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Minnesota Sex Offender Program Annual Performance Report 2016

Minnesota Sex Offender Program
February 2017

Legislative Report

Minnesota Department of **Human Services**

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

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I. Executive Summary

Again this year, considerable public attention has focused on the *Karsjens* federal class action lawsuit. Filed in 2011 by clients of the Minnesota Sex Offender Program (MSOP), it resulted in a trial occurring in February and March of 2015. The district court issued an order that same year on June 17th, finding the Minnesota sex offender civil commitment statute unconstitutional both in how it is written and in how it is applied.

The State appealed that order and the related remedies order to the 8th Circuit U.S. Court of Appeals. A three-judge panel of that court heard oral arguments on April 12, 2016, in St. Louis, Missouri. On January 3, 2017, the 8th Circuit issued its ruling which reversed and vacated the district court's order after concluding that the statute and its application to be, in fact, constitutional. The court then remanded the case to the district court for further proceedings. The plaintiffs may appeal the 8th Circuit decision to the entire court or to the U.S. Supreme Court.

As the on-going federal court case continues to unfold, MSOP continues to provide comprehensive sex offender treatment in a safe and therapeutic environment with 85% client participation rate. Clients are demonstrating progress, making changes, and advancing through treatment, as evidenced by the increasing numbers of clients in the later phases of treatment, court-ordered transfers to Community Preparation Services (CPS), and court-ordered provisional discharges into the community as well as one full discharge in 2016.

Phase I of the approved 2015 bonding request was completed this past year. In September, MSOP opened a new 30 bed wing for clients being transferred by the Supreme Court Appeals Panel (SCAP) to CPS. CPS is a less restrictive alternative setting outside the secure perimeter on the lower campus in St. Peter. Due to this recent expansion, we now have 89 total beds in that unlocked facility and it is already filled to capacity. Bonding for Phase II is in the Governor's budget for the 2017 legislative session, bonding that project would expand CPS even further to accommodate those clients that SCAP continues to grant transfer orders for.

The increase in client progress through treatment phases and the SCAP's ordered transfers to CPS have created a shift in placement needs at both campuses. The Moose Lake facility, housing and treating new admissions and early treatment phase clients, has experienced a reduction in population allowing the closure of a 25-bed unit. This has resulted in clients moving from Moose Lake to St. Peter and from the St. Peter secure facility to CPS. That movement has created a shift in staffing needs for all aspects of the MSOP program including increased psychology resources to provide risk assessments to the Supreme Court Appeal Panel required when clients petition for CPS, provisional discharge, and discharge.

MSOP's interdisciplinary team continues to maintain a strong infrastructure for a therapeutic environment supportive of client change. The third 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 while in treatment and while reintegrating to the community.

Commitment to staff safety is exemplified by the Minnesota Safety Council Meritorious Achievement Award in Occupational Safety awarded to the St. Peter program site for the 4th year in a row and the Moose Lake program site for the 2nd consecutive year.

MSOP highlights for 2016 contained in this report reflect continued focus on our mission to promote public safety by providing comprehensive treatment and reintegration opportunities for civilly committed sexual abusers.

II. Background

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

Because annual program statistics are closed out on December 31 of each year, it is quite difficult to complete the needed analysis of performance on strategic goals and report by the current statutory deadline of January 15. Due to this, MSOP requested and received an extension to February 15 because the program is committed to providing a complete and accurate report in addressing the necessary areas defined by the state. To avoid requests for deadline extensions in the future, MSOP will be pursuing a legislative change reflecting this practice in the 2016 session.

The statute specifies that this report include:

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

This program evaluation occurred in January 2017.

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

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

The St. Peter campus has two missions: reintegration and programming for the Alternative clients. Clients in phase III progress through privileges that allow opportunities to demonstrate their abilities to use new coping skills and risk management techniques in settings with less structure. St. Peter also provides the Alternative Program for clients with compromised executive functioning due to learning disabilities, developmental disabilities, head injury or trauma, and other issues that prevent them from being successful in conventional programming. These clients do all three phases of programming on the St Peter campus.

III. Program Overview, Strategic Mission, Goals, Objectives, and Outcomes

Description of the Program: The Minnesota Sex Offender Program provides comprehensive sex-offender-specific treatment to individuals (clients) who have been civilly committed by the courts to the MSOP.

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

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

All clients participating in treatment develop skills through active participation in group therapy and individual sessions. Clients are provided opportunities to demonstrate meaningful change through their participation in rehabilitative services programming such as education classes, therapeutic recreation activities, and vocational opportunities. MSOP staff observe and monitor clients in treatment groups as well as in all aspects of daily living to determine and provide feedback on how clients are applying new knowledge and prosocial skills.

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

Priorities: MSOP is committed to creating a safe and respectful environment for clients and staff. Respect is defined as transparent and proactive communication, accountability, and recognition of the individualized needs of clients. Inherent in respect is the belief that all people are capable of making meaningful change if they possess the motivation and tools to do so.

MSOP executive leadership has established five strategic goals. These strategic goals are organized under the following five program values: Therapeutic Environment, Program Integrity, Learning Organization, Employee Engagement, and Responsibility to the Public

[1] As discussed in section V, MSOP provides staffing for sex-offender-specific treatment to Department of Corrections inmates who are identified as likely to be referred for civil commitment upon their release from incarceration.

1. Therapeutic Environment:

Goal: To further develop, complete, and implement the Community Living Project at MSOP
Outcome: The Community Living Project (CLP) is a philosophy based on developing a therapeutic community as an approach to maintaining a healthy treatment environment in a residential setting. This multi-step initiative was designed to meet the specific and unique needs of the MSOP clientele. Numerous interventions and enhancements were considered by the project team which were empirically based in literature and identified as best practice within the sex offender treatment field. CLP theory promotes clients taking personal responsibility for daily issues and problems, skill-building to problem solve, and maintaining safe and positive behaviors in the living environment. The project was comprised of 4 primary areas which included conflict resolution, a tier privilege system, behavioral expectations unit re-design, and a "staff toolbox" to utilize in challenging situations. Many MSOP staff have been trained thus far, policies have been approved, and client councils established. Implementation of the project was rolled out in 2016 and several treatment units are currently piloting CLP, full implementation expected by July of 2017.

2. Program Integrity:

Goal: To hire a Fidelity Director who will evaluate and oversee the quality of programming and clinical interventions across MSOP
Outcome: A new department was created within MSOP in 2016 to measure adherence to the program model and to develop systems for continuous improvement of various aspects of treatment and delivery of clinical services. The Fidelity Department will gather data on staffing, staff training, and treatment received by clients. Monitoring this data and implementing strategies to address any issues identified will ensure the foundation of the program is in place to deliver an effective intervention and the continuation of meeting best practices within the field. Doug Latuseck, PsyD, LP, was hired as the Director of Fidelity in July and he has begun a comprehensive review of existing systems for staff recruitment, clinical training, and adherence to program design. Going forward, the Fidelity Department will have a broad impact on delivery of services, program evaluation, and on-going research at MSOP

3. Learning Organization

Goal: To increase overall awareness and provide opportunities for learning to the public and stakeholders about sex offender treatment, civil commitment, and reintegration of sex offenders in Minnesota

Outcome: This past year several clinicians and leadership were asked to provide training and present at local conferences in Minnesota as well as a national conference held in Florida. Those organizations where MSOP was represented included the state and national Association for the Treatment of Sexual Abusers (ATSA) as well as the Sex Offender Civil Commitment Program Network (SOCCPN). In addition, every fall of each year, MSOP administration and legal managers present a half day event to county and defense attorneys, risk assessment examiners, Special Review Board members, Supreme Court Appeals Panel judges, and others. In 2016, there were approximately 120 attendees. This event is to provide current information about the program, legal issues, and reintegration of clients. In addition, for 2017, a comprehensive education plan is being developed for further outreach to each of our judicial districts to highlight and discuss the safe reintegration of sex offenders in our communities.

4. Employee Engagement

Goal: Empower and encourage employees to be actively involved in the workplace through committees, events, activities, and projects

Outcome: Employee Engagement Committees continue to be very active at both MSOP sites. Employee retention is an important focus for our committees at MSOP and they are working together to establish strategies around improving retention across disciplines. Also this past year, through peer nominations, we have implemented an "Employee Recognition Program" to acknowledge those employees who go above and beyond in their daily duties. A process was developed and vetted in terms of selection and recognition. Several fundraisers were held as well at both St. Peter and Moose Lake facility sites this past year to raise money for their respective communities and identified charities. Over $10,000.00 was raised once again in 2016 by our employees through the Combined Charities Campaign. These engagement efforts that bring our staff together have been highly successful and continue to grow in participation and creativity.

5. Responsibility to the Public:

Goal: Safely supervise, case manage, and assist in the successful reintegration of clients who are provisionally discharged into the community

Outcome: Searching for and securing appropriate housing for those clients granted provisional discharge (PD) was a primary focus and challenge in 2016. We now supervise, monitor, and provide case management services for 7 individuals released into various communities. There are 6 additional clients as of this writing who have PD orders, however, we have not yet secured housing for them. We are assuring there is gradual, safe, and intentional reintegration by developing and implementing solid policies and procedures that govern our practices, assisting in job searching with clients, assisting clients in forming a positive support network, working with aftercare organizations, and approving and overseeing outings and increased liberty. Putting together safeguards, extra precautions, solid planning, and providing ongoing supervision is a priority for MSOP as clients continue to receive court orders for provisional discharge.

IV. Treatment Model and Progression

A. Program Philosophy and Approach

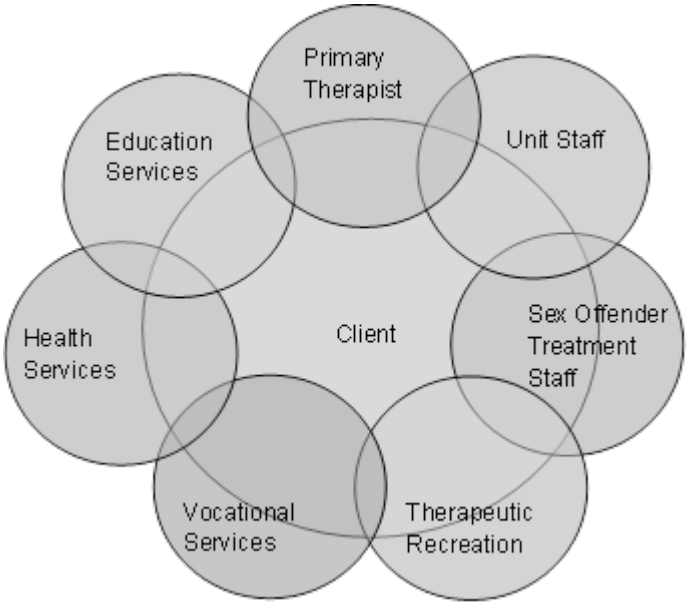
MSOP draws on several contemporary treatment approaches in its programming. These include cognitive-behavioral therapy, group psychotherapy, and relapse prevention. In addition, programming is influenced by the professional psychological literature in the areas of risk/needs/responsivity and stages of change, with additional philosophical influence from the "Good Lives" model.

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

Clients progress through three phases of treatment. In the initial treatment phase, clients acclimate to treatment and address treatment-interfering behaviors and attitudes. The next phase is the intermediate treatment phase with a focus on a client's patterns of abuse and on identifying and resolving the underlying issues in their offenses. Clients in the final treatment phase focus on maintaining the changes they have made and demonstrating their ability to consistently implement those changes and manage their risk while they work on deinstitutionalization and community reintegration.

B. Comprehensive and Individualized Treatment

MSOP provides a comprehensive treatment program. Clients acquire skills through active participation in psychoeducational modules and group therapy and are provided opportunities to demonstrate meaningful change through participation in rehabilitative services including education classes, therapeutic recreational activities and vocational work programs. Clients are observed and monitored not only in treatment groups, but in all aspects of daily living. This observation and monitoring is crucial for assessing clients' progress in making and maintaining meaningful personal change and in consistently applying treatment concepts, thereby decreasing their risk for re-offense.



Clients who participate in treatment have an Individualized Treatment Plan. Each plan is developed with the client and the client's primary therapist, and is grounded in the results of a sexual offender assessment. The plan's goals are written to address the client's individual risk factors for recidivism and specific treatment need areas. Treatment progress is reviewed on a quarterly basis, and plans are modified as needed.

MSOP clients who choose to engage in treatment participate in a sexual offender assessment that sets the foundation for their individualized treatment plan. Clients are then placed in programming based on their clinical profiles. MSOP provides sex-offender-specific treatment to meet the needs of all clients.

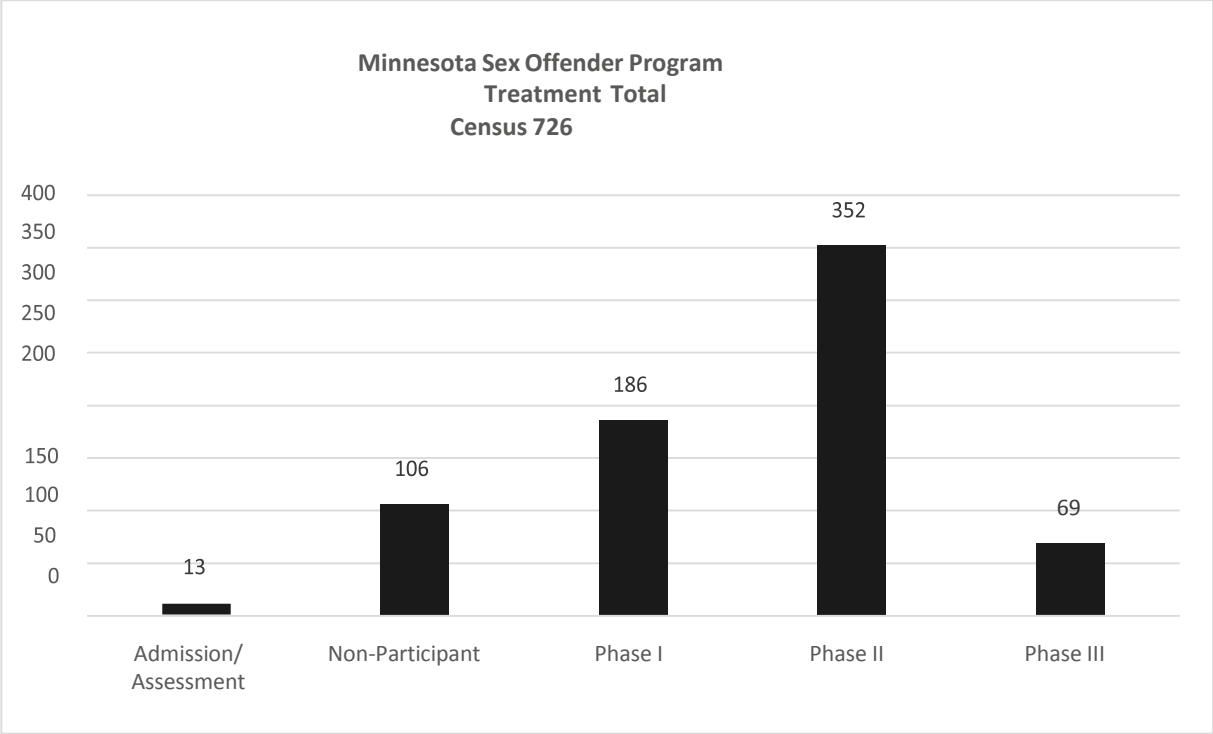
C. Treatment Progression

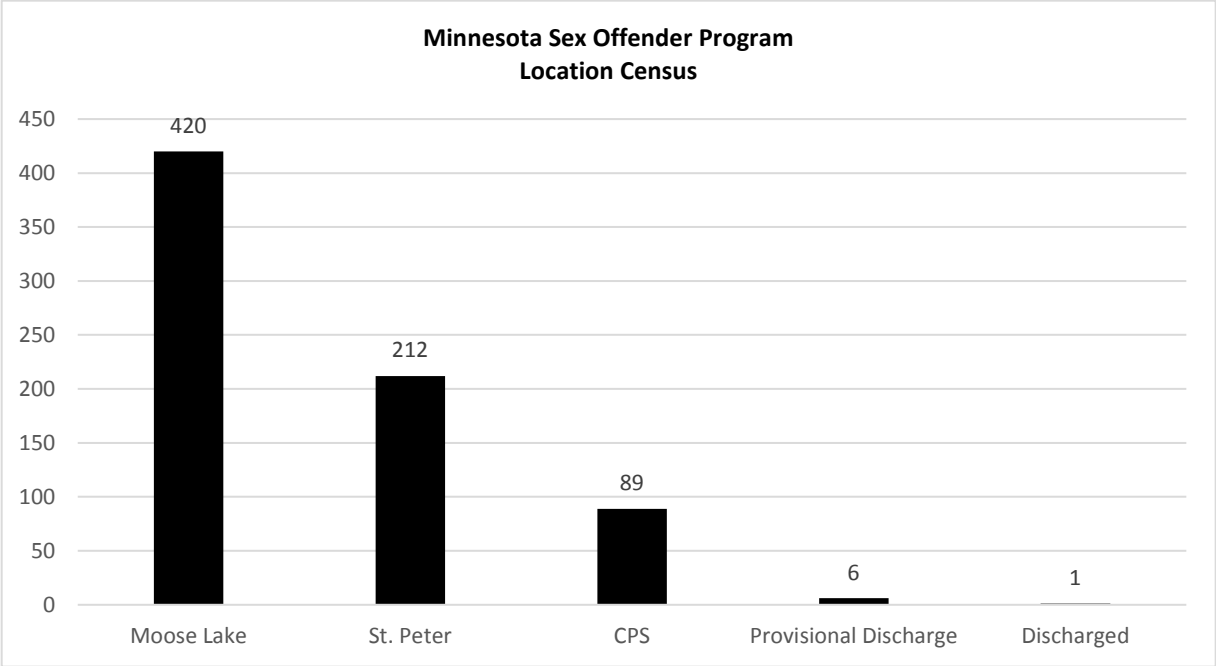
Clients address their own individual risk and treatment needs by adhering to their individualized treatment plans. They attend psychoeducational modules based on their treatment needs and core groups. On a quarterly basis, all clients are reviewed on MSOP matrix factors, which are based on the criminogenic needs in current research.

The matrix factors are:

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

On a quarterly basis, each client participating in treatment conducts a self-assessment and the results are compared with the observations and assessments of the client's primary therapist and treatment team. Individual treatment plans and treatment targets are modified accordingly.


Minnesota Sex Offender Program
Treatment Total
Census 726
400
350
300
250
200
150
100
50
0
13
106
186
352
69
Admission/ Assessment
Non-Participant
Phase I
Phase II
Phase III


Minnesota Sex Offender Program
Location Census
450
400
350
300
250
200
150
100
50
0
420
212
89
6
1
Moose Lake
St. Peter
CPS
Provisional Discharge
Discharged

V. MSOP Treatment at the Department of Corrections

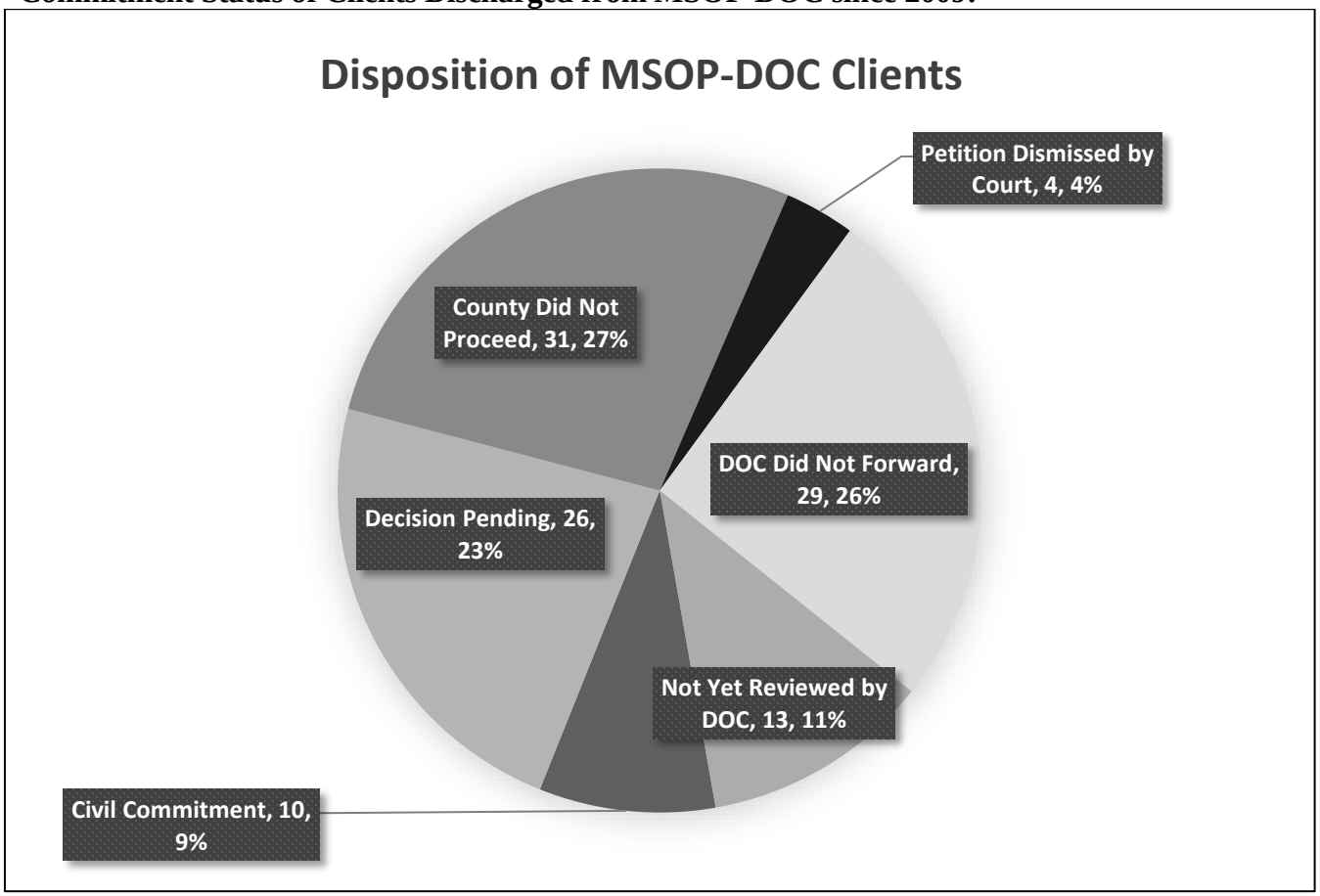
MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. This program provides sex offender treatment similar in scope and treatment design as the MSOP Moose Lake facility. Program participants are serving their correctional sentences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

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

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

There have been 161 men who have been admitted to the MSOP-DOC program since 2009. As of December 31, 2016, there are currently 48 clients in the program and 113 men who have been discharged from the program.

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



VI. Community Preparation Services and Reintegration

As part of the treatment program at MSOP, Community Preparation Services (CPS) is a free-standing, unlocked facility located on St. Peter's lower campus. CPS prepares clients for their transition and reintegration back into the community. The Supreme Court Appeals Panel (SCAP) grants orders for clients to transfer from the secure perimeter to CPS when clients meet criteria for transfer to continue their treatment in a less restrictive setting. Established in 2008, the program has experienced tremendous growth in the past few years, most recently in 2016. In August of this past year, Phase I of the bonding project to expand beds at CPS was completed and 30 additional beds were opened. A total of 43 clients moved from the secure perimeter into CPS during the calendar year. The new 30 bed wing was immediately filled to capacity which is 89. Since filling CPS to capacity, new transfer orders have been granted. However, those clients must remain inside the secure perimeter until additional beds become available. Phase II of the bonding bill is being requested which will expand CPS by 50 additional beds as well as renovate other space to provide the needed services outside the secure perimeter for those clients transferred by the court.

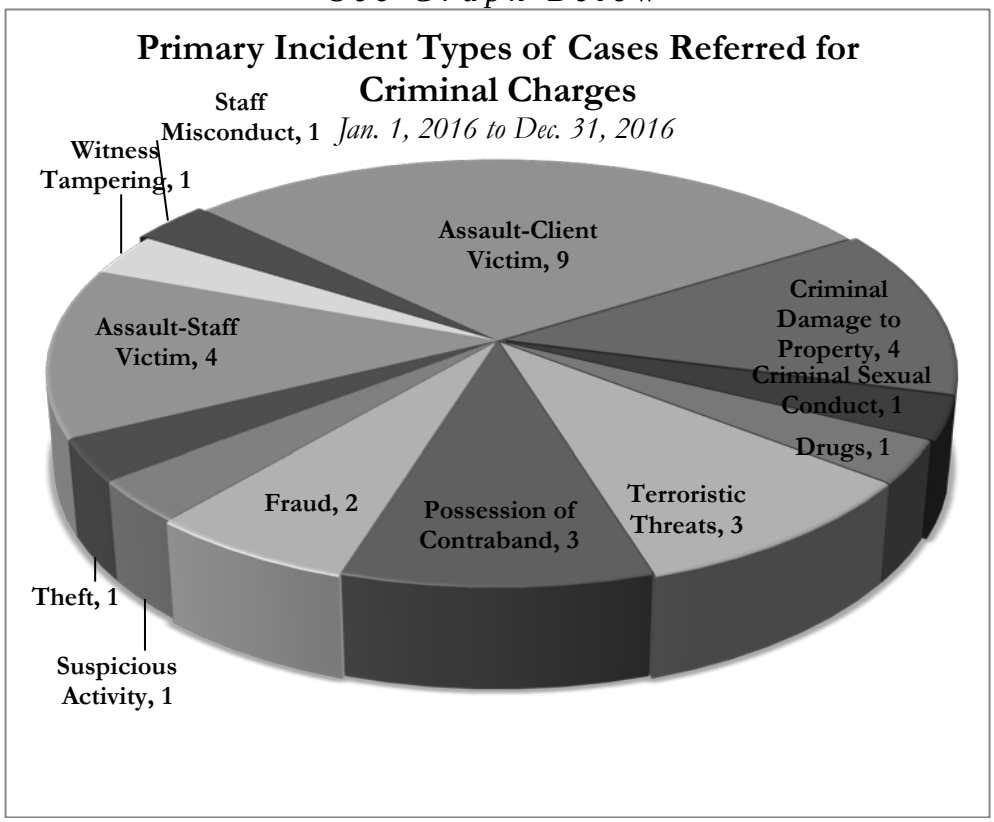
Also in 2016, a total of 8 clients were granted provisional discharge orders to move to the community and, for the very first time, 1 full discharge was granted. Currently there are 7 clients living in MN communities. There are also 6 others who have received provisional discharge orders and are awaiting to secure housing. Depending on the individual needs of the client, appropriate housing and out-patient treatment services are established. Reintegration Specialist staff provide supervision and case-management for those clients on provisional discharge.

VII. Office of Special Investigations

The Office of Special Investigations (OSI) provides MSOP with coordinated investigative services with the goal of aiding MSOP staff in providing a safe and secure treatment environment and to enhance public safety. In the event illegal activities are suspected, OSI is responsible for conducting an investigation and providing comprehensive investigative reports to local law enforcement. Responsibilities of OSI include (but are not limited to): investigation of suspected criminal activity, coordinating intelligence collection regarding security threat groups activities and other suspicious behaviors, and disseminating that information to program administrations, conducting covert surveillance of clients escorted into the community and those on provisional discharge, investigating circumstances that pose a threat to the security of a program facility, and serving as the official liaison with local, state, and federal law enforcement agencies.

From January 1, 2016 to December 31, 2016, OSI has investigated 93 MSOP cases focusing on client misconduct (there were 104 investigations in 2015). Thirty-one of these cases were referred for criminal charges, with charges being filed in 19 cases (three referrals were carried over from 2015.) OSI also provides information to the Department of Corrections (DOC) regarding clients who are not compliant with their conditional release agreements from the DOC. In 2016, five clients were returned to DOC for revocations of conditional release and three clients were charged with new criminal convictions and returned to DOC.

See Graph Below



VIII. Program-Wide Per Diem and Fiscal Summary

Minnesota Sex Offender Program Fiscal Year 2016 & 2017 Per Diem

	FY 2016		FY 2017	
Description	**Annual $$**	**Per Diem**	**Annual $$**	**Per Diem**
Direct Costs				
Clinical	**18,313,539**	**67.71**	22,195,251	82.51
Healthcare and Medical	**6,565,885**	**24.28**	6,886,274	25.60
Security	**34,885,367**	**128.98**	35,098,343	130.47
CPS & Community	**2,246,967**	**8.31**	3,389,947	12.60
Dietary	**2,706,680**	**10.01**	1,583,791	5.89
Physical Plant & Warehouse	**7,295,628**	**26.97**	7,126,273	26.49
Program Support*	**11,671,933**	**43.15**	13,316,121	49.50
Total Direct Costs	**83,686,000**	**309.40**	89,596,000	333.06
Operating Per Diem		**309**		**333**
Indirect Costs				
Statewide Indirect**	**39,099**	**.14**	**92,376**	**.34**
DHS Indirect***			**315,000**	**1.17**
Building Depreciation	**3,969,731**	**14.68**	**3,969,731**	**14.76**
Bond Interest	**5,359,200**	**19.81**	**5,359,200**	**19.92**
Capital Asset Depreciation	**101,897**	**.38**	**101,897**	**.38**
Total Indirect Costs	**9,469,927**	**34.99**	**9,838,204**	**36.64**
Total Costs	**93,155,927**	**344.01**	**99,434,204**	**369.64**
Projected Average Daily Client Count (ADC)	**739**		**737**	
Statutory Per Diem Rate		**344**		**370**

*Allocated cost of agency central functions such as, but not limited to: financial operations, budgeting, telecommunications
and media services, occupancy, compliance and internal audit, legislative coordination, and licensing.
**Minnesota Management & Budget charges for services such as central purchasing, payment processing, electric fund transfers, and other services provided to all state agencies.
*** Department of Human Services allocates costs from the commissioner's office and other support areas such as management services, financial operations, and human resources as identified within the Departments' Cost Allocation Plan.

MSOP Per Diem

While there are 21 civil commitment programs (20 state programs and one federal program) in the country, there is no uniform method for calculating the per diem cost of program operations. A survey conducted by MSOP Financial Services revealed that most programs do not include all costs associated with operating and maintaining a program. MSOP uses a comprehensive per diem calculation that includes all direct and indirect costs, including costs incurred by the state for bonding and construction of physical facilities. This all-inclusive per diem for fiscal year 2017 is $370 and fiscal year 2016 was $344.

IX. Annual Statistics

Current Program statistics through December 31, 2016 –

Total MSOP Clients	**721**
Clients by Location	
Moose Lake	420
St. Peter	301
Clients by Age	
18-25	7
26-35	122
36-45	177
46-55	204
56-65	148
Over 65	63
Average Age	**48**
Youngest	22
Oldest	85
Race	
American Indian/Alaskan Native	51
Black/African American	100
White Caucasian	532
Other/Unknown	38
Education	
0-8 Years	25
9-12 Years	55
High School Degree	335
GED	225
High School degree and GED	8
Some college or college degree	50
Unknown	23
Metro Counties (7-County Area)	299
Non-Metro Counties	422

Population Statistics
When civil commitment is pursued for an individual, upon expiration of a DOC sentence or a supervised release date, he or she is placed on a judicial hold while the petition is pending. Individuals on judicial holds have the option to remain in a DOC facility (210 days maximum) or to be admitted to MSOP.

Clients Pending Civil Commitment:

Clients on judicial hold status in the MSOP	3
Clients on judicial hold status in the DOC/jails	7
Total on judicial hold status	**10**

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

Clients Civilly Committed to the MSOP:

Clients who have been initially and finally committed during 2016*	17
Clients previously committed whose cases were reviewed and finalized for commitment during 2016	0
Total civil commitments to the MSOP during 2016	**17**

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

Many clients who are civilly committed to the MSOP also still remain under DOC commitment on supervised release status (dually committed). If these clients engage in actions or criminal behaviors which result in the DOC revoking their supervised release status or result in a new conviction, the clients are remanded to either a county jail or the DOC to serve a portion or all of their criminal sentences.

Dually-Committed Clients:

Clients who are under civil and DOC commitment in the MSOP	176
Clients who are under civil commitment and in a DOC or federal prison	13
Total number of dually committed clients as of December 31, 2015	**189**

Clinical Statistics

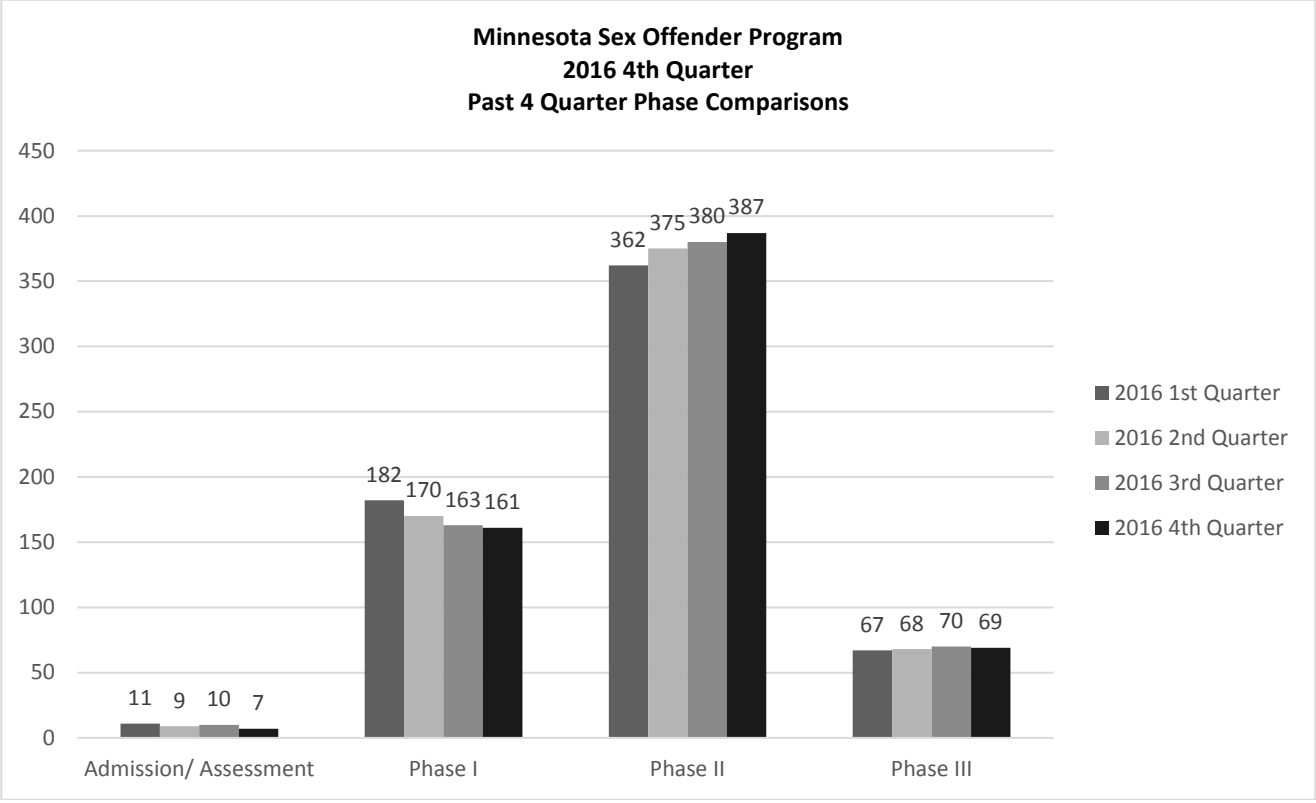
Treatment Participation

All new admissions are assessed for individualized treatment needs. While on the admissions unit, clients are able to participate in groups geared toward adjustment issues and treatment readiness as well as rehabilitative programming. Of the clients eligible for sex offender- specific treatment, approximately 85 percent were participating at the end of 2016.

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

Treatment Progression

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



The following chart illustrates the 2016 distribution of clients across the treatment units. The MSOP population is diverse with 22 percent of the clients residing on units that provide specialty programming while 77 percent reside on units providing Conventional Treatment. The remaining 1 percent of the population resides on the Admissions (ADM) programming unit, which does not provide sex-offender specific treatment.

	Location	Count	Percentage
Admissions	Moose Lake	7	1%
Alternative Program Units	St. Peter	101	14%
Assisted Living Unit	Moose Lake	16	2%
Behavioral Therapy Unit	Moose Lake	28	4%
Conventional Program Units	Moose Lake and St. Peter	554	77%
Mental Health Unit	Moose Lake	15	2%
	Total	**721**	

	Clinical Treatment	Clinical Programming	Total Clinical Services Hours
Phase I	8	7	15
Phase II	9	15	24
Phase III	10	20	30

Clinical Service Hours

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

Treatment hours are spent in Core Group, Psychoeducational Modules, therapeutic community meetings, reintegration services, modified programming, individual therapy, progress reviews, and assessments.

In addition to weekly treatment hours, clients are offered the opportunity to participate in clinical programming. Programming hours are comprised of educational, therapeutic recreation, vocational, and volunteer services. Assignment to programming is determined by the client's treatment phase and individual needs.

X. MSOP Evaluation Report Required Under Section 246B.03

In effort to maintain a treatment program that is grounded in current best practices, research, and contemporary theories, MSOP contracts with outside auditors to review the treatment program. This team consists of three professionals who are well respected, both nationally and internationally, in the area of sexual abuse treatment. Individually and as a group, they have consulted with similar programs throughout the world. They bring not only a perspective of current practices, but also years of professional experience.

Minnesota Sex Offender Program Site Visit Report 2016

Site Visitors:	Robert McGrath, McGrath Psychological Services Middlebury, Vermont
	William Murphy, University of TN Health Science Center Memphis, Tennessee
	Jason Smith, Assessment & Counseling Associates West Des Moines, Iowa and Middleton, Wisconsin
Location:	Minnesota Sex Offender Program, Moose Lake, Minnesota Minnesota Sex Offender Program, St. Peter, Minnesota
Dates of Visits:	December 5-9, 2016
Date of Report:	December 19, 2016

Purpose and Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment program. The consultation was a component of MSOP's quality improvement program. The present site visit was a follow-up to our (McGrath and Murphy) previous site visits. The last site visit was in January 2016.

During the current review, we spent two days at the Moose Lake site and two and one-half days at the St. Peter site. While we were on site, we reviewed and discussed our initial findings with Nancy Johnson, MSOP Executive Director; James Berg, Deputy Director; and Jannine Hebert, MSOP Executive Clinical Director for one hour via videoconference on December 8, 2016. We again reviewed and discussed our initial findings with senior managers at both sites, including James Berg and Jannine Hebert, via videoconference for one and one-half hours from the St. Peter site on December 9, 2016.

Evaluation Request

During the current site visit, the MSOP requested that we evaluate the following services at Moose Lake and St. Peter:

A. Therapeutic Recreation Program at Moose Lake
B. Community Preparation Services (CPS) at St. Peter
C. Conventional Program culture at St. Peter

Procedures

We reviewed the following written materials:

- Organizational Charts
  - MSOP Sex Offender Executive Operations
  - Clinical Organization at both site
  - Operational Departments at both sites
  - Moose Lake Rehabilitation Therapy Program
  - St. Peter Reintegration Services
- Community Preparation Services program client census 2009 to 2016
- Community Preparation Services Program Design, August 2016
- Community Preparation Services Handbook, August 2016
- MSOP Quarterly Reports, 3rd quarter 2016
- MSOP Theory Manual
- MSOP Clinician's Manual
- MSOP Rehabilitation Therapies brochure
- Rehabilitation Therapies sign-up sheets and schedules at St. Peter
- Rehabilitation Therapies participation statistics at St. Peter
- SRB Numbers as of 10/24/16
- Therapeutic Recreation Programming Policy 220-5050

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

- Met in individual and group meetings with senior management, including:
  - Jannine Hebert, MSOP Executive Clinical Director
  - Kevin Moser, Facility Director at Moose Lake
  - Terry Kneisel, Assistant Director at Moose Lake
  - Peter Puffer, Clinical Director at Moose Lake
  - Kathryn Lockie, Associate Clinical Director at Moose Lake
  - Nancy Stacken, Associate Clinical Director at Moose Lake
  - Chad Mesojedec, Education and Rehabilitations Service Director
- Toured the facility

- Met with the following staff groups without their supervisors present:
    - clinical supervisors (2 individual meetings)
    - clinicians (7 individual meetings)
    - psychologists (2 individual meetings)
    - rehabilitation staff (3 individual meetings; 1 group meeting with 3 staff)
    - unit directors (1 meeting with 2 directors)
- Met with 5 Unit Representatives in 2 small group meetings
- Conducted brief reviews of 8 client records

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

- Met in individual and group meetings with senior management, including:
    - Bonnie Wold, Facility Director at St. Peter
    - Christopher Schiffer, Clinical Director at St. Peter
    - Brenda Todd-Bense, Associate Clinical Director at St. Peter
    - Tim Benesch, Community Preparation Services (CPS) Director
    - Michelle Sexe, CPS Operations Manager
    - Pat Quigley, CPS Operations Supervisor
- Toured the facilities
- Met with the following staff groups without their supervisors present:
    - clinicians (2 individual meetings in conventional program)
    - clinical supervisors (2 individuals meetings with 2 conventional program supervisors and 1 individual meeting in CPS program supervisors)
    - security counselors (1 group meeting with 2 conventional program security counselors and 1 meeting with 1 CPS security counselor.)
- Conducted client interviews
    - at CPS, interviewed 1 advanced client and held brief discussions with several clients during visits to CPS units and work stations
    - at the Conventional Program, interviewed h 8 clients on a unit and brief discussions with several clients during unit visits
- Attended one conventional program community meeting
- Attend one clinician's team meeting

The administrative and clinical team provided site visitors with access to all documents requested, all areas of the facilities requested, and all staff and clients that the site visitors requested to interview.

Consultation Approach

We evaluated the program against best practice standards and guidelines in the field. These included the Association for the Treatment of Sexual Abusers (ATSA) Practice Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers and the sexual offender and general criminology "What Works" research literature. Concerning issues where

relevant guidelines and standards do not exist, we evaluated the program against common practices in sex offender programs, in particular other civil commitment programs.

Findings and Recommendations

For each of the three program areas that MSOP requested that we review, we detail here our findings and make recommendations for continued development.

A. Therapeutic Recreation Programs at Moose Lake

Therapeutic recreation is an essential component of sex offender civil commitment programs in the United States. Therapeutic recreation programs provide clients the opportunity through recreation and leisure activities to address dynamic risk factors in order to reduce risk to reoffend and facilitate successful community reintegration.

The purpose of the MSOP therapeutic recreation program is well detailed in the MSOP Theory Manual, which states:

> Many clients have underdeveloped social skills, and their emotional loneliness and social isolation can be a driving force in their offending. Other clients have difficulty interacting with others without engaging in bullying, intimidation, or domination. Others lack the ability to structure free time constructively and have had few if any prosocial hobbies or interests. Still others have never felt competent at anything besides sexual offending. Therapeutic recreation services provide crucial opportunities for:
>
> - Acquiring, rehearsing, and enacting interpersonal and problem-solving skills.
> - Demonstrating change in dynamic risk factors.
> - Learning how to structure free time productively and prosocially.
> - Developing new, prosocial interests and hobbies, which enhance successful reintegration into the community.
> - Garnering feedback from staff on clients' attempts to make progress in their treatment.
>
> Depending upon the nature of the activity, the staff providing therapeutic recreation can establish an environment where clients can acquire and rehearse new skills (p. 38).

Consequently, the Therapeutic Recreation (TR) department at Moose Lake offers programs in areas such as leisure education, team sports, fitness, art, hobby development, health and wellness, music, and gardening. TR staff plan and facilitate individual and small group recreational activities as well as facility-wide recreational and community-building events. The TR department also oversees activities for the Modified Program weeks, which are held approximately each quarter. Provision of TR services clearly enhances positive therapeutic aspects of the culture at the Moose Lake facility.

Recent TR initiatives over the last few months have included the opening of a music room, a

summer bean bag tournament attended by over 140 clients, horseshoe and domino tournaments, a staff and client softball game, and a "send-off" for clients who transitioned to St. Peter.

The Director of Rehabilitation Therapy Services oversees the TR program in addition to the education and vocational services programs. He brings considerable experience, creativity, and commitment to these services. Similarly, TR supervisory and front line staff we interviewed were professional and committed. There have been some recent TR staff shortages due to extended medical leave and a staff resignation, which will be important to address to maintain an appropriate staffing level.

To varying degrees, clinical supervisors and staff understand the role of TR in the rehabilitation of clients in the program. Experienced clinical staff who work closely with TR staff value the role of the program and respect TR staff's professional skills. It appears that newer clinical staff need more education about services that TR provides and how these services are closely linked with rehabilitation goals.

Overall, Unit Representatives and other clients we interviewed reported that TR was a valuable component of the Moose Lake program and that TR staff are competent and treat clients with respect. Some clients reported that some recreational activities were occasionally over-enrolled and said that they would like a wider range of TR offerings.

A major and reoccurring client complaint was that the cardiovascular exercise equipment is old and is in regular need of repair, and several staff members echoed these complaints as well. Beyond being a positive recreational activity, cardiovascular exercise yields considerable health benefits. Having and promoting cardiovascular exercise programming likely offsets health costs, which can be a major cost center in long-term residential programs such as the MSOP, which houses an increasingly aged population.

In terms of client participation, the "MSOP Rehabilitation Therapy Services Third Quarter Report: July, August and September, 2016" noted some decline in TR program attendance. Staff are restructuring some classes to generate more participation. Although Rehabilitation Therapy Services, including the TR program, collect raw data about client participation, quality improvement activities could be improved by working with the MSOP information technology staff to develop quarterly or yearly reports that collate and summarize data of interest.

A particularly noteworthy aspect of TR program is that overall it is well integrated with clinical services. For example, TR staff – as well as administration, security, and clinical staff – have been trained in the MSOP's Goal Matrix for Phases I, II and III. The Matrix is MSOP's primary dynamic risk measure. It is used to identify treatment needs, measure treatment progress, and benchmark criteria for moving clients between phases of the program. The Matrix provides a common language among clients and staff for talking about treatment goals and program progress.

TR staff have reviewed each of their program offerings and indentified which Matrix Factors (e.g., healthy lifestyle, group behavior, attitude to change, emotional regulation, interpersonal skills) are targeted in each offering. This helps clinical staff and clients identify TR programming that can

help a client address their Matrix treatment needs. We are not aware of any other sex offender civil commitment program that has such a well developed a common language for talking about treatment goals and program progress across clinical, rehabilitative services, health care, and security disciplines with a program. For example, all staff carry copies of the Matrix factors and posters featuring the matrix language are placed prominently throughout the facility and in all the group rooms.

In addition to using Matrix language and helping clients achieve Matrix goals, TR staff have further integrated with clinical services by attending and participating in a variety of clinical staff meetings and trainings, as well as Therapeutic Community meetings. Additionally, TR staff have requested and received specialized clinical training by clinical staff on a variety of mental health issues that impact client's participation in TR programs. However, clinical staff have not received much training about TR services and other MSOP rehabilitation services programs.

A brief review of 8 client records showed that some TR notes included references to client matrix factors. It appears that improvements can be made in incorporating matrix language into TR documentation, although the sample of records reviewed was small.

Although the therapeutic recreation program was the focus of our evaluation at Moose Lake, we visited educational and vocational services programs and talked with staff in those programs. Similar to the TR program, we very impressed with the quality of the educational and vocational services offered and the staff who provide these services.

Areas for Continued Development

1. We support plans for the Rehabilitation Services Director and the Clinical Director at Moose Lake to meet monthly to continue to integrate TR and clinical services.

2. The TR program should provide more training to clinical staff about the role of TR services in client rehabilitation. This includes the TR program providing clinical staff with copies of TR offerings and class descriptions to use in developing Individualized Treatment Plans (ITPs) with their clients. As well, we support the TR program's plan to incorporate information about TR programming into the electronic record system to further facilitate the development of ITPs that integrate RT services.

3. The TR program should work with the MSOP research department to develop quarterly reports about TR program service usage to inform quality assurance and improvement activities. This should, for example, include data about the number of clients that sign up for and are admitted into each RT program offering.

4. The TR program should consider providing some TR services to clients on their living units, especially to clients with special needs. Additionally, the clinical and TR programs

should consider implementing contingency management programs, which would include RT services, on small living units that house clients with special needs.

5. The TR program should ensure that cardiovascular exercise equipment is in working order and is reasonably available for clients' use.

B. Community Preparation Services (CPS) at St. Peter

In the past year there has been a number of developments and changes in CPS. First the program has continued to expand with a second building opening, and CPS now has a capacity to house 89 clients. As Table 1 indicates, all of the beds are now filled and there are two individuals at MSOP St. Peter who have orders for transfer and are awaiting a CPS bed. Further expansion cannot occur unless the legislature approves funding for further construction.

Table 1. CPS Census from 2009 to 2016

Date	2009 June	2010 June	2011 June	2012 June	2013 June	2014 June	2015 June	2016 January	2016 December
Census	3	5	7	9	12	22	38	51	89

There are now 7 individuals on provisional discharge living in the community and an additional 6 individuals who have been granted provisional discharge and are awaiting community housing placements. Of the 6 individuals who are awaiting community housing placements, 3 individuals are at CPS and 3 individuals reside in the alternative program at St. Peter. MSOP has encountered considerable community resistance when attempts are made to place clients in the community.

There are other challenges impeding the timely movement of clients through the program and into the community. It takes an average of 232 days between the time the petition is filed and an SRB hearing is held. Efforts are being made to reduce the number of days by seeking increased funding for additional staff. Additionally, there is an average delay of 318 days from the time of a SRB hearing to Part 1 of the SCAP hearing.

CPS has new director, a new administrative structure, and a revised program design. Under the new CPS administrative structure, Mr. Tim Benesch is now CPS Director, and clinical and security staff report to Mr. Benesch, who reports to Jannine Herbert, Executive Clinical Director. Previously, security and clinical staff had separate administrative structures and different chains of command. This led to some role confusion and tension between disciplines. This new structure addresses some of these issues, and we believe it is a positive development. The staff we interviewed were generally positive about the new administrative structure and viewed it as more efficient than the previous structure. We, as during previous site visits, found the staff competent and dedicated to the mission of CPS, and Mr. Benesch appears to be providing strong leadership.

Going forward, the CPS leadership team will need to ensure that all disciplines have input into

key program decisions. The program has developed a number of formal communication structures that should assist in this regard. The program has developed regularly scheduled meetings that involve security and clinical staff. Among these meetings are an 8:30 a.m. multidisciplinary meeting, a twice a week multidisciplinary meeting with clinical staff and security from the 2-10 shift, and a once a week CPS leadership meeting that incudes Mr. Benesch, clinical leadership, and security leadership. There has been a program focus on ensuring security is actively involved in decision making.

As we noted last year, the court is now ordering the transfer of Phase II and Phase III clients, and on one occasion a Phase I client, directly into CPS if it is deems that a client can be safely managed in the less restrictive CPS environment. There are now 23 Phase II clients and 56 Phase III clients at CPS. This means that CPS continues to service two broad populations whose treatment needs and programming are considerably different. The first population is the one that CPS was initially designed to serve. This population is composed of Phase III CPS clients who are deemed ready to prepare for and practice community reintegration skills. The second population is composed of clients who are earlier in the treatment process, that is, Phase I, Phase II, and some in early Phase III clients. For this population, there is less of a need to focus on community integration and more of a need to focus treatment efforts on targeting behavior management, problem identification, and skill practice and consolidation.

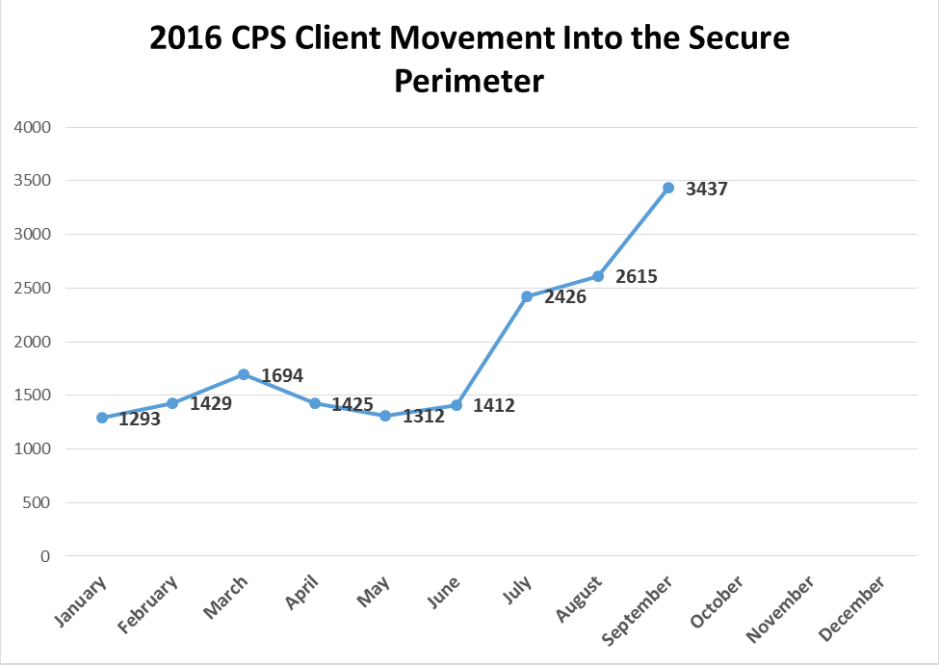
To address this changing CPS client mix, the MSOP has redesigned the CPS program. In addition to having three treatment phases, the program now has four stages, all of which are detailed in the document, Community Preparation Services Program Design, August 2016. Briefly, the four stages are: (1) Orientation, (2) Indentifying Vulnerabilities/Developing Strengths, (3) Demonstrating Change Across Settings and (4) Preparation for Successful Re- entry. Each stage is a minimum of three months and opportunities for liberties are tied to progress through the phases and stages. The final two stages provide the opportunities for increased community reintegration activities and require the client to be in Phase III of treatment. Staff are positive about this new stage system and believe it provides the needed structure for the program.

As the court has ordered an increased number of early-treatment-phase clients into the CPS, there has been some initial increase in behavioral problems but no serious incidents of aggression or violence. In general, the program has been successful in providing programming to both groups, but there are challenges. There is currently insufficient staffing to serve the new dual mission of CPS. Because units must be staffed to ensure safety with an increasing number of clients early in treatment who are not involved in off campus community reintegration activities, there has been some decreased opportunities for community involvement for those needing intensive community reintegration activities. These activities include supervised community outings, meetings outside the institution with clients' support groups, opportunities for volunteering in the community, and opportunities to attend various therapeutic activities such as outpatient client treatment at Pathfinders or attending AA or NA groups. These are all important activities to prepare clients for successful reentry. The program has tried to adjust to these demands by prioritizing those at higher CPS program stages, but this still impacts community reintegration services.

Another issue is that there is a shortage of clinicians and no dedicated nursing personnel for CPS, resulting in a large number of clients needing to enter the secure perimeter of St. Peter's to attended psychoeducational groups and medical appointments. Upon our request, the director at St.

Peter provided Figure 1 below, which shows a dramatic increase in CPS client movement into the secure perimeter. For example, there were 3437 client movements into the secure perimeter of St. Peter in September 2016. This high level of client movement requires significant staff time and increases potential security issues. It also distracts from the mission of CPS, which is to help clients learn to live outside a secure setting. Additionally, because of inadequate staffing levels, some security staff who do not work in the CPS or who may be unfamiliar with CPS clients, periodically provide community transportation and supervision services for CPS clients. The lack of knowledge these staff have about the CPS clients they supervise in the community raises possible security concerns.

Figure 1:



Areas for Continued Development

1. The MSOP needs to increase staff at CPS to ensure there is adequate time for community reintegration activities for those moving towards provisional discharge. This could be an increase in security staff or increases in recreational therapy staff to provide community visits.

2. The CPS program should move to self-sufficiency so it can provide its own transport, treatment, and nursing services. There is significant client movement between CPS and the secure perimeter of St. Peter, which raises safety issues and requires significant staff time. The program will run more efficiently if nursing services, clinical services, and community reintegration activities were delivered by CPS staff that have knowledge of the clients they serve.

3. The MSOP has developed transfer procedures for the clinical handoff of clients who are moving from within the secure perimeters of the St. Peter and Moose Lake facilities to CPS. There are meetings between the clinical staff either Moose Lake or St. Peter's and the CPS staff. We recommend that the program develop a similar handoff among security staff to facilitate client transition between facilities. This should ensure that security staff pass on information about client behavioral issues and approaches with clients that have been found successful.

4. The CPS should provide a structured method of ensuring that security staff who transport and supervise clients on community meetings have appropriate background information about clients. The CPS should consider preparing and providing relevant staff with briefing sheets on each client that would include information such as clients' victim characteristics, risk factors, and relevant behavioral issues.

5. CPS should more clearly specify criteria for how decisions will be made to increase liberties within the new phase/stage system.

6. The CPS program model indicates that individuals in Stages 3 and 4 of the program receive four hours of core group per week. We recommend that the program consider decreasing this treatment dose to two hours of core group per week and increasing reintegration activities for these clients. The Executive Clinical Director noted concern that these clients often face multiple stressors as a result of the lengthy time it takes to schedule SCAP hearings and difficulties with finding housing. Consequently, these clients may need increased therapeutic support. We recommend that if a client needs additional therapeutic support, this be individualized rather than requiring that all clients receive four hours of core group per week.

7. The CPS program has been providing education to clients inside the Moose Lake and St. Peter perimeters in order to prepare them for transition to CPS. We support these efforts. It is important for all clients to understand how CPS operates so that clients do not have unrealistic expectations when transferred to CPS.

8. The CPS is convening a stage progression panel to approve movements between phases. We recommend that someone from security, such as the CPS operational manager, be included on this panel.

9. As clients progress from the secure institutional settings at Moose Lake and St. Peter, to less secure institutional settings at CPS, to provisionally discharge in the community, and eventual full discharge, security and supervision services should be stepped down gradually to help clients get used to and develop skills in learning to live safely with lesser levels of care. Currently, MSOP staff supervise all client community reintegration activities, even after clients are provisionally discharged. We recommend that part of the reintegration step down process include unsupervised community reintegration activities for clients who are getting closer to meeting full discharge criteria.

10. MSOP has demonstrated an impressive ability to implement initiatives throughout the organization. In regard to the changes in client population movement and the restructuring of CPS, the following are important infrastructure supports to facilitate the change process: updating and/or developing supporting policies and procedures; clarifying lines of communication; describing change in staff roles and responsibilities; notifying the key stakeholders of the changes; and training the key stakeholders on the changes. The program could benefit from devoting resources to attend to these infrastructure needs so staff have a clear understanding of expectations, which will help to maintain good staff morale.

C. Conventional Program Culture at St. Peter

During the last year, the St. Peter conventional program has experienced considerable client turnover. Approximately 40 Moose Lake clients moved to the St. Peter conventional program and approximately 40 St. Peter Conventional clients moved to the CPS program. This level of client turnover has the potential to impact the program's culture.

The St. Peter staff are committed to the mission and vision of the organization and strive to do good work. There are talented and optimistic people in key positions who have embraced the challenges of receiving groups of clients from Moose Lake who are in earlier stages of treatment. It is obvious that considerable effort and planning has occurred to make the transition of clients from Moose Lake to St. Peter as smooth as possible for both staff and clients. Of particular note were clinical handoff meetings between sites, a formalized process of assigning current clients to assist new clients in the transition, and ongoing clinical consultation between clinical staff at St. Peter and Moose Lake. This effort and planning has helped to maintain a therapeutic community with relatively few negative cultural impacts at the St. Peter site.

The security staff and clinical staff reported that they did not experience a significant cultural impact with the transition of Moose Lake clients. Staff have an optimistic view of the direction the program is headed and an understanding of the basic guiding principles of the program. The clinical staff have many opportunities to engage in formal clinical supervision meetings, informal discussions, cross departmental meetings, and team building activities. Opportunities for direct clinical supervision of group therapy is also in process. Clinical staff consistently reported ample opportunity to receive guidance and supervision in a context where disagreement, expressing points of view, and proposing alternative opinions is welcomed. This contributes to collaboration and building a cohesive treatment team. These efforts reflect a commitment from MSOP leadership to not only manage the ever-changing environment at St. Peter, but also to grow the clinical knowledge and skill of the staff.

The clients that were interviewed did not experience the transition of clients from Moose Lake as being significantly disruptive to the therapeutic culture. There was an appreciation for the work by MSOP staff in establishing a group of clients (i.e., Client Assist Team) to assist Moose Lake clients in the transition. Also contributing to a relatively smooth transition is the Community Living Project initiative, which is designed to help improve the therapeutic culture of the program by providing a system for clients to engage in peer mediation and develop appropriate standards of

behavior.

The areas most impacting the culture at St. Peter are staff shortages, onboarding of new staff, rapidly changing aspects of the program, and adjusting to Moose Lake clients' level of general criminality. Clients' continue to be most impacted by what they view as inconsistency in Matrix rating scores between clinical staff. The inconsistencies reportedly occur between Moose Lake and St. Peter clinical staff as well as differences between the clinical staff at St. Peter. MSOP leadership is aware of these areas impacting culture and has been taking steps to address them.

Staff vacancies and staff changes continue to be a challenge. The 11/1/16 organizational table shows that 23% of clinical positions remain vacant, with one clinical supervisor having almost 38% of his clinical positions remaining unfilled. Several staff indicated that vacancies are, in part, still a carryover from the last year's hiring freeze. Lack of staff and the process of new staff learning their job responsibilities are the most consistently reported areas impacting the morale of staff in clinical and security positions. Shortages in clinical staff have resulted in higher caseloads, increased documentation requirements, and reductions in treatment services. The Facility Director, Bonnie Wold, reported vacancies have not only impacted the clinical department, but also security department and have resulted in increased overtime costs and the need for staff to cover units in which they are less familiar with the clients. Staff working overtime hours and working on units where they are not familiar with clients can have a negative impact on the culture of a unit.

Clients experience staff shortages and being re-assigned to a new therapist as "starting over" in treatment and thus delaying their progression through the program. In the past, some clients described that when the Moose Lake clients transferred, they had expectations of being at a higher phase in treatment. When this did not happen, it had an impact on their motivation and treatment engagement. During the most recent transition of clients, this was addressed during clinical handoff meetings. This helped to some degree with client expectations, however, the therapist ratings of Matrix factors still tended to differ across locations and between therapists. Clients being re-assessed to be less far along in treatment than what they had previously been rated, has a negative impact on the client's morale as well as clinical staff and security staff as they respond to the client's dissatisfaction.

Clients transferring to St. Peter from Moose Lake are engaging in behaviors on the unit that are reflective of difficulties with general criminality. Staff have been reacting to these behaviors and managing them. The client therapeutic community is also addressing them. This is probably why the culture has not been significantly impacted. Proactively addressing the general criminality of this population may be helpful to move beyond the need for reactive approaches.

Areas for Continued Development

1. The efforts to improve communication, provide clinical oversight (through the current meeting schedule), conduct clinical hand offs, use a client transition team, support the therapeutic community (Community Living Project Initiative), and provide a clinical supervision structure are all having a positive effect on the culture and we support these efforts continuing.

2. Regarding staff vacancies, as reported in the prior evaluation, we support previously successful strategies to recruit and retain staff. These include reinstituting staff hiring bonuses, a loan repayment program, and staff finder fees.

3. Clients arriving from Moose Lake have been presenting with higher levels of general criminality and are posing some management issues. Overall, clinical staff and security staff have been successfully responding to these issues but could benefit from having training in working with this population to assist in developing more proactive procedures and interventions.

4. Clients at St. Peter, although not experiencing a significant cultural impact by the influx of clients from Moose Lake, are experiencing an impact on their morale and the therapeutic culture related staff changes. The clients believe it is like they are "starting over" each time they are assigned a new therapist. Additionally, clients reported experiencing inconsistency across therapist ratings of Matrix factors. MSOP has been making strides in this area by using clinical handoffs and ongoing communication between a client's previous therapist and current therapist. We continue to support the use of the Matrix. We are impressed by the knowledge that staff at all levels of the organization have about Matrix factors. However, as mentioned in the previous evaluation, the program should consider more precisely defining the anchors for each Matrix item. Consistency in ratings would undoubtedly have a positive impact on the therapeutic culture for both clients and staff.

5. MSOP is a constantly changing organization. Regular training on what it means to be a changing organization and the impact that it has on work relationships, services, and overall job satisfaction would helpful to maintain a positive work culture.