needs" is a desperate attempt at reinventing the rationale for commitment in a way that returns the focus to 'clinical impressions' without any accountability. Now MSOP wants to spin dynamic factors as reflecting evils particular to each sex offender, such that something terrible and ominous can be said against each one in commitment or release proceedings. In other words, things that MSOP calls "dynamic risk factors" are all adverse claimed "deficits" that the sex offender must "work on, and, so it is claimed, only MSOP treatment in commitment can allow that. This is the rankest departure from science imaginable, and a deliberate subsidence into the miring depths of pure character assassination in service of rationalizing a 'permanent employment plan' for MSOP 'therapists' – at the expense of their captives' permanent loss of freedom as fodder to this vicious system.

By our very nature, humans are not only changeable, we are constantly changing, even when we don't want to and when we are unaware of such personal change. Even firm intent to recidivate can, and usually does melt away over time as individuals experience and witness numerous events, learn of myriad things, and have discourse with any number of other individuals. Life is full of advance repentance of such temptations to do evil deeds, whether petty or enormous. As surely as each one of us has experienced some such abandoned temptation, it is unfair to treat others as incapable of such abandonment of temptation. To commit someone to lifetime detention engages exactly that presumption, and then puts the seal of judicial condemnation, not upon the deed, but upon the man.

10. MSOP's "Need Areas" Rhetoric Is Excuse-Making to Commit and to Keep Detained.

According to the Minnesota Sex Offender Program (MSOP) "*Program Theory Manual*," "Overview Of Treatment For Sexual Abusers" section, MSOP adheres to the triad of principles known as "risk, need, and responsivity" ("RNR"). "Responsivity" refers simply to claimed

effectiveness of certain treatment approaches. However, "risk" and "need" refer to various factors about individuals committed to MSOP that are deemed by treatment staff to increase the likelihood of recidivism by that individual. While some of these "risk" and "need" factors are dynamic (capable of change by the particular MSOP detainee), most rest on facts of one's biography, including most dating all the way back to one's childhood. These are immutable, "static" factors of historical fact that cannot be altered. Accordingly, no matter how perfectly one participates in, and even completes MSOP treatment, he can be still deemed 'too dangerous to release,' simply because of these happenstances of personal background, about which he had no control at the time, and about which he can do nothing now.

Melissa Hamilton, "Risk-Needs Assessment: Constitutional and Ethical Challenges," 52 *American Criminal Law Review* 231 (Spring 2015), at 240-42, succinctly summarizes this assessment technique thus:

> "Risk-needs tools normally score at least several demographic characteristics of the individuals evaluated. Among various instruments, these entail age, gender, citizenship, and marital status [citing for these the following instruments and guides: PCRA; PTRA; VRAG; Static-99; COMPAS; and MnSOST-3.1); see also *Sonja B. Starr*, Evidence-Based Sentencing and the Scientific Rationalization of Discrimination. 66 *Stan. L. Rev.* 803, 823 n. 76 (2014) (listing instruments that incorporate gender). PCRA includes the Psychological Inventory of Criminal Thinking Styles (PICTS) with a gender-based scoring system]. Risk-needs tools orient toward rating demographic variable regarding various aspects of family of origin, including having lived with both biological parents until age sixteen, a criminal family, parental alcohol problem, and current family situation. Ratings are commonly provided relative to the individual's personal history, namely criminal background, educational attainment, and employment stability [citing as to these: VRAG; LSI-R; COMPAS; PCRA; Static-99; HCR-20; and PTRA]. The instruments often contain measures implicating socioeconomic status, such as financial condition, ownership of home, residential stability, and living in a neighborhood with high crime or illegal drug activity [citing on these: LSI-R; COMPAS; PTRA; see also *Edward Latessa et al.*, "Creation and Validation of the Ohio Risk Assessment System, Final Report," 49 app A & note 84 (2009), available at http://www.ocjs.ohio.gov/ORAS_FinalReport.pdf (describing the Ohio Risk Assessment System: Pretrial Assessment Tool).
>
> "Some risk-needs tools compile and rate various aspects of personal and social functioning. Examples consist of elementary school maladjustment [e.g., VRAG; see also LSI-R (rating school suspensions and level of participation in school activities)] and problems with personal support [e.g., HCR-20], in addition to factors focused on reliance on social services or public assistance [e.g., LSI-R], which may suggest deficits in personal responsibility. Various measures rate relationship issues involving family, consisting of relationship with parents and marital/family problems, and social functioning, such as a history of problems with relationships, social adjustment problems, lack of pro social support, and maintaining criminal acquaintances. [collectively citing: PCRA; LSI-R; HCR-20; COMPAS].
>
> "Addictions and mental conditions are commonly integrated therein. These include problems with alcohol or drugs, a history of a mental disorder, personality disorder, psychopathy, or of mental health treatment. Several of the instruments judge

attitudes, such as temperament towards supervision and change, lack of insight, personal instability, and problems with stress and coping. [collectively citing on these: PCRA; VRAG; LSI-R; PTRA; HCR-20; and COMPAS]

> "....[R]eliance upon risk-needs assessments when they incorporate potentially problematic factors in the important arena of criminal justice decisions incites constitutional and moralistic concerns. ...The moral issues involve political unease when decisions are based on immutable characteristics over which individuals have no personal control or that may serve directly or by proxy to replicate discriminatory practices."

Each of the underlined words/phrases in this quote refer to matters that are either historical, beyond the control of the individual in question or otherwise immutable, concern one's freedom of thought (e.g., "attitude"), or simply blame the individual for the mental/emotional shortcomings or problems that hamper him. When MSOP applies these claimed recidivism factors under guise of "dynamic" considerations,' it is actually simply claiming such immutable factors, such matters of personal choice and freedom of thought, and mental and emotional states besetting the individual, which the individual either cannot change or which are not legal subject of a demand for change or relinquishment.

Indeed, *MSOP Report*, at p. 15, describes "criminogenic needs" as comprised of "need areas," including "sexual deviancy, antisocial attitudes and beliefs, relationship problems, and problems with self-regulation." In other words, everything that MSOP calls "dynamic" risk factors are all adverse claimed "deficits" that sex offender must 'work on.' The *MSOP Report*'s implication is that only treatment can allow that, and only MSOP will do. That is to say, these things that MSOP calls "dynamic" are things claimed to absolutely require treatment – in other words, 'things to work on' as an excuse to commit!

> "Notwithstanding the issue of what objects of interest are irregular, it is evident that fantasy and sexual interest are not always linked to actual sexual activity. A recent study comparing samples of undergraduate males with convicted child molesters showed the former had more fantasies overall and more with sadomasochistic themes, even after adjusting for the potential for the molester group to underreport because of offenders' likelihood to provide biased responses in an attempt to provide socially desirable answers." (*M. Hamilton, supra*, at p. 561)

See also on this point: *Kerry Sheldon & Dennis Howitt*, 'Sexual Fantasy in Paedophile Offenders: Can Any Model Explain Satisfactorily New Findings from a Study of Internet and Contact Sexual Offenders?', 13 *Legal & Criminological Psychology* 137, 153 (2008) (finding in a small sample no association between fantasies with children and child molestation).

An illustration of this true MSOP intent never to release its detainees pertains to pedosexuals/pedophiles (to whom MSOP refers collectively as "sexual deviancy"). Two-thirds of MSOP detainees have evinced this attraction. MSOP contends in support of commitment and of denial of release that simply being a pedophile presents "criminogenic needs"; that the pedophile must be committed; and that he "needs" treatment, or if he has already had treatment, that he needs more treatment, *ad infinitum* until death. According to MSOP, in order to satisfy the "meaningful change" standard for release from MSOP detention, a pedophile would have to prove that he no longer has pedophilic attractions. Because this is an impossibility, the

pedophile will always be deemed to have ultimately "failed" treatment, and will remain locked up in MSOP until death, if MSOP gets its way.

This, of course, defies Prof. Hamilton's observation as to the ubiquity of 'deviant' sexual attractions/interests. Were the MSOP view true, pedophilic crimes would contend in prevalence with 'normophilic' sex acts between consenting adults. Yet, "[i]nterest in illegal sexual interactions (children or nonconsenting persons) can be found in a substantial part of the (male) population. The majority of them, however, never seem to act on these interests." (*Hamilton*, p. 561)

Indeed, MSOP describes "criminogenic needs" as comprised of "need areas," including "sexual deviancy, antisocial attitudes and beliefs, relationship problems, and problems with self-regulation." In other words, everything that MSOP calls "dynamic risk factors" are adverse claimed "deficits" that sex offenders must "work on." MSOP's implication is that only treatment can allow that, and only MSOP will do. From time to time, MSOP treatment staff will cite a new deficit that a given sex offender detainee must work on. By doing this, MSOP staff permanently forestall treatment completion by any given detainee and therefore his eligibility for release. That is to say, these things that MSOP calls "dynamic" are things claimed to absolutely require treatment – in other words, 'things to work on' as an excuse to commit and to keep committed.

11. MSOP Applies Ad Hoc Roadblocks to Progression Through Treatment Based on Abuse of the Tremendous Disparity in Power Between Treatment Staff and Participating Detainees.

Dr. Berlin's *Report to Schiff Hardin & Waite*, etc., at p. 10, offers this further insightful observation as to another parallel between Minnesota's MSOP and the treatment program in Illinois' sex offender commitment system:

> "...[I]t can become all too easy [as a therapist] to dismiss genuine differences of opinion, or differences in construals and perception, as tactics that are an impediment to treatment. Thus, when a therapist is trying to get others to see things his (or her) way, he is generally viewed as being 'persuasive,' whereas when a patient tries to get others to see things his way, there is the risk that he will be viewed as being 'manipulative.' Engaging in permissible legal suits can be viewed as a tactic; sitting quietly and keeping to one's self can be viewed as an instance of being 'isolative and withdrawn'; and vigorously expressing a different point of view can be labeled as 'resistant to treatment, lacking in empathy, and oppositional.' Talking in therapy about the possibly improper actions of teenaged victims, or about one's own childhood victimization, can be viewed either as 'a failure to assume responsibility,' or as 'taking a victim's stance.' Of course, each such observation about a given patient in treatment could actually, in point of fact, be quite accurate. However, because there is such a tremendous disparity in power between staff and patients, in my judgment, it is imperative that some truly independent system of checks and balances be put permanently in place to avoid any such inadvertent abuse of that power."

MSOP therapists regularly make such judgments in treatment notes about a given participant, and in turn use the fact of such observations as one reason to deny phase advancement to that participant, and occasionally, as a reason to demote the detainee to a lower phase. These subjective judgments, with no way to contest them, and in most cases no means to find out about them until much later -- if ever, are fundamentally unfair to a treatment participant against whom they are made. Worse, because they are made without announcement, and because there is no body of independent hearing-officer-like decision makers as to such judgments, such judgments cannot be challenged in any meaningful effective way. A treatment participant has no protection or recourse from abuses that occur in this ad hoc judgment-making process.

12. MSOP Engages Only in a Sham of Treatment.

In *Kansas v. Hendricks*, Justice Kennedy, as the 'swing vote,' wrote a short concurrence emphasizing that treatment underpins the civil nature of involuntary confinement and that treatment must be more than a 'mere pretext':

> "If the object or purpose of the Kansas law had been to provide treatment, but the treatment provisions were adopted as a sham or pretext, there would have been an indication of the forbidden purpose to punish." (*Hendricks*, 521 U.S. at 371).

As Justice Kennedy correctly predicted, 'the practical effect of the Kansas law may be to impose confinement for life. ...Psychiatrists or other professionals engaged in treating pedophilia may be reluctant to find measurable success in treatment even after a long period and may be unable to predict that no serious danger will come from release of the detainee.' (*Kansas v. Hendricks*, *supra*, at 521 U.S. 372) That prediction applies even more accurately, when after more than 20 years of MSOP operation, only two persons had been released. The recent group of four 'show releases discussed above does not significantly change this infinitesimal release percentage.

Warren J. Maas, "Erosion of Constitutional Rights in Commitment of Sex Offenders," 29 *William Mitchell Law Review* 1241, at 1258, 1262 (2003), states:

> "The concerns Justice Wahl raised in *Blodgett* [557 N.W.2d 171, 201 (Minn. 1996)] apply with equal force to *Linehan II* and the SDP statute; that is, if the treatment is 'sham' or 'placebo' in nature, the statute runs afoul of constitutional proscriptions against double jeopardy and preventive detention."... One method to determine whether the treatment program is a 'sham' or 'placebo' would be to look at the focus of the treatment program. The focus of the treatment program at MSOP appears to be preventing breaches of security and only tangentially on treatment."

Only 11% of the annual MSOP budget is allocated to treatment. Likewise, only 11% of its staff is involved in treatment. The largest component of the high operating cost of MSOP-ML

is that of security staffing (almost a one-to-one ratio with detainees). However, security staffing needed to monitor the new Complex One and the projected Complex Two units is minimal, due to open sight-lines in their design.

In 2011, MSOP administrators declared that no releases were anticipated anytime in the foreseeable future. MSOP's projected number of detainees in 2020 is based solely on current rates of commitment, with no deduction for any projected releases. In the absence of any anticipation of any releases in any of the next several years, it is clear that MSOP is utterly disingenuous about treatment in MSOP as a pathway to release. In its *MSOP Report*, *supra* (p. 9), MSOP boasts that it offers 'the longest treatment durations,' apparently as a goal in and of itself. This supports the inference that, as its goal and that of the legislature, MSOP intends to keep its detainees confined for as long as possible.

In that circumstance especially, such endless, pointless treatment becomes apparent as 'adopted as a sham or mere pretext' (*id.*, p. 371), leaving only such lifetime preventive detention, a subject exclusively for criminal sentencing. See, e.g., *Jackson v. Indiana*, 406 U.S. 715, 738 [1972] [indefinite confinement of criminal defendant incompetent to stand trial, whether or not in a mental hospital, invalidated]; accord: *Zadvydas v. Davis*, 533 U.S. 678, 690 [2001]. Cf.: *People v. Feagley*, 535 P.2d 373 (Cal. 1975), ordering release of a 'sexually dangerous person,' the court stating that 'adequate and effective treatment is constitutionally required' because, without it, 'the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense.' (*Id.*, at 387), 'nothing ...but bare incarceration for the protection of society'. (*Id.*, p. 396).

On a factual level, in sharp distinction from Kansas' assertion of 31.5 hours per week of treatment of Mr. Hendricks, Minnesota's MSOP currently provides only 4-8 hours of such 'treatment' weekly —effectively nothing more than a 'show' of what really is just a pretense of earnest treatment. The issue of a strong right to treatment is addressed *infra*, in accordance with *Janus & Logan*'s conclusion that, in such commitments, such a strong right to treatment must exist, without which such commitments are void.

By the foregoing facts, and by others alleged in the *Gladden v. Swanson* et al. *Complaint*, at ¶¶ 345-411, the only plausible inference is that the claimed treatment aim of the SPP/SDP Act is merely a sham – a pure pretext for unqualified, permanent preventive detention.

Not to be ignored is *Duwe*'s finding that, in a random sample of those committed to MSOP, less than 10%, according to MnSOST's (highly inflated) actuarial rating, would be at least equally likely (50-50) to sexually reoffend if released—completely irrespective of whether they participated in, much less 'successfully' so, in MSOP treatment. In effect, treatment is administered in MSOP purely to legitimize the true aim of punitive preventive detention, despite knowledge that almost all in MSOP do not present any significant likelihood of sexual re-offense if released. Thus, not only is SPP/SDP commitment in Minnesota actually a matter of pure preventive detention, as sheer incapacitation, deterrence, and further retribution, it is extremely excessive at such preventive detention. Because MSOP-style 'treatment' is not needed to achieve this low level of probability of re-offense, there is no measurable 'success rate' for

MSOP treatment; detainees would present essentially the same low risk without any such treatment at all.

At *Karsjens* Conclusion 36, Judge Frank of Minnesota's United States District Court declared:

> "...[T]he statute, as applied, is a three-phased treatment system with "chutes-and-ladders"-type mechanisms for impeding progression, without periodic review of progress, which has the effect of confinement to the MSOP facilities for life. As a result, section 253D, on its face and as applied, is not narrowly tailored and results in a punitive effect and application contrary to the purpose of civil commitment. See *Hendricks*, 521 U.S. at 361-62."

13. The Constitution Requires A Committed Person To Be Released When He No Longer Meets Commitment Criteria.

Janus & Logan, supra, explain this contention at p. 341-42: "Another central limit on the states' commitment authority is the principle that the duration of a civil commitment must be related to its purpose. That is, regardless of the validity of the initial judgment of commitment, confinement must end when its justification expires." (citing *O'Connor v. Donaldson*, 422 U.S. 563 at 574-75, 45 L Ed 2d 396, 95 S Ct 2486 [1975]: "Nor is it enough that Donaldson's original confinement was [422 US 575] founded upon a constitutionally adequate basis, if in fact it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed. *Jackson v Indiana, supra*, at 738, 32 L Ed 2d 435, 92 S Ct 1845; *McNeil v Director, Patuxent Institution, supra.*").

"In the *parens patriae* context, this principle is illustrated by *Donaldson*, which stated that it is not enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if in fact it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed.' [*Donaldson*, 422 U.S. at 574-75]"

Discussing *Donaldson* and *Jones v United States*, 463 US 354, 77 L Ed 2d 694, 103 S Ct 3043 (1983), the Supreme Court, in *Foucha v. Louisiana*, 504 U.S. 71, 79, 118 L Ed 2d 437, 112 S Ct 1780 (1992), concluded: "We held, however, that "[t]he committed acquittee is entitled to release when he has recovered his sanity or is no longer dangerous," *id.*, at 368, 77 L Ed 2d 694, 103 S Ct 3043; "i.e., the acquittee may be held as long as he is both mentally ill and dangerous, but no longer."

Neither *Kansas v. Hendricks*, *Kansas v, Crane*, nor any other holding since *Foucha* has addressed this issue. It is worthy of note, however, that Justice Breyer's dissent in *Hendricks*, at 521 U.S. 393-94, observed that:

> "*Salerno* ...involved the brief detention of that person, after a finding of "probable cause" that he had committed a crime that would justify further imprisonment, and only pending a speedy judicial determination of guilt or innocence. This Court, in

Foucha, emphasized the fact that the confinement at issue in *Salerno* was 'strictly limited in duration.' 504 US, at 82, 118 L Ed 2d 437, 112 S Ct 1780. It described [521 US 394] that "pretrial detention of arrestees" as "one of those carefully limited exceptions permitted by the Due Process Clause." *Id.*, at 83, 118 L Ed 2d 437, 112 S Ct 1780. And it held that *Salerno* did not authorize the indefinite detention, on grounds of dangerousness, of "insanity acquittees who are not mentally ill but who do not prove they would not be dangerous to others." 504 US, at 83, 118 L Ed 2d 437, 112 S Ct 1780."

Therefore, *Foucha* still must be deemed controlling on this point.

Thus, when a given committed sex offender no longer meets the commitment criteria of the SPP/SDP statute, that commitment must end, if the statute is not to be deemed one aimed at pure infliction of supplemental criminal punishment, and if it is not reduced to sheer preventive detention.

14. The Standard of 'Successful Treatment Completion Plus Demonstrated Meaningful Change,' With Recidivism Risk Reduced to 'Very Low Levels,' Effectively Presenting a Demand for a 'Zero-Percent' "Public Safety Guarantee" Before Allowing Release, as Applied by MSOP Officials, the SRB, and the SCAP, Make Release Unattainable by Any MSOP Detainee Except by Those Politically Selected From Time to Time as a Faux Showing That Release Through Treatment Is Purportedly Possible.

Most states having sex offender commitment laws have provisions calling for ending a given sex offender's commitment whenever he no longer meets the commitment standard. Minnesota has no such provision. Indeed, in Minnesota, MSOP's provisional release standard (not to entirely end the commitment) is far more restrictive on an end to an detainee's confinement than the standard for commitment is for commencing such confinement. This standard of 'successful treatment completion, plus demonstrated meaningful change,' with recidivism risk reduced to very low levels is shared only by North Dakota. However, North Dakota already has a substantial number and percentage of releasees to date (27, as of 2015, reflecting 32%), compared to its far-smaller total of committed sex offenders to date (56, in 2015). This implies that North Dakota applies its standard far less harshly than does Minnesota. In Minnesota, making matters worse, to allow a given release, MSOP must develop a release plan for the prospective releasee, and it can block any release simply by declining to develop that plan for him.

As explained by *Eric Janus* in *Failure to Protect*: (etc.), *supra*, at p. 138:

> "...[T]he Wisconsin and Minnesota courts diverged in their interpretations of their respective discharge standards [in sex offender commitments]. In Wisconsin, the courts held that an individual must be released if his risk of re-offense fell below the threshold for commitment, which was substantial probability of re-offense. The Minnesota courts, in contrast, held that discharge would be permitted only if the individual could make an acceptable adjustment to society, an unreliably vague standard

that suggests a far lower level of risk than the 'highly likely' standard required for commitment in Minnesota. To put the difference in simple terms, Wisconsin would release people if they no longer fit into the 'most dangerous' category, whereas Minnesota would release only those who fit into the 'least dangerous' category."

After decades of treatment of individuals, the uniform conclusion by MSOP is that each individual remains 'too dangerous to release' (even despite advancing age). *D.M. Doren*, "The Model for Considering Release of Civilly Committed Sexual Offenders," in *A. Schlank & F. Cohen* (eds.), *The Sexual Predator: Law and Public Policy, Clinical Practice*, Vol. III (Kingston, N.J., Civic Research Institute, Inc. 2006), points out that sex offender commitment programs that use a treatment-completion standard for release have a near-zero release rate. This includes Minnesota's MSOP.

Thus, as to pedosexuals, MSOP will always say in excusing its refusal to release same, even after a decade or more of its treatment, that the detainee continues to have pedophilic attractions, and therefore presents some level of risk of re-offense – and hence does not possess a "guarantee" of public safety. Therefore, MSOP is simply a thinly disguised, artificially 'treatment justified' permanent (natural-life) preventive detention scheme.

In an effort at justifying its policies, MSOP states that the sex offender commitment programs of other states "have survived legal challenges because they are designed to provide treatment that has the potential for individuals meaningfully participating in them to reduce their risks sufficiently to be released back into the community." But by demanding this 'zero-percent' "public safety guarantee," MSOP is not within the contemplation of such judicial decisions elsewhere.

Of course, attractions do not equal actions. Human experience – over history and currently – is filled with those who, notwithstanding having some kind of sexual orientation (a universal human attribute), remain celibate, often over an entire lifespan, and more commonly, after the hormonal ardor of youth has passed, for the balance of a lifespan.

Many of these members of society are in fact pedosexuals, who have simply not acted on their orientation in any criminal way. Hence, the claim by MSOP that a pedosexual will inevitably commit another sex crime is false. Therefore, even as pure incapacitation, (i.e., preventive detention), this is no justification for such preventive detention. Such commitment is instead just punitive in intent and function.

Conversely, however, it is simply impossible to be certain that any convicted sex offender will not sexually reoffend, any more than that any hitherto crimeless pedosexual will not someday commit a sex crime of that nature. Nonetheless, MSOP sets the bar to qualify for release unattainably high: "ensuring that a Level III sex offender never recidivates sexual harm." (*MSOP Report*, p. 43). Explaining this, *MSOP Report*, p. 20, states: "Successful treatment reduces risk, but does not eliminate it. In some cases, the reductions achieved through treatment, when weighed against the case as a whole, remain insufficient to guarantee public safety...." Judging from MSOP's lack of releases, it can be inferred that "some cases" refers to all MSOP detainees.

Of course, the only "guarantee" of public safety would be if the probability of recidivism were reduced to zero percent. No treatment of sex offenders known to humanity makes any claim to be able to achieve such a result – or anything close to it. This includes the other states' commitment programs, which aim for lesser, arguably achievable goals. Minnesota's MSOP stands alone in insisting upon such an absolute guarantee of public safety before releasing any given detainee.

Regardless how devoted any given sex offender detained in MSOP is to not ever reoffending, and how personally certain he is that re-offense is not going to happen if released, there is simply no way to sufficiently convince his MSOP captors of those facts. Thus, the 'zero-percent' "public safety guarantee" that MSOP demands for release effectively means that one must die while still detained in MSOP in order to present a zero-percent probability of re-offense. This is simply lifetime permanent preventive detention with just some insincere treatment layered-on as disguise, both for legal appearances and for placating the detained through fraudulently held-out hope of release.

Occasionally freeing one slave does not abolish the evils of slavery, especially when the slave can be recaptured at any time and returned to involuntary servitude. Analogously, conditionally releasing six individuals out of more than 775[9] committed over a twenty-year span – to 'provisional discharge' (far from truly free) –does not cure or remediate the punitive evil of MSOP lifetime preventive detention.

15. MSOP Does Not Anticipate or Intend Any Releases Beyond Such Isolated 'Show Releases' Anytime Within the Foreseeable Future and Is Not Serious About Facilitating Release Through Treatment.

As in preceding sections, *supra*, the findings of *Dr. Fred Berlin*'s *Report to Schiff Hardin & Waite*, etc., at pp. 11-12 as to treatment failure at the parallel Illinois sex offender commitment facility are extraordinarily apt in MSOP as well:

> "'Given the large numbers of patients, the length of time that many of them have been there, and the small number who have progressed with the support of staff to a less restrictive, although potentially still highly supervised, community-based phase of treatment (let alone, to one of the more advanced phases of inpatient residential treatment), one can only question the resolve of achieving such goals in a timely manner. Thus far, in spite of the fact that the program has been in existence for a number of years, and in spite of that fact there have been estimates by some program staff that treatment may need to average about three years in length, less than a handful of patients have been advanced to the latter phase of the treatment program. It is unclear that the program has recommended any more than three patients for conditional release.

[9] (including those who died in MSOP confinement, most from old age)

"'... I am unaware of any evidence suggesting that long-term institutionalized care has been associated with an enhanced outcome when treating sexually disordered patients. ... In spite of public misperceptions to the contrary, the recidivism rate for many sex offenders treated in the community has been quite low.

"'One can ask, 'How can the public be kept safe?' Alternatively, one can ask, 'How in the context of keeping the public safe, is it also possible to still be fair and just to committed patients in treatment?'

"'These two questions are not the same, and only the latter question may lead to a commitment to try to treat patients in as expeditious a fashion as possible. In my judgment, individualized treatment planning seems not to have considered recommending, and trying to assist, even some small percentage of patients in progressing through all five phases of inpatient care at a relatively accelerated rate. In fact, few, if any, patients have ever progressed to level five. Of course, in order for a patient to be able to progress into, and beyond level five, the program would first need to have put into place an established system that would allow for a subsequent lengthy period of intensive community-based supervision, monitoring, support, and the possibility of re-hospitalization if needed, following inpatient discharge. In my professional opinion, to the extent that that sort of individualized treatment planning has not been done, planning to try to get each patient through the system in as safe, and expeditious a fashion, as is possible, that represents a substantial departure from accepted practice, judgment and/or standards in the field of inpatient mental health care, even when one takes into account the nature of the population in treatment.'"

Exhibit C to the *Affidavit of Jannine Hébert* (Document 385-1) in the *Karsjens* case (attached hereto as Appendix C for the Court's convenience) depicts phase comparisons for the quarter-years ending in '2013 3rd Quarter.' Note that a total of only 595 detainees (treatment participants, plus "Admissions") is shown as of the 3rd Quarter of 2013. At that time, approximately 698 detainees were present in MSOP. Hence, the difference reflects 103 detainees not in treatment at that time -- primarily 'refuseniks' who decline to participate in treatment.

This last number has not increased proportionately with the total of MSOP detainees. This reflects the recent change in Dept. of Corrections practice to rigorous enforcement of the ISR directive to MSOP detainees under ISR to participate in MSOP treatment. Violation of this directive is punished by revocation of ISR/Conditional Release ("CR"), with substantial prison terms imposed. This coercion artificially inflates the number of MSOP treatment participants and limits the number of refuseniks to those no longer under ISR/CR. Because the length of sex offense sentences has exponentially increased over the time that MSOP has been in operation, the pool of those who have completed such sentences-plus-attached-CR has grown only slowly. This singlehandedly accounts for the lack of growth of the number of refuseniks.

The decline in the number of Phase 1 participants and the growth of Phase 2 participants since the end of 2011 has been due to two developments. First, the initiation and pendency of the *Karsjens* case inspired some formerly unmotivated Phase 1 participants to believe that this case would result in an order for accelerated release of those in Phase 3 and also those close to completing Phase 2.

More recently, as a second development, the continued increase in Phase 2 participants is due to a deliberate acceleration by MSOP treatment staff of promotion of those in Phase 1 into Phase 2. Since these promotions are often more hasty than the progress of the promoted detainees would appear to warrant, it would seem that this 'wave' of unexpected promotions is due to a deliberate effort by MSOP treatment administration to appear for litigation purposes to be more efficient at treatment than really is the case or their true preference. This also accounts for the very recent (not shown in Appendix C), sudden, large increase in the number of promotions of Phase 2 participants to Phase 3. This suggests that, if the pending litigation ends without judicial grant of the reliefs sought, these latest increases in treatment advancement will cease, and many now promoted will be demoted. This is no genuine improvement; it is mere posturing.

To date, of the approximately 783 who have been committed to MSOP (including at least 53 who have died in such detention), only four MSOP detainees have been released from detention by MSOP, and then only to a status similar to Intensive Supervised Release known as "provisional discharge." All of these were in treatment in MSOP for about 20 continuous years at their release. (This does not include Ray Hubbard, released in the 1990s under MSOP's predecessor agency [Minnesota Sexual Psychopathic Personality Treatment Center – "MSPPTC"], but whose "provisional discharge" was later revoked for nothing more than a psychiatrist's fear that he might eventually reoffend at some unknown time in some unknown scenario). Currently, not counting those 53 who have died, approximately 730 individuals are under commitment to MSOP.

The period of treatment estimated by MSOP officials has escalated from two years initially to four years, then to "several years," as a deliberately vague figure. After that, MSOP officials refused to offer such an average estimate, instead defending such 20+-year treatment terms, saying defensively that treatment takes "many" years. All of the ills cited by Dr. Berlin in the foregoing quote apply with equally full force against Minnesota's MSOP. Currently, approximately 730 individuals are under commitment to MSOP. It therefore is a reasonable inference that MSOP has not, and still is not seriously undertaking any treatment program intended to result in reasonably expeditious completion of treatment and release of those committed.

> "...[I]n 2011, MSOP declared that no releases were anticipated for the foreseeable future. The fact that MSOP's projection of 1109 detainees in MSOP custody by 2020 is based on current rates of commitment, but with no releases confirms that MSOP has no expectation of releases. It is not serious about treatment as a path to release.
>
> "The way that MSOP conducts its treatment program confirms that it is not seriously attempting to advance any detainee toward release, but to the contrary is tacitly, deliberately thwarting such reasonable progress toward release."
>
> (*Lawyer X, Deviant Justice – The American Gulag*, at p. 190)
>
> "In sum, it appears that MSOP clinical staff have spent a great deal of effort inventing rationales for denying treatment advancement and completion to MSOP

treatment participants. This again confirms that MSOP is not serious about facilitating releases through treatment." (*Id.*, pp. 192-93).

16. By Its Policy of Non-Release, MSOP Implicitly Acknowledges That Its Treatment Is Such a Failure as to Leave All Plaintiffs Too Dangerous to Release, in Its View.

In this light, especially because MSOP does not have the confidence in its own treatment to release more than one detainee to date of its approximately 730 detainees currently, it is clear that MSOP has no effectiveness at treatment and that MSOP's only claim of recidivism reduction is by reason of sheer preventive detention.

17. The MSOP SRB-SCAP Process, Including Assessments Conducted in That Connection, Shows the Unfairness of the Only Means to Reduction in Custody Level in MSOP, Much Less toward Release.

We start with the federal court's own simple declaration in *Karsjens*, "The Fourteenth Amendment does not allow the state, DHS, or the MSOP to impose a life sentence, or confinement of indefinite duration, on individuals who have committed sexual offenses once they no longer pose a danger to society." (*Karsjens et al. v. Jesson et al.*, June 15, 2015 Order, p. 68). The Constitution requires a committed person to be released when he no longer meets commitment criteria.

At *Karsjens* Conclusion 31, the federal District Court declared:

> "...[S]ection 253D, as applied, is not narrowly tailored because those risk assessments that have been performed have not all been performed in a constitutional manner. The testimony of several risk assessors at the MSOP support a conclusion that the risk assessors have not been applying the correct legal standard when evaluating whether an individual meets the criteria for transfer, provisional discharge, or discharge. For example, Dr. Pascucci's testimony indicated that she did not use the correct standard for discharge under *Call*, which requires that a person be "confined for only so long as he or she continues both to need further inpatient treatment and supervision for his sexual disorder and to pose a danger to the public." *Call*, 535 N.W.2d at 319 (emphasis added). In other words, the Minnesota Supreme Court has indicated that discharge must be granted if the individual is either no longer dangerous to the public or no longer suffers from a mental condition requiring treatment. (See *id.*) Moreover, the MSOP did not use the correct legal standard until after these proceedings commenced in 2011, despite the fact that the Minnesota Supreme Court decided the *Call* case in 1995. Therefore, section 253D, as applied, is not narrowly tailored in that there is no requirement to apply the correct legal standard in risk assessments and it results in a punitive effect and application contrary to the purpose of civil commitment. See *Hendricks*, 521 U.S. at 361-62."

Thus, when a given committed sex offender no longer meets the commitment criteria of the SPP/SDP statute, that commitment must end, if the statute is not to be deemed one aimed at pure infliction of supplemental criminal punishment, and if it is not reduced to sheer preventive detention.

A commitment for mental illness can be brought to an end at any time that the committed individual can show that he no longer meets the commitment criteria. An individual committed as SPP/SDP cannot achieve freedom in that way, but must prove a series of higher standards of an even more vague and impressionistic nature, thus turning on an act of unassailable discretion – which discretion, with only two exceptions to date, has invariably been exercised against such release. The sheer numbers of such denials of release alone demonstrate the unreality of any true standard of any reliability in that decision. In reality, such decisions have been based on a de facto standard of 'any probability above dead zero' of the possibility of commission of a future sex crime. Because there is no method short of death that anyone convicted of any crime can ever prove such a complete lack of any risk of such future recidivism, this is simply preventive detention run riot. It is rank hysteria and categorical hatred in action at its worst.

In this light, especially because MSOP does not have the confidence in its own treatment to release more than three detainees to date of its approximately 730 detainees currently, it is clear that MSOP has no effectiveness at treatment and that MSOP's only claim of recidivism reduction is by reason of sheer preventive detention. The MSOP purported system of both phase advancement and release/reduction in custody is not just irreparably broken; more accurately, it has been irredeemably defective by design from its inception, and remains so to date.

Evidencing this, Dr. Freeman testified as to the SRB that MSOP officials train the SRB members, and that MSOP -- the same entity conducting the sex offender treatment -- is actually controlling scheduling of SRB hearings and the procedure of the SRB. Dr. Freeman testified in the trial that she found this whole arrangement "odd." (*Trial Tr.*, v. 4, p. 822).

The SRB holds a hearing on each petition. Before that hearing, Plaintiffs receive legal assistance but not an independent psychological or psychiatric exam or risk assessment. Further, certain legal arguments, including constitutional claims, cannot be made in these proceedings. MSOP presents risk assessments and other professional opinions at the SRB hearing. *Karsjens*, Tr. 5122: 2-8, PA 975; PX 178, PEXB101-102 (Question 10): PEXB 455-465 (showing that MSOP provides the SRB with relevant Class Member records, the MSOP's SRB Treatment Report, and the MSOP's Sexual Violence Risk Assessment).

The SRB then issues a recommendation. In nearly every instance, the SRB recommends what the MSOP tells them to recommend. *Karsjens*, Tr. 2995: 18-21, PA 917; Tr. 5153: 8-18. MSOP Defendants and MSOP control the SRB operation, including appointing and determining the number of SRB members, PX 177, PEXB 478-479; training SRB members, Tr. 3240: 16-22, P.A. 930; Tr. 5149: 2-7,PA 979; and scheduling SRB hearings, PX 177, PEXB479 (Question 12).

There is no time limit on SCAP decisions and it is not uncommon for this process to take years. *Karsjens*, Doc 658 at 76. The process overall, from filing the initial petition to receiving a

final SCAP decision does take years. *Karsjens*, PX 252, PEXB 317; Tr. 5142: 8-12, PA 977. There are not enough SRB members, Tr. 947: 1-7, PA 741, and therefore not enough hearings to meet the demand. MSOP lacks the staff to complete the reports needed by the SRB and SCAP, Tr. 1501: 10-16; Tr. 1549: 3-10, P.A. 780; PX 100, PEXB 51. Further, the system design builds in delays. Doc 658 at 46; Tr. : 19 - 5121: 6, PA 973-974. Mr. Benson admitted the whole process is set up in a way that cannot work to discharge Plaintiff-MSOP detainees. Doc 917 at 68: 5 – 70: 16, PA 556-558.

At a later point in testimony, Dr. Freeman added that she deemed the SRB process unfair to petitioning sex offenders, in that "the State has a risk assessor or an evaluator and the client does not.... ...[T]here are clinicians that represent the State or the program in [an SRB proceeding], and the client has nobody except their attorney. They have no clinical professional individual representing them or who has had the opportunity to do an assessment for them.... I think that having a committee of individuals who perhaps are not experts on sex offender management and who are trained by the same individuals who run the program could result in unfairness, yes.... ...[T]he fact that the individuals on the committee aren't necessarily experts on sex offender management could [also] make it unfair for all individuals, yes." (*Id.*, pp. 899-900).

Minnesota's statutes only permit release decisions, and petitions therefor, to be carried on through the SRB-SCAP process; there is no alternative procedure for review of the need for continued sex offender commitment to be conducted by the committing court, or by any court of general jurisdiction. The SCAP has the sole authority to grant a reduction in custody. At the SCAP hearing, "[t]he petitioning party seeking discharge or provisional discharge bears the burden of presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief." *Minn. Stat.* § 253D.28, subd. 2(d). The standard that must be met is "a preponderance of the evidence that the transfer is appropriate." *Minn. Stat.* § 253D.28, subd. 2(e). In contrast, other states' sex offender commitment statutes, including those of Wisconsin and New York, allow committed individuals to petition the committing court (not a board) at any time to be discharged or for a reduction in custody.

When MSOP staff persons perform risk assessments, they do not consistently apply the correct legal standards when evaluating whether a person meets the criteria for transfer or dischgarge. *Karsjens Tr.* 1647: 22 1648: 5; 1648:14-24, PA 814-815. Risk assessors lack training, resources and consistency. Tr. 1655:18-21. 1656: 2-5, PA 816-817 (no manual or guide exists regarding how to perform risk assessments); Tr. 1647-22 – 1648:24, PA 814-815; Tr. 1648: 14-24, PA 815 (no formal training on legal standards or criteria for release); Tr. 5231: 17-20, PA 986 (no one at MSOP is a certified trainer on actuarial instruments); Tr. 1501: 10-16; Tr. 1549: 4-10, PA 780 (creating delays in Special Review Board (SRB) hearings, because staff vacancies delay necessary risk assessments).

Most shockingly, the testimony of Dr. Anne Pascucci, one of the risk assessors for MSOP and assigned the duty of determining specifically whether a detainee seeking provisional discharge, clearly shows that despite (or perhaps because of) the training she received on that

standard by her superior, Dr. Herbert, her understanding is completely incorrect about that standard and how it is to be applied, as the following extended passage reveals:

"Q. When you started, did you have any formal training on the legal criteria to be released from sex offender commitment in Minnesota?

"A. No.

"Q. Have you ever had any formal training outside the department by a lawyer or some legal training with respect to the statutory requirements in Minnesota for release from civil commitment?

"A. Outside of DHS is that the Department?

"Q. Outside of DHS.

"A. No.

"...Q. Have you been trained by any of the lawyers at DHS with respect to the statutory criteria?

"A. Not formalized; it would be consulting.

"Q. When you do your risk assessments, do you consult with counsel to determine if they agree with your evaluation of the legal criteria?

"A. No.

"...Q. One of the statutory factors for transfer, for an example, is whether it can be accomplished with a reasonable degree of safety for the public?

"A. Correct.

"Q. You agree with that?

"A. Yes.

"Q. What does reasonable degree of safety mean under the law?

"A. To me, it would mean -- it's kind of hard for me to define. Reasonable would be, to me, is it likely that it can be done with safety.

"Q. I want to make sure I got it right. I wrote it down but it doesn't necessarily mean I got it right. To you, it means that, is it likely that it can be done with safety, is that --

"A. Well --

"Q. -- what you said?

"A. -- simply put, yes.

"...Q. Let's just start with the definition. We can talk more as we go. Is likely more or less than 50 percent?

"A. It depends on if you're talking about preponderance of the evidence, so it would be 51 percent.

"...Q. Okay. And what is -- on the transfer issue, what is the burden of proof? Who has the burden of proving that it's likely that it can be done with safety? The state of Minnesota or the petitioning patient?

"A. Well, it depends on -- if you're in the judicial appeal panel, Phase I or Phase II, the burden of proof would be on the client. In Phase II, the burden of proof would be on the state.

"Q. And that was -- you're talking about the Supreme Court Appellate Panel which everybody refers to as the SCAP?

"A. Correct.

"Q. In the first phase, your view is that the burden is on the petitioner, and in the second phase the burden is on the state; is that right?

"A. Correct.

"Q. Okay. And you think that burden is the same in Phase I and Phase II, just that it flips?

"A. I'm not sure I understand the clarification you're asking for.

"Q. Well, you said in the Phase I, the burden is on the petitioner?

"A. Correct.

"Q. In the Phase II the burden is on the state.

"A. Correct.

"Q. It's the same burden. It just shifts from the petitioner --

"A. Oh, yeah." (*Trial Tr.*, v. 8, pp. 1647-1652).

All of the foregoing underlined portions of this excerpt are incorrect beliefs as to that state of the law.

Stunningly, Dr. Pascucci testified that she applies the *Call v. Gomez* standard in a way that takes into account a detainee's propensity for non-sexual violence, something clearly contrary to the language of *Call* itself:

"Q. ...When you read "continues to pose a danger to the public," as you have written here in Mr. Terhaar's report at page 18, you consider both sexual -- the risk of sexual danger and nonsexual danger, correct?

"A. Simply, yes." (*Trial Tr.*, v. 8, p. 1694).

Applying this to Eric Terhaar, a juvenile at the time of his crime, Dr. Pascucci testified in this way:

"Q. So in your opinion, Mr. Terhaar is dangerous to the public in a sexual disorder manner?

"A. There is a probability for that.

"Q. Okay. And when you say "probability," what does that mean?

"A. That he possesses vulnerabilities that predispose him to violence, including sexual violence.

"Q. Okay. But probability is like, what, 10 percent, 20 percent, 50 percent?

"A. I can't quantify a probability in this case.

"Q. You do all the time. You use the Stable and the Static and you come up with words like low and moderate and you put percentages on them all the time based on those instruments. Is it low, moderate, high? What's Mr. Terhaar's probability?

"A. I cannot quantify it." (*Id.*, p. 1692)

Essentially then, Dr. Pascucci opposed Terhaar's release on the ground of an unknown probability of violence of any type, including, but not limited to sexual violence.

Dr. Pascucci also testified that one reason that Terhaar should not be released is because his long institutionalization has given him no life skills (*id.*, p. 1696), irrespective that no such ground for continued commitment exists, either in the statute or in case law pursuant to it.

Dr. Pascucci also agreed with the scientifically false proposition that "deviant sexual arousal is the strongest risk predictor factor," and indicated that this is a factor given prominence in assessing an MSOP detainee for provisional discharge. In point of fact age, not deviance, is the most powerful factor governing probability of re-offense, by itself equal in weight to all other factors combined. This myth of the purported power of "deviance" is simply a rationale to

continue to detain someone for natural life, since deviance (i.e., paraphilic sexual orientation) is a lifetime condition with no cure. (*Id.*, p. 1658).

Of further significance, Dr. Pascucci also stated that, in her assessments for provisional discharge, she usually contacts treatment clinicians to seek their input as to treatment "strength/weakness ...how they are doing in treatment." (*Id.*, p. 1660). This, of course, is not properly part of an assessment of likelihood of sexual re-offense by a sex offender. It is purely another impressionistic part of the universally discredited and extremely inaccurate "clinical risk assessment" approach.

Karsjens et al. Findings 147-149 state that since January 1, 2010, the SRB has recommended granting twenty-six petitions for transfer, eight petitions for provisional discharge, and no petitions for discharge. The MSOP supported all of the provisional discharge petitions recommended to be granted by the SRB. As of July 2014, the SCAP has granted transfer to CPS twenty-eight times, provisional discharge once, and full discharge zero times. Not stated in those findings, only one of the eight provisional discharge recommendations was followed by SCAP. This reflects a political bottleneck to release, even when one clearly qualifies for release under MSOP's extreme restrictive decision-making. Also note that no requests for provisional discharge that were unsupported by MSOP were recommended by SRB or granted by SCAP.

In testimony at trial of the *Karsjens* case, Jannine Hébert blamed the "release process" for the failure to release any significant number of MSOP detainees. (Trial Tr., v. 12, pp. 2798-2800).

MSOP Executive Director Johnston testified at that trial that a number of reasons prevented Minnesota from releasing many MSOP detainees, citing as the first reason "community fear" of sex offenders. (*Trial Tr.*, v. 13, p. 2938). Of course, no such criterion or factor is statutorily provided as to MSOP release consideration, whether as to SRB consideration, MSOP support for an SRB petition, or SCAP consideration. That such a political consideration can block release of an MSOP detainee confirms the unconstitutionality of the MSOP commitment scheme as permanent preventive detention.

Johnston also complained of "a lot of [bureaucratic] layers and hoops as impediments to release. (*Id.*, p. 2939), as well as a lack of resources – "resources at the SCAP level, at the SRB level, at the psychology level in our facilities." (*Id.*, p. 2938.) Of course, such impediments and lack of resources were intentionally created by the legislature and/or by MSOP itself. This too is an example of politics deliberately keeping the door closed to release from MSOP.

In addition, Ms. Johnston cited the commitment process itself as committing too many, i.e., including those who should not have been committed. (*Id.*, p. 2945). Again, this was a political decision.

Even more fundamentally, Commissioner Jesson confirmed in testimony that, if the Court orders provisional discharge for as few as 25 MSOP detainees, the budget of the Dept. of Human Services cannot provide state-owned or contracted housing for even just that number without further legislative authorization. (*Trial Tr.*, v. 5, p. 925). This lack of preparation to accommodate any significant number of releases further demonstrates that MSOP has never been

serious about releasing any individuals committed under the MCTA of 1994 and is not serious about such release at this time.

Karsjens et al. Findings 150-157 reveal that SRB hearings are scheduled by the MSOP. Currently, the SRB may hold up to four hearings a day for a total of sixteen hearings per month, although there are no restrictions on the number of hearings the SRB can hold. Parenthetically, at this rate, were every decision in favor of release, and were every such SRB decision affirmed by SCAP, it would take a theoretical minimum of at least 3 years and nine months to empty MSOP, assuming no more commitments occurred meanwhile. Except for the current pendency of this case, that last assumption is highly dubious.

There is no time limit on the SCAP decisions. The SRB and the SCAP petitioning process, from the filing of the initial petition to receiving a final SCAP decision, can take years. Some petitions can take longer than five years to complete the petitioning process. Backlogs, especially of MSOP-unsupported petitions, are enormous. As of June 2014, approximately 105 SRB petitions were pending decision and 48 petitions were pending a SCAP decision. The shortest number of days between the time any petition was filed and the time of the hearing on that petition was twenty-nine days (Terhaar's case, suggesting political expediting of that particular case for appearances' sake). This expediting occurred only after the Rule 706 Experts issued a report unanimously recommending full discharge for Terhaar, and after the Court issued an order on June 2, 2014, ordering Defendants to show cause why Terhaar's continued confinement is not unconstitutional and why Terhaar should not be immediately and unconditionally discharged from the MSOP. The outcome of that process was merely a transfer of Terhaar to CPS, not a provisional-discharge release for him. Terhaar remains incarcerated to date in CPS at the MSOP St. Peter facility.

MSOP has previously attempted to address delays in the petitioning process, but has not seriously attempted to address the problem recently. In 2013, Commissioner Jesson set a goal of having petitions supported by the MSOP heard more quickly. Obviously, this did nothing to address the huge backlog of MSOP-unsupported petitions, even though expediting these was likewise within Commissioner Jesson's power. The Court found that this SRB and SCAP process is unduly lengthy and is bogged down with difficult procedures; and that the process denies individuals the services necessary to navigate it. These delays, in substantial part, are a result of insufficient funding and staffing. MSOP lacks sufficient staff to complete the reports needed by the SRB and the SCAP.

The Court, in *Karsjens et al.* Findings 158-160, clarified that Commissioner Jesson determines the number of SRB members and selects the SRB members after an application process. Currently, seventeen or eighteen positions out of twenty-four available positions are filled. A committed individual retains the right to seek a state-court writ of habeas corpus during the petitioning process. *Minn. Stat.* § 253B.23, subd. 5. However, that habeas procedure does not provide for an independent psychologist or psychiatrist to conduct an evaluation of the petitioning committed individual, and the petitioner is not provided counsel as a matter of right.

(Parenthetically, the same holds true in any federal habeas corpus proceeding.) No bypass mechanism is available for individuals to challenge their commitment.

As *Id.*, Findings 161-165 explain, no one connected to MSOP or the DHS is required under the *MCTA* to petition for transfer or reduction in custody of MSOP-detained individuals who meet the statutory requirements for such a reduction in custody. No policy or practice exists at MSOP, or any requirement in *MCTA*, that would require MSOP to file a petition on an individual's behalf, even if MSOP knows or reasonably believes that the individual no longer satisfies the statutory or constitutional criteria for commitment or for discharge. Defendants could choose to, and indeed, do have the discretion to file a petition for a reduction in custody on behalf of committed individuals at the MSOP. MSOP knows that at least some Class Members meet the reduction in custody criteria or no longer meet the commitment criteria but continue to be confined in MSOP. Despite its knowledge that individuals have met the criteria for release, the MSOP has never petitioned on behalf of a committed individual for full discharge.

In fact, as observed in Findings 166-170, MSOP never filed a petition for a reduction in custody on behalf of a committed individual before 2013. In fact, MSOP has only filed a petition for a reduction in custody on behalf of a committed individual seven times in the history of the program. Of those seven petitions, six were for individuals in the Alternative Program slated for transfer to Cambridge, but ultimately never transferred to Cambridge. The seventh petition was for Terhaar for transfer to CPS (as mentioned *supra*) (Testimony of Dr. Haley Fox, *Trial Tr.*, v. 7, p. 1590). That petition for Terhaar was the only one filed by MSOP for transfer to CPS on behalf of any individual in the history of the program. No one from MSOP told him about the filing of that petition for transfer to CPS. On the contrary, Terhaar intended to seek full discharge from MSOP, not merely such transfer to CPS. Not stated in these findings, it is quite apparent that this was a crafty, surreptitious move by MSOP to falsely cast an appearance to the press that they were moving Terhaar to a status 'closer' to release – ignoring that only one person in recent history has been released from CPS, and then only to provisional discharge. MSOP has no established process or practice to determine whether to petition on behalf of an MSOP detainee.

Findings 171-174 observe that an MSOP detainee must have a fully completed provisional discharge plan to support a provisional discharge petition. MSOP's SRB policy states that when a petition for provisional discharge is supported by the treatment team, the MSOP staff is authorized to assist the individual petitioner with a provisional discharge plan. However, MSOP only assists those in Phase III of treatment with provisional discharge plans; it does not assist those in Phase I or Phase II to create a provisional discharge plan. MSOP does not provide legal advice to its detainees regarding filing a petition.

Thus, Findings 175-176 observed that various MSOP detainees have expressed confusion and uncertainty regarding the petitioning process, and some have been deterred from petitioning due to the daunting petitioning process. Between January 2010 and June 2014, 441 MSOP detainees potentially eligible for discharge had not filed a petition for a reduction in custody.

As the Court summarized in Findings 177-181, MSOP has never supported a full discharge petition and has only supported less than ten petitions for provisional discharge. MSOP will only support a petition for a reduction in custody if the petitioning individual fully completes the treatment program. MSOP has only supported one petition for transfer to CPS from a committed individual in Phase I (i.e., Eric Terhaar). For the very first time, just within the last year, the MSOP has supported one petition for transfer to CPS from an MSOP detainee in Phase II. [Deb McCulloch testified that she believes that "there are people both at Moose Lake and at St. Peter that could be served in a less restrictive environment. But I also believe -- and there's a good example that was presented in the court and in our report that there are people that should be discharged completely from commitment." (*Trial Tr.*, v. 2, pp. 255-56

The testimony of Beth Peterson as to MSOP detainee Harley Morris, who died of terminal cancer while in MSOP custody at age 78, is illustrative by way of example. Dr. Peterson testified that Mr. Morris was then on hospice support at Moose Lake. Dr. Peterson conceded that Morris was not then dangerous, and that he should have been transferred outside of the secure facility. Yet, no official or staff person at MSOP ever petitioned for his transfer to a different facility. Dr. Peterson agreed that the Assisted Living Unit at Moose Lake is for patients who are elderly or have serious medical conditions and that there are patients on the Assisted Living Unit that could be transferred out of the secure facility. (*Trial Tr.*, v. 7, pp. 1393-94). Yet, again, MSOP has never petitioned for their transfer to a less restrictive alternative. Anyone in the Assisted Living Unit of MSOP cannot be a danger to the public in any realistic sense.

At *Karsjens* Conclusion 33, this Court declared:

> "...[S]ection 253D, as applied, is not narrowly tailored because the discharge procedures are not working as they should at the MSOP. The Court finds that this is the result of the MSOP refusing to petition on behalf of committed individuals, the MSOP failing to provide discharge planning to committed individuals until they are in Phase III, and Defendants' failure to address impediments and delays in the reduction in custody process. These failures further delay Plaintiffs' ultimate discharge from the MSOP. As a result, section 253D, as applied, is not narrowly tailored, and results in a punitive effect and application contrary to the purpose of civil commitment. See Hendricks, 521 U.S. at 361-62."

Conditioning restoration of the liberty of any Plaintiff Class Member upon any process of psychological assessment is constitutionally improper. The statutory basis for our confinement, i.e., the *MCTA of 1994*, has already been held to deprive each MSOP detainee of substantive due process, both on the face of that statute and as it is applied to same. Given this holding, the only truly appropriate relief is to dissolve each said commitment and to grant every MSOP detainee immediate release without conditions of "provisional release" under that unconstitutional statute.

As a matter of public safety, approximately two-thirds of MSOP detainees remain under intensive supervision administered by the Minnesota Department of Corrections in connection with their ongoing sentence-based paroles. As to the remaining detainees, upon their release, each of them will be subject to the most intensive monitoring and surveillance by police agencies

ever known in Minnesota history as to persons not under current investigation for specific crimes.

While offering assistance and training in life skills, etc. is helpful, compelling anyone to accept such services as a condition of their rightful freedom is itself also anathema to the Due Process Clause.

18. MSOP's Fraudulent Promises of Release

As stated *supra*, only 11% of the annual MSOP budget is allocated to treatment. Likewise, only 11% of its staff are involved in treatment. Again, this shows that MSOP does not actually intend 'successful treatment' to be a means of release. Therefore, it deliberately ensures that no one will be declared to have 'successfully treated.' To reduce per diem costs per detainee on average, MSOP actually wants to incarcerate more detainees in its two facilities.

Despite declaring in January 2011 that "...there are several clients who are close to earning provisional discharge," MSOP subsequently released only the two detainees mentioned *supra*. If this is the definition of "close" in MSOP-speak, then no appreciable change through internal MSOP action can actually be expected in the foreseeable future. Without any serious intent of reform, such MSOP statements are mere puffery to stave off judicial intervention.

Elsewhere in its 2011 *Report*, MSOP proceeds on the assumption that it will not release any of its detainees at least through 2022. That is permanent preventive detention.

19. The Permanent Preventive Detention Intent of MSOP

Plaintiffs who occasionally do manage to complete a treatment regimen and present themselves for a declaration of eligibility for release are almost invariably delayed for such evaluation and instead are assigned a never-ending repeating series of post-treatment tasks to qualify for such evaluation and/or, when finally evaluated, are declared not to have sufficiently "meaningfully changed" notwithstanding treatment to qualify for release. Because the only officially deemed means of achieving such "meaningful change" is ostensibly through treatment, these individuals are then remanded to repeat treatment, from the beginning.

Under these true circumstances, "treatment" does not function as, and is not intended to rehabilitate any committed sex offender to a point of release. To the contrary, treatment as thus designed and operated is purely a time-consuming mandatory merry-go-round, to occupy the time and attention of those committed while the true intended natural-life term of their commitment, as pure preventive detention, gradually lapses at each detainee's death. Such commitment whose true primary purpose is such preventive detention, with treatment only as a

pointless superficial add-on strictly for appearances' sake, inherently deprives Plaintiffs thus committed of substantive due process.

MSOP policies and practices governing release are inherently unattainable as to any MSOP detainee, and are driven by political control and influence, rather than by any universally accepted and applied academic professional standards for release, effectively amounting to an unattainable 'zero-percent-of-recidivism' "guarantee of public safety." This unattainability of release, regardless of mode, intensity, or reasonable duration of treatment, confirms the true permanent preventive detention nature of sex offender commitment pursuant to said *Act* as this aspect is upheld by Minnesota appellate court holdings.

Unlike other states having sex offender commitment laws, Minnesota lacks a requirement for a periodic report to the committing court regarding each sex offender's allegedly continuing need to remain committed. The issue such reports address elsewhere is whether the committed sex offender continues to meet the commitment standard. Some such 'commitment states' require an annual court hearing, while others only hold such a hearing if controverted allegations so require. In some states, the state is required to re-prove the commitment case in court periodically.

In order to gain provisional release, a detainee must be approved by the "Special Review Board" ("SRB") of the Minnesota Department of Human Services, appointed by the Commissioner of that Department. Because of the aforementioned executive order (*supra*, at ¶ 133), the proposed release must then be approved by the "Supreme Court Appeal Panel" ("SCAP"). However, SRB relies heavily on MSOP treatment team reports and on an MSOP risk assessment in making its recommendations to SCAP. In turn, SCAP itself also relies greatly on MSOP's assessments of its detainees. MSOP therapists have stated that public pressure is being exerted on both SRB and SCAP to be extraordinarily conservative in release decisions. However, MSOP's own refusal to prepare <u>any</u> release plans (except for the two token releases in 2012-13), demonstrates that MSOP itself also is extraordinarily conservative in decision-making about release.

20. <u>MSOP's Lack of Releases Demonstrates Its Preventive Detention Aim.</u>

At *Karsjens* Conclusion 32, this Court declared:

> "...[S]ection 253D, as applied, is not narrowly tailored because individuals have remained confined at the MSOP even though they have completed treatment, can no longer benefit from treatment, or have reduced their risk below either the "highly likely to reoffend" standard or below a "dangerous" standard. The fact that no one has been fully discharged from the MSOP since the program was created and that only three individuals have been provisionally discharged, one of whom was subsequently returned to civil confinement and who passed away at the MSOP, underscores the failure of section 253D, as applied, to be narrowly tailored to confine only those individuals who

should remain civilly committed at the MSOP. Therefore, section 253D, as applied, is not narrowly tailored and results in a punitive effect and application contrary to the purpose of civil commitment. See Hendricks, 521 U.S. at 361-62."

MSOP release standards are also inconsistent and inherently biased. The failure to release more than four detainees over the life of the MSOP program demonstrates that MSOP practice is a result of orders from political leaders and is not based on professional judgment. MSOP implementation, enforcement, and application of said 1994 *Act* to its detainees violates their constitutional right to substantive due process protections.

21. The Duration of MSOP Detention Lasts Through Old Age.

Eric S. Janus & Wayne Logan, "Substantive Due Process and the Involuntary Confinement of Sexually Violent Predators," 35 *Conn. L. Rev.* 319 (Winter, 2003), lays out the background for this analysis thus:

(at p. 366): "...[U]nlike the criminal law, SVP laws effectively allow confinement based on the 'status' of being a dangerous person." [See, e.g., *People v. Kibel*, 701 P.2d 37, 44 (Colo. 1985) (noting the argument that sex offenders are held based on their status – 'their dangerous character' – rather than an act.]

(at p. 370): "Without careful judicial scrutiny to root out ineffective treatment programs, SVP commitment becomes indistinguishable from lifetime imprisonment."

(at p. 372): "In *People v. Feagley*, [565 P.2d 373 (Cal. 1975)] the California Supreme Court ordered the release of an individual committee under the State's sexually dangerous person statute, holding that 'the effect of a statutory declaration of the right to treatment may be negated by evidence that such treatment is not in fact provided.' [*Id.* at 396] Without treatment, the court noted, 'nothing remains but bare incarceration "for the protection of society."' [*Ibid.*] The court held that 'medical treatment [is] the raison d'etre of the mentally disordered sex offender law, it is its sole justification.' [*Id.* at 386] Moreover, 'adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense."' [*Id.* at 387 (quoting *Wyatt v. Stickney*, 325 F.Supp. 781, 784 (M.D. Ala. 1971))]

(at pp. 377-78): "To set the reasonableness benchmark, courts can look first to empirical data on sex offender treatment duration. In the correctional setting, most state-run sex offender treatment programs extend for no more than three years. [*Mary West et al.*, State Sex Offender Treatment Programs (50-State Survey) 4 (2000)] The treatment program in Kansas, for instance, was designed to be completed in eighteen months. [*McCune v. Lile*, 122 S.Ct. 2017, 2025 (2002) (noting that the Kansas Sexual Abuse Treatment Program lasts for eighteen months).] Similarly, the well-known program implemented by the California Dept. of Mental Health – the Sex Offender Treatment and Evaluation Project [SOTEP] – involves a 'comprehensive cognitive-behavioral treatment program' with an inpatient phase of approximately two years (fourteen to thirty months).

[*Janice K. Marques, et al.*, "Effects of Cognitive-Behavioral Treatment on Sex Offender Recidivism: Preliminary Results of a Longitudinal Study," 21 *Crim. Just. & Behav.* 28, 36 (1994).] A survey of Minnesota sex offender treatment programs in prisons and community settings showed that the average length of treatment ranged from 2.5 months to 37 months. [*Minnesota Office of the Legislative Auditor*, "Sex Offender Treatment Programs" 55-58 (1994)] The Minnesota SVP program itself is designed to be completed in a minimum of four years. [E-mail from Anita Schlank, Ph.D., Clinical Director of Minn. Sex Offender Program, to Eric S. Janus (Aug. 19, 2002), (noting that most patients are unable to complete the program in the minimum period)]

"Thus, three years appears to be a rough benchmark for treatment judged by professionals to achieve some treatment efficacy, if any is forthcoming. Social science data suggest that beyond that point at best only a small correlation exists between length of treatment and reductions in sexual offending recidivism. [See *R. Karl Hanson & Monique T. Bussiere*, "Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies," 66 *J. Consulting & Clinical Psychol.* 348, 352 (1998) (noting the median correlation of 'length of treatment' and recidivism as .00)], raising the question of whether anything other than the interest of incapacitation is being served....

(at p. 380): "Courts should evaluate evidence of risk in light of research indicating that 'the most effective known technique for reducing risk of relapse is intensive supervision in the community, [*Robert A, Prentky & Ann. W. Burgess*, Forensic Management of Sexual Offenders 236 (2000)] and that community aftercare can be made sufficiently "tight" to reduce risk to a minimum for many offenders.' [Id. at 243] Reasonableness decisions, particularly about SVP detainees who fall at the lower end of the risk scale, need to take into account these methods to achieve public safety in the community, short of full-blown institutional confinement. Due process demands no less."

(at p., 382) "...[A[]s time passes – and if SVP regimes continue to be beset with dismally low release rates – the illusory nature of the treatment promise will become undeniable." [Note: this prediction has been fulfilled in Minnesota.]

Distinctly, under the 1994 *MCTA*, as upheld by authoritative state appellate court rulings, the duration of commitment in any event extends through middle- and old-age, stages of life by which all known statistics demonstrate unequivocally that sex-crime recidivism has dropped to negligible levels of statistical probability, even for prior recidivists. This violates the precept that, to comport with substantive due process, commitment must last no longer that reasonably necessary to achieve its non-punitive rationale. If such rationale is deemed to be to protect public safety, and assuming strictly *arguendo* that said rationale is not simply another term for inherently punitive preventive detention, then this established inverse statistical correlation as to recidivism as age advances past age forty proves that commitment under said *Act*, with detention in and beyond middle-age, inherently loses its relation to said rationale, thereby depriving substantive due process to all Plaintiffs in that age range.

Janus & Logan, supra, expand on this principle and its application in sex offender commitment as follows:

(at p. 351): "Due process commands that the conditions and duration of confinement bear some reasonable relation to its civil purpose – treatment – without which

incapacitation serves as mere preventive detention.... When it is clear that the treatment goal is hopeless, release may be required." [*Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1980) ("Adequate and effective treatment is constitutionally required because, absent treatment, appellants could be held indefinitely as a result of their mental illness."]

(at p. 352): "The duration principle requires release when circumstances become constitutionally inadequate to support civil commitment and has been applied in two types of situations. First, the court has ordered release when the circumstances that originally justified commitment no longer obtain." (citing *O'Connor v. Donaldson*, 422 U.S. 563, at 575 (1975)). "The Court extended the principle to the police power context in *Jones v. United States*," (463 U.S. 354(1983)). (*Ibid.*)

(at pp. 352-53): "The Court first articulated the duration principle in its seminal 1972 decision of *Jackson v. Indiana*, providing that 'at the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.' [406 U.S. at 738] The principle has been recited and applied repeatedly since then [see, e.g., *Young*, 531 U.S. at 265; *Foucha*, 504 U.S. at 79; *Jones v. United States*, 463 U.S. 354, 368 (1983)] and is one characteristic of SVP laws cited to establish and sustain their legitimacy. [See, e.g., *Kansas v. Hendricks*, 521 U.S. 346, 368-69 (1997) (concluding that because state law "permitted immediate release upon a showing that the individual is no longer dangerous or mentally impaired, we cannot say that it acted with punitive intent"); *Martin v. Reinstein*, 987 P.2d 779, 786 (Ariz. App. 1999) (stating that an SVP "must be afforded treatment and must be examined at least annually to determine whether his mental disorder has sufficiently improved that he no longer poses a danger to the public."); *In re Young*, 857 P.2d 989, 997 (Wash. 1993) (en banc) (stating that "committed persons must be released as soon as they are no longer dangerous"); *State v. Post*, 541 N.W.2d 115, 127 (Wis. 1995) ("Thus, the duration of an individual's commitment is intimately linked to treatment of his mental condition.")]

"The duration principle requires release when circumstances become constitutionally inadequate to support civil commitment, and has been applied in two types of situations. First, the Court has ordered release when the circumstances that originally justified commitment no longer obtain. The principle was applied in *Donaldson*, where the Court squarely held that commitment 'could not constitutionally continue after [its justifying] basis no longer existed.' [422 U.S. at 575] The Court extended the principle to the police power context in *Jones v. United States*, [463 U.S. 354 (1983)] where the Court examined the permissible duration of commitment for an insanity acquitee. Rejecting the argument that the defendant's civil commitment could extend no longer than the maximum prescribed criminal sentence, the Court, quoting *Jackson*, observed that '[t]he Due Process Clause "requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."' [*Jones*, at 368, quoting *Jackson*, 406 U.S. at 378)]

(pp. 353-4): "The second category of duration cases involves a subtle, but important difference: Although the state's purpose for commitment remains constitutionally valid, its accomplishment within a reasonable period has become doubtful, and thus the commitment has exceeded its permissible duration. Implicit in these cases is the constitutional expectation that states have only a reasonable period of time to accomplish their legitimate commitment objectives. These cases recognize that the constitutional permissibility of confinement depends not only on the harshness of conditions, but also

on duration. Punitiveness is not only a momentary measure, but also a cumulative one. Confinement that is non-punitive, in short, can become punitive if its duration is excessive."

"In *Jackson*, for instance, the Court invalidated Indiana's right to hold, for an indefinite period, a criminal defendant deemed incompetent to stand trial. [*Jackson*, at 733] The State, rather, could hold *Jackson* for the 'reasonable period of time necessary to determine whether there is a substantial chance of his attaining the capacity to stand trial in the foreseeable future.' [*Ibid.*] And, even though the state's interest in evaluating Jackson and rendering him competent for trial remain unabated, the Court held that Jackson's 'continued commitment must be justified by progress toward that goal.' [*Id.* at 738] Likewise, in *United States v. Salerno*, [481 U.S. 739 (1987)] the Court emphasized that the pretrial detention permitted by the federal *Bail Reform Act* had 'stringent time limitations.' [*Id.* at 747] This made explicit the connection between duration and punishment, but intimate[d] no view as to the point at which detention in a particular case might become excessively prolonged, and therefore punitive, in relation to Congress' regulatory goal [*Ibid.*, n. 4]"

(at 354): "The *Zadvydas* majority cited *Jackson* for the proposition that 'where detention's goal is no longer practically attainable, detention no longer 'bear[s] [a] reasonable relation to the purpose for which the individual [was] committed. [*Zadvydas v. Davis*, 533 U.S. 678 (2001) at 690] The Court concluded that a deportee may not be held once it is determined that there is 'no significant likelihood of removal in the reasonably foreseeable future.... And for detention to remain reasonable, as the period of prior post-removal confinement grows, what counts as the "reasonably foreseeable future" conversely would have to shrink.'" [*Id.* at 701] [*Zadvydas* confirms the view of numerous district court and appellate holdings finding serious constitutional problems with indefinite detention by the Immigration and Naturalization Service ("INS"). See, e.g., *Ma v. Reno*, 208 F.3d 815, 821-22 (9th Cir. 2000) (holding that the INS may not indefinitely hold alien where no reasonable likelihood existed for removal); *Koita v. Reno*, 113 F.Supp.2d 737, 741 (M.D. Pa. 2000) (stating that mandatory detention requirement of INS may violate substantive due process rights); *Kay v. Reno*, 94 F.Supp.2d 546, 552 (M.D. Pa. 200) (holding that the INS's mandatory detention requirement violated the alien's substantive due process rights); *Duong v. INS*, 118 F.Supp.2d 1059, 1067 (S.D. Cal. 2000) (holding that indefinite incarceration of alien violated his substantive due process right); *Nguyen v. Fasano*, 84 F.Spp.2d 1099, 1110-11 (S.D. Cal. 2000) (holding that, when removal of deportable alien is not foreseeable, detention by the INS becomes punitive after a certain amount of time).]

(at 355): "These cases teach that punishment comprises not only unduly harsh conditions, but also confinement that is durationally out of proportion to the state's non-punitive purpose. Whether confinement is punitive thus turns on proportionality – which, in turn, can depend on duration. Although the state's 'interest' remains constant (assuming that the need for treatment, evaluation, restoration, deportation, or protection remain unchanged), at some point the cumulative imposition on the individual's liberty outweighs the government's interest, requiring an end to the confinement. In the terminology of *Mendoza-Martinez*, the confinement has become 'excessive in relation to the alternative purpose assigned.' [*Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 169 (1963).]

"In the same way, confinement can become excessive in relation to treatment, the 'alternative purpose' that ensures the non-punitiveness of police power commitments. [See, e.g., *Thielman v. Leean*, 140 F.Supp.2d 982, 1000 (W.D. Wis. 2001) (noting that "because one of the purposes for which sexually violent persons are committed is to receive treatment, the conditions and duration of plaintiff's confinement must be reasonably related to that purpose.").] States are entitled to a reasonable opportunity to achieve a reduction of risk via treatment. Confinement becomes excessive when there is no 'reasonable progress toward that end, and when there is 'no significant likelihood of ...[risk reduction] in the reasonably foreseeable future.'" [*Zadvydas*, 533 U.S. at 701]. Like the alternative purposes in the duration cases, treatment no longer outweighs the cumulative imposition on the individual's freedom.

(at p. 356): "As the cases plainly demonstrate, incapacitation alone supports, at most, confinement that is strictly time limited. That is the lesson of *Salerno* and *Foucha*. In *Zadvydas* as well, the Court stated that dangerousness did not provide a justification for indefinite 'preventive detention'...." [*Zadvydas* at 691].

(at p. 358): "In other words, the *Jackson* line of cases suggests a strong right to treatment, one in which effective treatment facilitates real progress toward community reentry." [emphasis in original]

"If otherwise, the state would have no actual purpose beyond incapacitation – which in itself, as discussed, fails to qualify as a long-term, non-punitive purpose sufficient to satisfy due process." [See *Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1980) (stating that "[a]dequate and effective treatment is constitutionally required because, absent treatment, appellants could be held indefinitely as a result of their mental illness.")]

"...[T]he Court has clearly stated that a non-punitive purpose is a constitutional predicate for a civil commitment scheme. Thus, if a state's treatment conduct falls below this weakest threshold – i.e., if it is insufficient to negate the punitive intent – it should be expected that the commitment scheme would be found unconstitutional, and its committees rightfully released. In *Young*, even Justice Scalia appeared to assume that release from commitment would be appropriate if the state's treatment purpose were negated by appropriate evidence." [See *Seling v. Young*, 531 U.S. 250, 269-70 (Scalia, concurring) ("[I]f those proceedings fail, and the state courts authoritatively interpret the state statute as permitting impositions that are indeed punitive, then and only then can federal courts pronounce a statute that on its face is civil to be criminal."]

(at p. 359): "Finally, we have shown that a strong right to treatment can be derived from the Jackson principle that the duration of confinement must be reasonably related to the purposes of confinement. Confinement that is non-punitive, because it is undertaken with the proper intent, can become punitive if it is excessive in duration, as compared to its purpose. States have only a reasonable period to accomplish their treatment objective, which is the reduction in risk sufficient to allow release. This is an individualized right that is predicated on efficacy. Further, because it implicates the duration of confinement, it is clearly enforceable by release." [emphasis supplied].

Incapacitation alone cannot constitutionally support confinement of long or indefinite duration. "Dangerousness" does not provide a constitutionally valid justification for indefinite preventive detention. Assuming treatment is a sincere purpose of Minnesota's sex offender commitment regime under said *Act* as implemented, it remains a principle of substantive due

process that punitiveness is not a merely momentary measure, but also a cumulative one. Confinement that is non-punitive on a purely momentary basis through provision of adequate treatment can become punitive if the duration of said confinement is excessive. Therefore, the Minnesota sex offender commitment regime under said *Act* has only a reasonable period of time to accomplish the legitimate commitment objective of effecting through treatment rehabilitation of offenders to allow for their release.

Minnesota's sex offender commitment regime under said *Act* as implemented through MSOP provides only minimal treatment at a phenomenally glacial pace, such that said treatment is not adequate, and cannot possibly justify the decades-long duration of confinement. The periods of time consumed by MSOP in a claimed effort to deliver effective treatment is extremely unreasonable in duration to that claimed end. Therefore, by this violation of the duration principle, Defendants deprive Plaintiffs of due process.

This institutional MSOP bias against release, reflected by MSOP's provisional release standard itself, and by pronouncement by MSOP of its conservative release policy, comprises yet another substantive due process violation. In cases of detainees who have advanced into middle- or old-age while in MSOP confinement, such a detainee could not currently be committed, due to his aging-reduced risk. Yet that detainee cannot be freed from his commitment of many years ago under the MSOP standard for release. That standard is not satisfied even if a detainee can show that he either no longer has the mental disorder relied upon for his commitment or is no longer highly likely to commit future sex crimes; even so, only "successful completion" of treatment will suffice to allow release. This is so even though MSOP has a risk assessment department whose calculation of current risk of re-offense is reduced by the actuarial impact of such aging. Despite that MSOP is thus well aware of such reduced risk of re-offense, it withholds this vital information from the detainee and his counsel, from SRB, from SCAP, and from everyone else. That is a present denial of due process.

22. If MSOP Is to Continue at All, Its Treatment (as Described Below) Should Be Brief and Directly to the Point of Convincing Treated Sex Offenders Not to Attempt to Commit Any Further Sex Crimes.

"Treatment" of sex offenders, properly understood, isn't what is commonly understood as treatment at all. There is no meaningful role for either individual psychoanalytical treatment or "group therapy" (especially where, as does MSOP, rapists are 'homogenized' in groups-in-common with pedophiles, since the motivations and dynamics that divide these two groups are vast and utterly inconsistent). The Court, in Finding 70, ascertained that MSOP does not attempt to individualize treatment. Dr. Freeman testified that MSOP treatment improperly homogenizes both rapists and pedophiles in the same treatment 'boilerplate' modality. (*Trial Tr.*, v. 4, pp. 881-82).

According to Finding 105, MSOP treatment participants are unaware of, and uncertain as to, how to progress through treatment. Finding 93 determined that motivation to participate in treatment is reduced by the lack of clear guidelines for treatment completion and of projected time lines for phase progression. Reciprocally, the *OLA Report* found lack of motivation to be a barrier to progression in MSOP treatment. Slow movement through the program was found by Site Visit Auditors to cause demoralization, increased hopelessness, and reduced motivation and engagement. [See also D. McCulloch testimony, *Trial Tr.* v. 1, p. 84, ll. 17-21, p. 102, ll. 6-8] Dr. Vietanen testified that she was ethically troubled by her experiences as a treatment therapist in MSOP because "clients didn't move forward or move out, and that it didn't seem possible to do treatment in a way that was going to result in a positive outcome, i.e., returning to the community." (*Trial Tr.*, v. 10, p. 2288). Due to a lack of sufficient staffing and to an onerous emphasis on report-writing, Dr. Vietanen was not allowed to perform individual treatment except in cases of a serious problem at the moment. (*Id.*, p., 2289).

Finding 106 noted that some MSOP detainees have stopped participating in treatment, despite satisfying phase progression requirements, because they knew it was futile and they would never be released. Some detainees for over twenty years have completed the treatment program three times, but now are only in Phase II, simply because of later treatment program changes.

Finding 95 recaps the figures from Exhibit C to the Affidavit of Janine Hébert as to the distribution of MSOP detainees among those in treatment as opposed to those not, and as to the numbers and percentages of those in the respective phase of treatment. This last set of figures casts a picture of Phase 1-heavy distribution. Finding 96 updates these phase percentages through 2014, reflecting a lesser percentage in Phase 1, with a correspondingly larger percentage in Phase 2. However, less than 10% were then in Phase 3. It should be noted that the 1% figure of treatment 'refuseniks' is well-known among MSOP detainees to be patently, egregiously false. The true figure is easily at or above 15%. The fact of this falsehood casts all other percentages into equal doubt.

Also note that this estimate of a current 80-85% treatment participation rate among MSOP detainees would not be true were it not for DOC ISR requirements that each parolee committed to MSOP participate in treatment as a condition of not being revoked and returned to prison. Were that not such a requirement, nearly all parolees under commitment to MSOP would cease participating in treatment. Also, recall from discussion *supra* that most who are under such compulsion to undergo treatment do so in name only, seldom, if ever, attending core group therapy sessions; effectively, this is simply remaining a refusenik indirectly.

Now that MSOP's 'treatment' has been found by the Court to be no recognized form of treatment at all, and has been part of the Court's ruling of denial of substantive due process, shouldn't this requirement of participation also be struck down?

The fact that MSOP clinical officials (along with the great majority of those in charge of sex offender commitment treatment programs elsewhere) have not yet grasped this elemental fact

demonstrates the hopelessness of simply "developing" or "adjusting" current treatment regimens. What is needed is complete replacement of the entire theory of sex offender treatment.

What should replace the current conceptualization is a starkly contrasting model of simple, short, candid indoctrination, with completely voluntary adjunctive therapy held out for those who express a need or compelling desire for it, in order to ensure their personal non-reoffending after release. The standard indoctrination should consist of two branches:

(1) A short course of education into the physical, cognitive, and emotional facts of sexuality, from the perspective of victims, both adult and child. The emphasis here is upon convincing the offenders in this study of the often devastating consequences to victims of their actions and of the impossibility of avoiding infliction of that devastation while continuing to commit sex crimes.

(2) A short, simple examination of the massive array of monitoring, surveillance, investigation, and apprehension agencies, their countless, highly dedicated personnel, and their techniques, including high-tech tools, all poised to ensure that no released sex offender will be able to sexually reoffend, and that, when any move toward such perpetration is detected, or merely any attempt is made to evade supervision or registration, the offender will face immediate arrest and many years of further incarceration.

This proposed regimen, easily designed for maximum impact, combined with such post-release measures (which, if only by default, are currently performed very conscientiously by every police department of any area in which any sex offender resides or works, or which he frequents), will ensure non-re-offense far more effectively than 20 years of MSOP-style 'treatment' aimed at impossibilities and ending only in extreme frustration and rage.

Conclusion

Based on all of the foregoing observations on the true state of affairs in MSOP, the Resident Advisory and Family Council urges the Minnesota Legislature to repeal Minnesota Statutes Chapter 253D in its entirety. The latest MSOP annual performance report casts the impression that 'everything is perfect and beautiful' in MSOP. However, as the foregoing shows, nothing could be farther from the truth.

If you, as legislators, refuse to repeal this abomination unto the guarantee of due process and the protection against bills of attainder, then know what you are doing by perpetuating the monstrosity of MSOP. MSOP embraces "cognitive behavioral therapy" ("CBT") as its centerpiece of treatment of sex offenders. In a nutshell, CBT seeks to change one's thinking about the nature of sex crimes and thereby, through the natural process of cognitive dissonance, to change sex offenders' behavior from sexual offending to living a crime-free lifestyle. To try to change a sex offender's thinking, the typical combination of punishments and rewards of

"behavioral" treatment are imposed upon each offender. In other words, CBT is simply a rewrite of traditional "brainwashing" from Korean War days and the War in Vietnam. However, despite years of such brainwashing (especially in the latter war), as soon as the brainwashed were released to return home, all vestiges of such supposed cognitive and behavioral changes disappeared, and the victims returned to life as before, with resumption of previous attitudes, often more emphatically held and expressed. In short, in the long run brainwashing is an utter failure.

This realization is probably why sex offender commitment programs elsewhere in the country are now largely in the process of giving up on CBT. See *Jennifer E. Schneider et al., "SOCCPN Annual Survey of Sex Offender Civil Commitment Programs 2014,"* SOCCPN, San Diego, Oct. 27, 2014 (The percentage of treatment programs in use in the various commitment programs that use "cognitive behavioral" treatment as an "organizing principle" of their treatment program (as does MSOP) has fallen by half since 2007 (2007: 90%; 2014: 47%). No other treatment program takes several years or more to have any claimed effect on its participants. Such authorities elsewhere are doing so even though there is no 'magic bullet cure' of a replacement treatment program. Obviously, authorities in other states have tired of paying for similar programs that, like MSOP, engage in many years or even decades of treatment only to announce that it has had no effect or insufficient effect to declare its participants now 'safe enough' to release. Thus, such treatment programs in other states actually have substantial release numbers annually, whereas MSOP has almost none – ever.

Continuation of the MSOP so-called treatment program is nothing but ever-thinner attempted cover for what amounts to permanent detention of sex offenders as extended punishment for their past crimes. Even the very notion that such detention is needed as "preventive" against similar future crimes has now been completely dashed against the rocks of science, given that most of these former sex offenders are now in their late fifties and beyond. The recidivism statistics clearly reveal that this category in particular is comprised of those least likely to ever sexually reoffend in the future, and that such likelihood is so low as to be measurable in the low single-digit percentages of probability, if not even lower still.

MSOP thus is effectively nothing more than a permanent employment plan for fanatical haters of sex offenders who have gained college degrees in studies in mutual admiration of such states of hatred. This must cease now. The impact of MSOP on Minnesota's annual governmental budget is extreme (and extremely wasteful, compared to allocation to effective sex crime prevention programs).

Worse yet, the precedent that MSOP sets as a program is frightful in its implication that similar detention/'treatment' programs can be founded to keep all manner of persons combined because some set of the public can be whipped up into a furor of fear and hatred of them. Will this be drunk drivers, or drug addicts and/or alcoholics, or career criminals, or perhaps those with extreme political views, including a belief in a rightful place for political violence and unrest, or perhaps those whose lifestyles some find too bohemian or those with unusual religions who are suspected of immorality and generally parasitical business practices?

Looking back at the 1994 creation of commitment of sex offenders in Minnesota, the statements of legislators then and of those who urged them to pass that legislation were emotional and were of the scientifically incorrect belief that sex offenders are driven by an urge to reoffend such that further recidivism is all but certain (the '100% recidivism' myth). Viewed charitably, the best that could be said is that such commitment was an experiment to see if some treatment could reduce this imagined terror of near-certain recidivism to some lesser, societally acceptable level of unlikelihood of recidivism. However, in the fanatical minds of those who administer MSOP and their 'clinical' employees, it is now clear that they, at least believe that no such reduction is even possible, or that it can be achieved by any sex offender only rarely, and only after decades of effort (the 'complete persona makeover' theory).

Consider that numerous legal commentators have objected to sex offender commitment legislation and its administration in practice as a deliberate erosion of the criminal justice process as a means of dealing with crime. Effectively, the main precept of the sex offender commitment movement is that sex offenders cannot be deterred by the penalties of the criminal law or the likelihood of getting caught for their sex crimes. However, in reality, sex crime statistics show that the incidence of sex crimes, and more particularly, recidivistic sex crimes, has plunged precipitously – literally appearing to fall off a cliff on graphic charts. This is true of Minnesota, as well as elsewhere.

The time period over which this reduction in sex crimes occurred closely tracks that same period in which criminal penalties in Minnesota were repeatedly drastically escalated multiple times (as a matter of sentencing guidelines, for instance). Moreover, during that same period, efforts to investigate sex crimes greatly increased, including the wide availability of DNA PCR technology making crime-scene DNA comparisons to sex offender databases easily and fairly cheaply possible for the first time. Therefore, it seems quite clear that the reduction in sex crime incidence, and especially a reduction in recidivistic sex crimes, is due to deterrence through fear of detection, apprehension, and criminal punishment.

In other words, contrary to the asserted predictions at the time of the 1994 MCTA in Minnesota, criminal deterrence now works admirably at preventing sex offenses, and particularly at deterring sex-crime recidivism. In this light, the claimed justification for a need to override the primacy of the criminal law as to recidivistic sex crimes has now been proven to be incorrect. It follows that MSOP commitment simply is not necessary for purposes of preventive detention. It simply should be brought to an end now.

Even if the Legislature differs on this, the MSOP program should be limited to a short maximum period of treatment in confinement. Such treatment should consist of the pragmatic matters suggested in the final section of Part 2, *supra*. Beyond this there simply is no science to support any known therapies.

In any event, there simply is no massive danger of widespread recidivism. It is a proven fact that those sex offenders who are committed are only as likely to commit another sex crime as is any other non-committed sex offender. As stated above, that general rate of sex-crime recidivism is extremely low. Even though one may always argue that there is at least some small

danger of recidivism, there simply is no way to determine who will reoffend, versus who will not.

Using the 3% current sex-crime recidivism rate over all offender ages, this means that if 100 sex offenders were seated in an otherwise empty auditorium and a committee of so-called forensic experts were seated on the stage, those experts would not be able to tell which three of those one hundred would reoffend. This fact is undenied and is undeniable. In essence, this signifies that roughly 97 out each 100 sex offenders under commitment in MSOP would never have committed another sex crime even if they had not been committed.

Conversely, it also means that, out of the 730 currently confined by MSOP, only roughly 22 would ever commit another sex crime. Locking up 730 people simply to prevent 22 potential victimizations may have emotional appeal, but it is a terrible waste of tax dollars and it is grievously unfair.

Please end all this now.