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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Minnesota Sex Offender Program: Annual Performance Report (2019)

Direct Care & Treatment Division

January 27, 2020

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I. Executive summary

The Minnesota Sex Offender Program (MSOP) provides comprehensive programming to individuals who have been court-ordered to participate in sex offender specific treatment. Clients are civilly committed by the courts and placed in treatment for an indeterminate period of time, usually following completion of their prison sentence. As of December 31, 2019, there are 731 MSOP clients in St. Peter and Moose Lake facilities, 26 clients at the Department of Corrections who were returned due to revocation or new criminal sentencing, and 22 clients on provisional discharge currently living in the community.

MSOP continues to provide sex offender treatment in a safe and therapeutic environment with a voluntary 83% 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), court-ordered provisional discharges into the community, and full discharges.

Phase I of the approved 2015 bonding request was completed in 2016 and MSOP opened a 30 bed wing for clients being transferred by the Commitment Appeals Panel (CAP) to CPS. CPS is a less restrictive alternative setting outside the secure perimeter on the lower campus in St. Peter and has operated since 2008. Due to that expansion, we have 89 total beds in the non-secure facility. It has been filled to capacity since the addition opened in 2016. Bonding for Phase II was in the Governor's budget for the 2016, 2017, 2018, and 2019 legislative sessions, however, the bonding requests have not been approved. Bonding that project would expand CPS to accommodate those clients that CAP continues to grant transfer orders for. The waitlist for clients to move to CPS currently is at 42. Without additional bed space and infrastructure added outside the secure perimeter, the state is forced to defy a growing number of court order transfers. The governor is again proposing, this year, funding to resolve that issue.

Once again this past year, our active Employee Engagement Committees at MSOP participated in very successful fundraising across sites. The program raised over $11,000 to donate to Combined Charities.

MSOP's interdisciplinary teams continue to maintain a strong infrastructure for a therapeutic environment supportive of client change. Changes were made this past year within clinical leadership which was an opportunity to promote stability and professional development. This past year we explored and implemented numerous cost savings ideas, time and program efficiencies, and instituted streamlining processes across MSOP departments.

Quality and safety being of highest priority for our program, MSOP was again recognized and received safety awards at the Minnesota Safety Council for excellence in workplace safety at the 85th Annual Minnesota Safety and Health Conference last spring. In addition, MSOP underwent several successful licensing audits that were conducted by both the Department of Human Services and the Department of Health this past year.

In 2019, there were new provisional discharge orders granted for 5 clients by CAP and an additional 6 clients were granted full discharge from civil commitment. As of December 31, 2019, there are 22 clients on provisional discharge in the community who are all supervised and managed by MSOP Reintegration Agents. A positive

adjustment, participation in outpatient treatment, having ongoing supervision, and establishing a pro-social support system in the community, are all necessary and important for successful reintegration.

Strengthening our therapeutic living environments, ensuring program quality and integrity, growing as a learning organization, encouraging ongoing employee engagement, all while maintaining our responsibility to safety and security, are the values we are invested in and continue to promote. MSOP highlights for 2019 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. During the 2016 legislative session, a proposal for extending the report's due date to February 15 of each year was approved. This assures a complete and accurate report that reflects all data and statistics of the entire reporting year.

The statute specifies that this report include:

- Program descriptions, including strategic mission, goals, objectives and outcomes
- Calculation of program-wide per diem
- Annual statistics
- Program Evaluation Report occurred in December 2019 (attached)

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

The St. Peter campus has two primary missions which are programming for the alternative clients and preparation for reintegration. St. Peter 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 participate in all three phases of programming on the St. Peter campus. Clients in Phases II and III participate in opportunities that demonstrate their abilities to use new coping skills and risk management techniques in settings with less structure.

III. Program Overview

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 provisionally discharged and/or completely discharged from 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.

[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.

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

MSOP Strategic Goals and Outcomes

Program Integrity

Description:

Program integrity defines the extent to which all program services have been delivered as intended. Integrity ensures that MSOP is carrying out common goals that maintain consistency and quality across departments and sites, encourages compliance and accountability, and protects public funds.

Goal:

1. Increased use of best practices across targeted areas and departments at MSOP by using quality assurance system.
2. Enhance and maintain continuity and consistency of programming.

Strategies:

- Develop and implement a process that evaluates our system relative to current best practices and research in the field.
- Revise ongoing audit system to enhance quality of programming and services.
- By 6-1-20, the MSOP research department establishes and prioritizes hypotheses for research projects.

Therapeutic Environment

Description:

The therapeutic environment refers to the physical, social, and psychological spaces that are specifically designed to support change for each individual and the community as a whole. It involves keeping "the client in the center of the room," speaking the same language, having a unified approach while upholding ethical morals and values, understanding theory, and balancing treatment, safety, and security. It is individualized, flexible, and designed to support differing functional levels and approaches to care.

Goal:

1. An established treatment culture is fully integrated into all departments and across all shifts.
2. A strong and comprehensive therapeutic environment exists for all staff and clients.

Strategies:

- Increase training for staff that will weave a "treatment culture" across the program and will enhance understanding of roles within a secure setting.
- Role model how treatment threads throughout the program across all departments and encourage all staff to take responsibility in this process.
- Enhance culture and environment through therapeutic language and messaging during staff supervision and across meeting settings.

Responsibility to the Public

Description:

The extent to which MSOP maintains safety within the facilities and to the public, demonstrates transparency consistently, fulfills obligations to stakeholders, is responsive and timely to concerns and questions, and is fiscally responsible.

Goal:

1. Increased awareness and education regarding MSOP's commitment to public safety.
2. MSOP clients are well prepared to enter the community with safe and healthy engagement.

Strategies:

- Increase community awareness by teaching, presenting, and networking about sexual offending behavior, civil commitment in MN, sex offender treatment, and risk at a wide variety of public forums.
- By soliciting feedback from clients on PD, outpatient providers, agents, etc., increase and refine client reintegration preparation strategies inside the perimeter and at CPS to enhance public safety and client success.

Learning Organization

Description:

MSOP promotes and maintains a strong learning environment with valuable learning opportunities to meet the diverse professional development needs of staff within an organic and evolving program. MSOP strives to create, transfer, and modify philosophy and policies to reflect new knowledge and insights.

Goal:

1. Staff are confident and competent in their roles and recognize how they contribute to client change.
2. Reputation as being a state-of-the-art sex offender treatment program is enhanced.

Strategies:

- Learning and supervision gaps are addressed on all watches.
- To build on competencies, support and engage staff in self-assessment as part of their professional development.
- Build comprehensive framework and promote "One MSOP Team" concept fostered by multi-discipline and multi-location exchanges for learning and solution finding.
- Increase professional networking opportunities "bringing the outside in."

Employee Engagement

Description:

MSOP promotes a culture where all staff are essential to maintaining a safe and therapeutic treatment environment. Employee engagement encompasses the relationship between the employee and the work. MSOP provides opportunities for staff to contribute meaningfully to the program, to be supportive of one another, to recognize and acknowledge employee commitment, and to encourage new ideas and alternative ways of thinking.

Goal:

1. MSOP has an engaged work culture.
2. Staff build and maintain healthy person-centered supervisory relationships to enhance overall employee satisfaction.

Strategies:

- Staff are supported and encouraged to invest in self-care activities.
- Staff have opportunities to learn about and understand the expected benefits of change as well as participate in creative ways to promote positive client change.
- Collaboration with other departments becomes the norm through joint efforts and inclusiveness of ideas across departments and disciplines.

IV. Treatment and Model Progression

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.

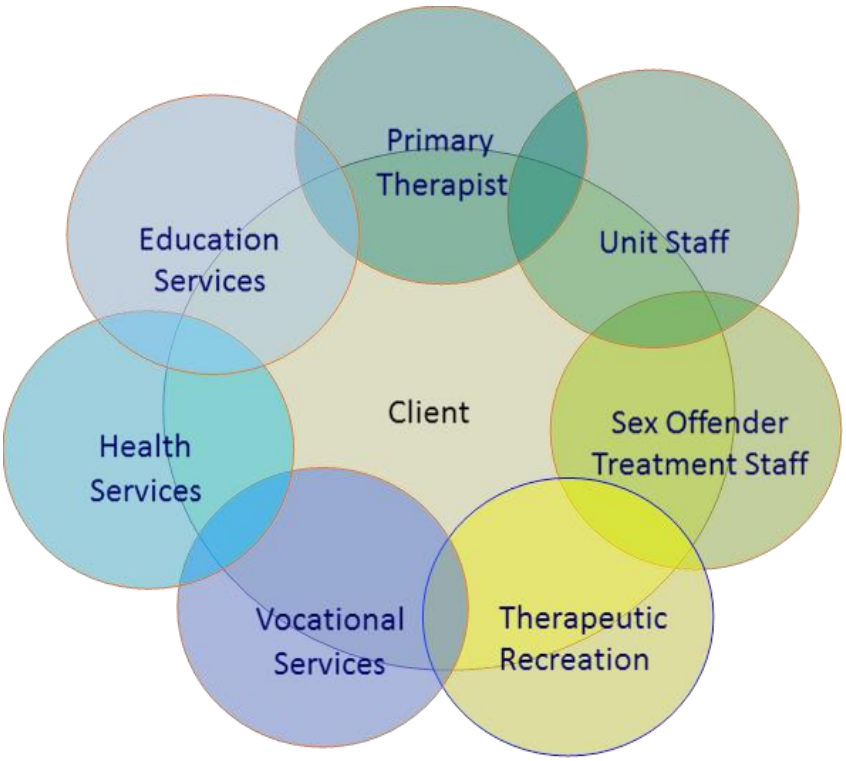
Each client participating in treatment is guided by an individualized treatment plan that defines measurable goals. These goals are updated as the client progresses through treatment.

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.

Comprehensive and Individualized Treatment

MSOP provides comprehensive treatment. 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 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. 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 annually or as needed.



MSOP clients who choose to engage in treatment participate in a sex 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.

Treatment Progression

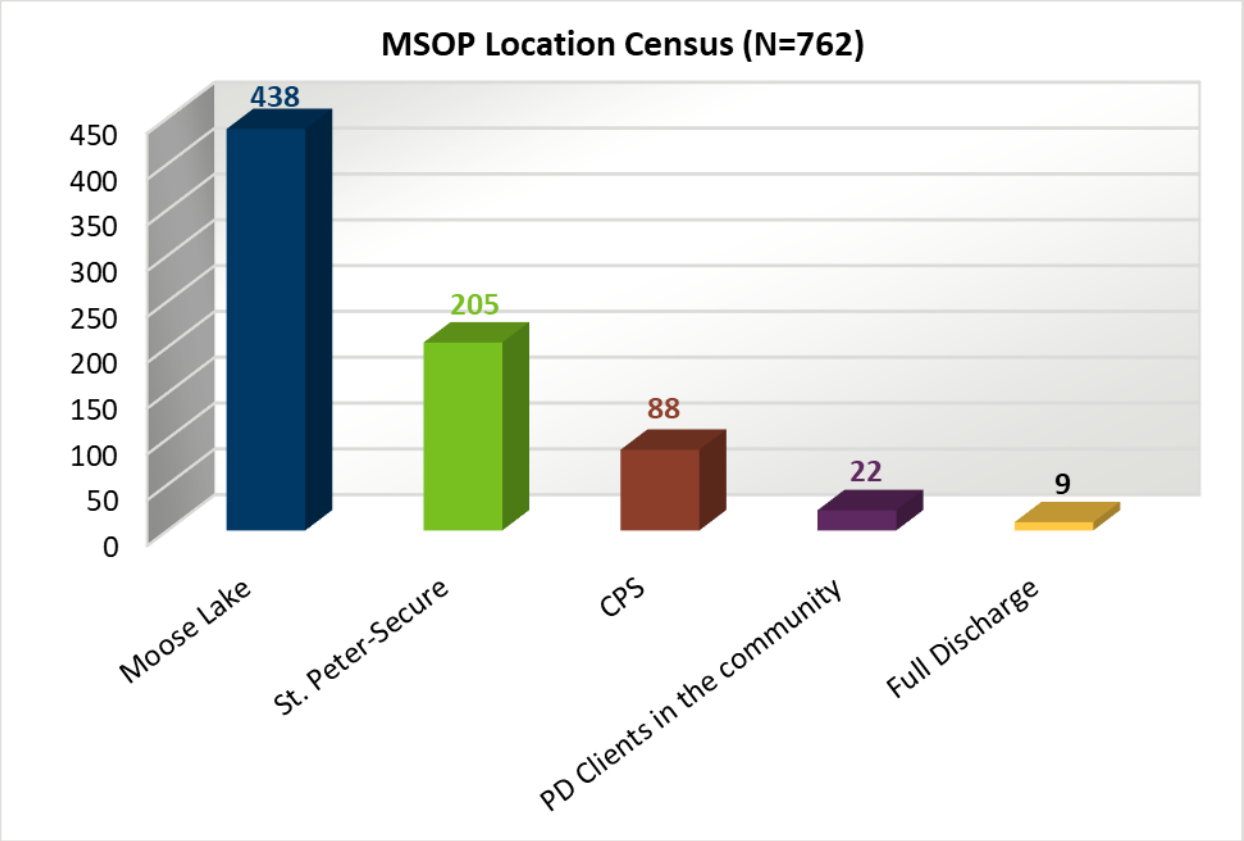
Clients address their own individual risk and treatment needs by adhering to their Individualized Treatment Plans. They attend psychoeducational modules based on their treatment needs and core groups. On a quarterly basis, all clients are reviewed on MSOP matrix factors, which are based on the criminogenic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

The matrix factors are:

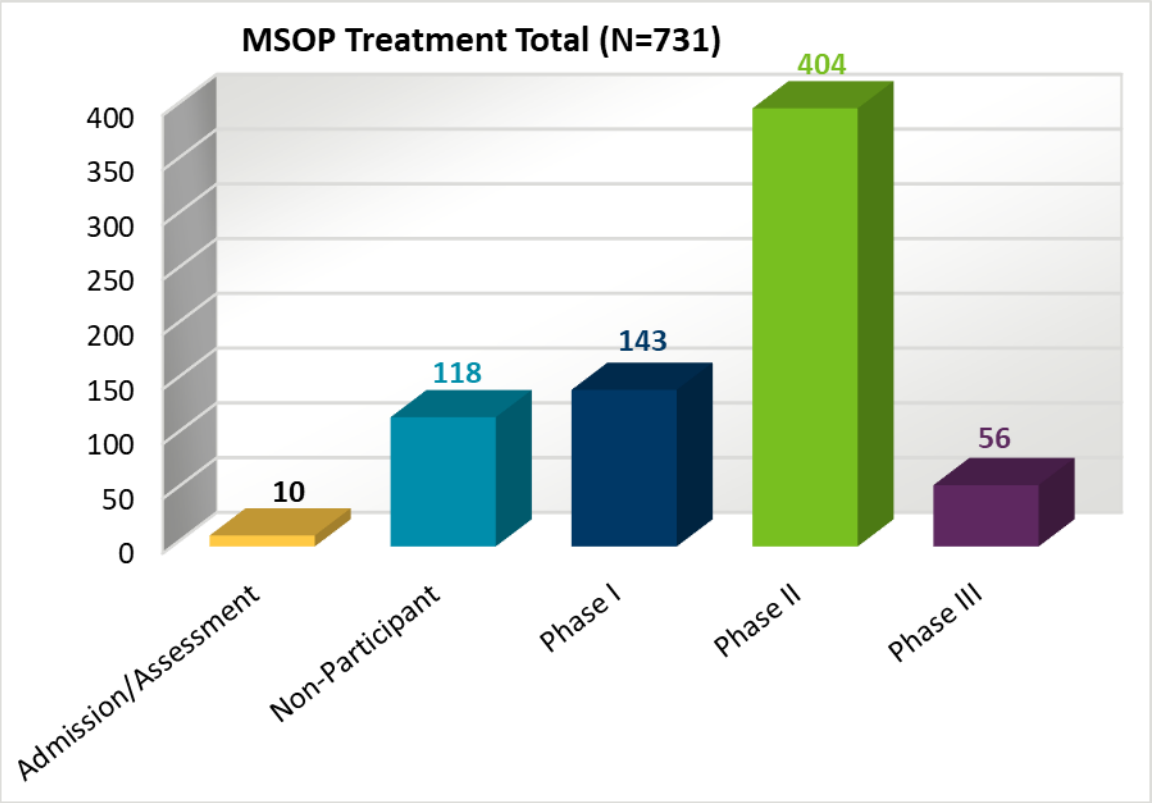
- Group behaviors
- Attitude to change
- Self-monitoring
- Interpersonal skills
- Sexuality
- Cooperation with rules and supervision
- Healthy lifestyle
- Life enrichment

- 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. Individualized Treatment Plans and treatment targets are modified accordingly.



Note: In the history of the MSOP, 37 clients have been given provisional discharge orders. 22 are currently living in the community on provisional discharge, 5 have been revoked, 9 have been fully discharged, and 4 have provisional discharge orders issued and are waiting placement/appeal.



Note: Chart Data as of 12/31/2019

V. MSOP Treatment at the Department of Corrections

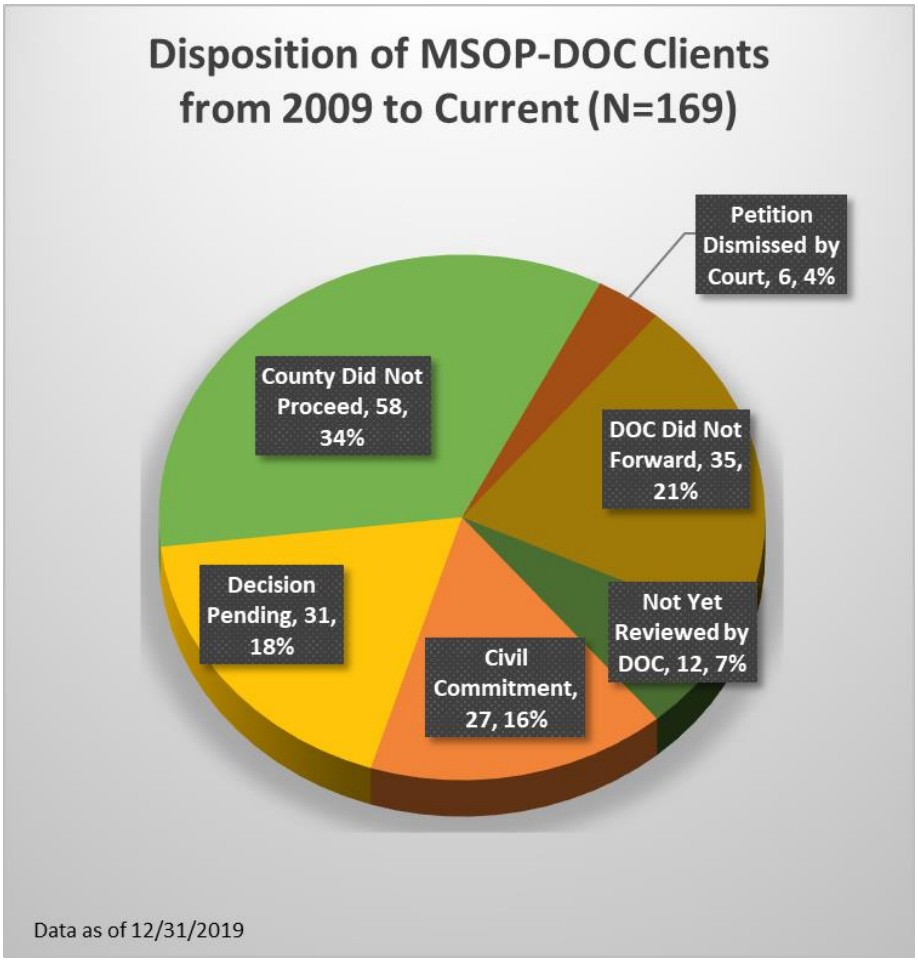
The MSOP operates a collaborative, 50-bed, sex offender treatment program located at the Minnesota Correctional Facility in Moose Lake. This program provides sex offender treatment similar in scope and treatment design to the MSOP-Moose Lake facility. Program participants are serving their correctional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

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

1. The county may not pursue commitment due to a client's significant progress toward management of risk factors.
2. The county may pursue commitment if the client is civilly committed to MSOP and able to continue treatment at the DOC.

There have been 217 men admitted to the MSOP-DOC program since 2009. As of December 31, 2019, there are 48 clients in the program and 169 men discharged from the program.

VI. Commitment Status of Clients Discharged from MSOP-DOC since 1/1/2009



VII. Community Preparation Services and Reintegration

Community Preparation Services

As part of the treatment program at MSOP, Community Preparation Services (CPS) was developed and operates as a free-standing, unlocked, "step-down" residential facility located on St. Peter's lower campus. CPS prepares clients for their transition and reintegration back into the community. When a client petitions for a reduction in custody, the Commitment Appeals Panel (CAP) grants orders for clients who meet the statutory criteria for transfer from the secure perimeter to CPS to continue their treatment in a less restrictive setting.

Established in 2008, the program has experienced tremendous growth in the past few years. In 2016, a total of 43 clients were granted transfer orders from CAP to CPS. All 89 beds were filled to capacity. In 2017, another 31 clients received transfer orders from the courts. However, there are no available beds at CPS so many of the clients with transfer orders have been unable to move and therefore remain inside the perimeter. In 2018, 22 more clients received transfer orders from the Commitment Appeal Panel, with an additional 16 more in 2019. Due to bed capacity limitations, a waitlist of 42 clients existed as of December 31, 2019.

Phase I of the bonding project to expand beds at CPS was completed in 2016 which provided 30 additional beds to that facility. However, due to continued transfer orders from the courts, CPS immediately filled its bed capacity. Phase II of the bonding bill was requested at the 2016, 2017, 2018 and 2019 legislative sessions to 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. However, those bonding requests were not passed by the legislature. This bonding request will come before the legislature again this session.

Reintegration

The Reintegration department within MSOP is responsible for establishing housing, out-patient sex offender treatment, supervision and monitoring, and case-management services for those clients granted a Provisional Discharge (PD) by CAP.

In 2019, the CAP issued orders granting provisional discharge to five clients and orders granting full discharge to six clients. As of December 31, 2019, there were 22 clients on provisional discharge living in communities in Minnesota. The court-ordered Provisional Discharge Plan is based on the individual needs of clients. The MSOP reintegration agents provide close supervision to safely manage and monitor clients on provisional discharge.

VIII. Program Per Diem and Fiscal Summary

Description		FY 2020 Approp. $$	Per Diem
Direct Costs			
Clinical	$	19,050,756	69.49
Healthcare and Medical Services	$	6,599,805	24.08
Security	$	38,101,579	138.99
Community Preparation Svcs	$	6,526,464	23.81
Dietary	$	2,460,951	8.98
Physical Plant & Warehouse	$	8,083,445	29.49
Program Support	$	12,394,300	45.21
Total Direct Costs	$	93,217,300	340.04
Operating Per Diem		*$*	*340*
Indirect Costs			
Statewide Indirect	$	94,124	0.34
DHS Indirect	$	2,781,722	10.15
DCT Operations Support	$	1,790,189	6.53
Building Depreciation	$	4,216,563	15.38
Bond Interest	$	5,670,200	20.68
Capital Asset Depreciation	$	90,840	0.33
Total Indirect Costs	$	14,643,639	53.42
Total Costs	$	107,860,939	393.46
Average Daily Census (ADC)		749	
Published Per Diem Rate		$	393

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 2020 is $393.

Direct Costs – Costs attributed to providing care and treatment to clients, maintaining facilities and providing general support services to operate the program.

Indirect Costs – Costs not directly attributable to the program but are allocated/assigned as a cost of the overall operations of the program.

NOTE: *The program support costs mainly consist of legal (including litigation), SRB/CAP, and Workers Compensation expenses.*

In the 2019 Legislative Session, changes to Minnesota Statutes, Section 246B.10 were passed that added a county liability for cost of care for clients provisionally discharged from MSOP. Cost of care charges for clients provisionally discharged from MSOP are calculated based on the services provided to individual clients and consist of two components: 1) housing, and 2) supervision & treatment. The new cost of care rates for provisionally discharged clients were effective July 1, 2019 and range from $80 - $515 per day.

IX. Annual Statistics

Current program statistics through December 31, 2019 are listed below.

- Total MSOP Clients: 731

Clients by Location	Count	Percentage
Moose Lake	438	59.9%
St. Peter-Secure	205	28.0%
CPS	88	12.0%
Total	731	100.0%

Clients by Age	Count	Percentage
21 - 25	3	0.4%
26 - 35	84	11.5%
36 - 45	187	25.6%
46 - 55	175	23.9%
56 - 65	195	26.7%
Over 65	87	11.9%

Age Ranges:

- **Youngest:** 24 years
- **Oldest:** 86 years
- **Average Age:** 51 years

Clients by Race	Count	Percentage
American Indian/Alaskan Native	53	7.3%
Black/African American	101	13.8%
Other/Unknown	38	5.2%
White/Caucasian	535	73.2%
Asian/Pacific Islander/Multi Racial	4	0.5%
Total	731	100.0%

Clients by Education	Count	Percentage
Elementary School	17	2.3%
Some High School	51	7.0%
GED	214	29.3%
High School Degree	333	45.6%
High School Degree and GED	7	1.0%
Some College	44	6.0%
College Degree	17	2.3%
Unknown	48	6.6%
Total	731	100.0%

Commitment Type	Count	Percentage
PP Final	42	5.7%
SDP Final	420	57.5%
SPP Final	9	1.2%
SPP/SDP Final	257	35.2%
Judicial Hold	3	0.4%
Total	731	100.0%

Commitment County	Count	Percentage
Metro	290	40.8%
Non-Metro	441	59.2%
Total	731	100.0%

* Metro counties include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Population Statistics

Admissions	Count
New Admissions	14
Transfers In	24
Total Admissions	38
Departures/Transfers	
Transfer – Provisional Discharge	8
Transfer – DOC Revocation	11
Transfer – Forensic Nursing Home	14
Transfer – New Criminal Sentence	7
Departure - Death	5
Departure – Court Order Dismissal	2
Total Departure/Transfers	47
Net change (Admissions – Departures/Transfers)	-9

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	Count
Clients on judicial hold status in the MSOP	3
Clients on judicial hold status in the DOC/Jails	3
Total on judicial hold status	6

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 and the client was not already admitted, the individual is committed and transferred to MSOP.

Many clients civilly committed to the MSOP remain under DOC commitment on DOC supervised release status ("dually committed"). If these clients engage in actions or criminal behaviors resulting in the DOC revoking their supervised release status, or resulting in a new conviction, the clients are returned to DOC to serve a portion or all of their criminal sentences. Even in DOC custody, these clients remain under civil commitment and will return to the MSOP upon completion of their periods of incarceration.

Dually-Committed Clients:	Count
Clients who are under civil and DOC commitment in the MSOP	134
Clients who are under civil commitment and in a DOC or federal prison	24
Total number of dually committed clients as of December 31, 2018	158

Clinical Statistics

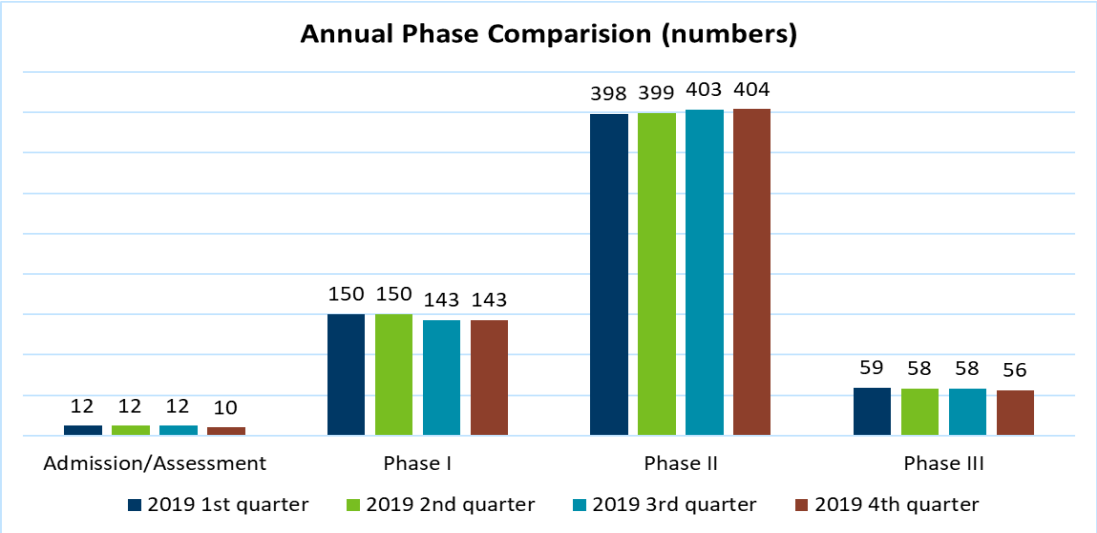
Treatment Participation

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 (721), approximately 83 percent were participating at the end of 2019.

Once the civil commitment process is finalized, an individual is encouraged to participate in treatment. If the individual chooses to engage in treatment, a sex offender assessment is completed and an Individualized Treatment Plan is developed to address 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. Note, clients granted provisional discharge are not included in this chart.



The following chart illustrates the 2019 distribution of clients across the treatment units. The MSOP population is diverse with 20 percent of the clients residing on units that provide specialty programming while 78 percent reside on units providing conventional treatment. The remaining two percent of the population resides on the Admissions/Assessment unit, which does not provide sex-offender specific treatment.

Treatment Unit	Location	Count	Percentage
Admission/Assessment	Moose Lake	10	1.4%
Alternative Programming	St. Peter	96	13.1%
Assisted Living	Moose Lake	21	2.9%
Behavioral Therapy	Moose Lake	25	3.4%
Conventional Programming	All 3 sites	579	79.2%
Total		731	100.0%

Clinical Service Hours

Clinical service hours at the MSOP include both clinical treatment hours and clinical 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 a minimum of nine hours per week. Clinical treatment hours are spent in core groups, psychoeducational modules, therapeutic community meetings, reintegration services, modified programming, individual therapy, progress reviews, and assessments. The number of treatment hours offered at the MSOP is consistent with similar civil commitment programs across the country.

In addition to weekly treatment hours, clients are offered the opportunity to participate in clinical programming. Clinical 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. An example of the minimum total clinical service hours offered to clients, based on their treatment phase, is provided in the table below:

Estimated Weekly Hours of Clinical Service by Phase

Treatment Phase	Clinical Treatment	Clinical Programming	Total Clinical Service Hours
Phase I	8	8	16
Phase II	10	13	23
Phase III	10	14	24

X. MSOP Evaluation Report Required Under Section 2468.03

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, St. Peter, Minnesota

Dates of Visit: October 21-25, 2019

Date of Report: November 12, 2019

Purpose and Overview

The Minnesota Sex Offender Program (MSOP) contracted with the consultants to review and evaluate its treatment programs at St. Peter. The consultation was a component of MSOP's quality improvement program. The present site visit was a follow-up to our previous site visits. The last site visit at St. Peter was in December 2017.

During the current review, we spent four and one-half days at St. Peter. On the last one-half day that we were on site, we reviewed and discussed our initial findings with Nancy Johnston, MSOP Executive Director (via videoconference), and Jannine Hebert, MSOP Executive Clinical Director. We then reviewed and discussed these initial findings with senior managers at St. Peter and via videoconference with Moose Lake senior managers for one hour.

Evaluation Request

During the current site visit, the MSOP requested that we evaluate the following three programs:

I. Community Reintegration Services (CRS)
II. Community Preparation Services (CPS) at St. Peter
III. Clinical Services at St. Peter, namely, the Conventional Program (CP) and Alternative Program (AP)

A particular focus of the evaluation request was to examine the working relationships between operations and clinical staff.

Procedure

We reviewed the following written materials:

- Organizational Charts
- Program census data
- Recent MSOP Quarterly Reports for each St. Peter department
- Community Preparation Services Program Design, August 2016
- Community Preparation Services Handbook, August 2016
- MSOP Theory Manual
- MSOP Clinician's Manual
- MSOP Provisional Discharge and Reintegration fact sheet
- Client Provisional Discharge Supervision Continuum Standards
- Provisional Discharge Case Plan
- End of Confinement Review Committee policy
- Standard Provisional Discharge Plan Conditions
- Client Tier Level System policy
- Redefining the St. Peter Adapted Program Overview PowerPoint
- New Adapted Program treatment manuals undergoing development
- Group schedules
- Rehabilitation therapy Services Course Catalog 4th Quarter 2019
- Organizational charts
- MSOP Fact Sheet
- Recent MSOP Site Visit Reports

During the site visit we engaged in the following activities:

- Met in individual and small group meetings with senior management, including:
    - Nancy Johnston, MSOP Executive Director
    - Jannine Hebert, MSOP Executive Clinical Director
    - Bonnie Wold, Facility Director at St. Peter
    - Brenda Todd-Bense, Clinical Director at St. Peter
    - Kristin Dehrkoop, Associate Clinical Director at St. Peter
    - Paul Rodriguez, CPS Director
    - Heidi Menard, Associate Clinical Director at CPS
    - Michelle Sexe, CPS Operations Manager
    - Scott Halvorson, Reintegration Director
- Attended the following meetings the AP, CP, and CPS programs:
    - All Staff Forum (1)
    - Shift change meetings (5)
    - Therapeutic Community Meetings (6)

- Met with the following staff groups without their supervisors present across the AP, CP, and CPS programs:

    - clinical supervisors (5 individuals during three meetings)
    - operations supervisors (5 individuals during two meetings)
    - clinicians (multiple informal discussions during visits to groups and various meetings)
    - front line operations staff (multiple informal discussions during visits to residential units)

- Attended 12 group therapy sessions (9 core and 3 psycho-education groups)

- Conducted several unscheduled informal individual and small group client meetings during unit visits and after group treatment sessions across the AP, CP, and CPS programs

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. Administration and the local union have been putting forth effort to improve communication and build a collaborative working relationship. The evaluators were informed that some union stewards reported that certain clinicians feared reprisals if they declined to meet with us. Therefore, we elected not to put these clinicians in the position of deciding to refuse or accept a meeting. As a result, no formal interviews were scheduled with clinicians.

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 programs for adults convicted of sexual offenses, and in particular other civil commitment programs.

Findings and Recommendations

First, we detail several overall program findings with respect to strengths and recommendations for continued development. Second, we detail findings for each of the three specific MSOP programs reviewed, namely, Community Reintegration Services (CRS), Community Preparation Services (CPS) at St. Peter, and Clinical Services at St. Peter, which are the Conventional Program (CP) and Alternative Program (AP).

Overall Findings

<u>Strengths</u>

1. Increasing numbers of MSOP clients are being placed and safely integrated back into the community.

Thirty-four clients have been placed in the community on provisional discharge and six clients have been fully discharged. Of the six clients who have been fully discharged, three clients were discharged following a period of being on provisional discharge and three clients were fully discharged directly into supervised community settings without a period on provisional discharge.

With respect to community safety, no MSOP client who has been placed in the community has been arrested or charged for a new sexual offense or any other type of criminal offense.

2. MSOP St. Peter continues to have a strong and committed administrative and clinical leadership team at the upper management level. There has been relatively little staff turnover at the upper management level in recent years, which has provided for considerable consistency in the operation of the program.

3. MSOP St. Peter has continued to maintain a culture that is committed to continuous quality improvement. For example, numerous multi-disciplinary work groups have focused on improvements in areas such as record keeping, treatment programming, staff collaboration, and disciplinary procedures.

4. MSOP holds "all staff forums" twice a year to which all staff are invited. Staff representing each of MSOP's major departments provide updates about their program and recognize staff and program accomplishments. The forums model open communication about the program's functioning and reinforce MSOP's mission.

5. Overall, clinical and operations staff reported that they like and respect the people that they work with. They value the collaborative nature of the working relationships within each of their teams.

6. For the sixth year in a row, MSOP St. Peter has received an award for safety from the Minnesota Safety Council for having injury rates well below the industry standard.

Areas for Further Development

1. MSOP should advocate for simplifying the provisional discharge process. To be provisionally discharged, a client must petition the Special Review Board and the Supreme Court Appeal Panel. This process is typically quite lengthy. It contains more steps, is more complicated, and is costlier than discharge processes in similar programs in other states. MSOP should also consider whether their internal process for recommending a client for provisional discharge can be streamlined.

Specific Program Findings

I. Community Reintegration Services (CRS)

CRS has grown considerably over the past few years as an increasing number of clients have been placed on provisional discharge status in the community. At the time of the present site visit, 22 clients were on provisional discharge in the community, whereas at the time of our previous site visit to St. Peter in December 2017, nine clients were being supervised on provisional discharge status in the community. Since 2000, of 32 clients that have been granted provisional discharge, 30 have been provisionally discharged to the community.

Strengths

1. The CRS program design continues to be refined and is consistent with evidence-based practices in the field.

2. CRS has a high success rate of safely integrating clients back into the community. No MSOP client who has been placed in the community has been arrested or charged for a new sexual offense or any other type of criminal offense. Only 6 of 34 clients (18%) placed in the community on provisional discharged have been returned to the facility. Three of the six who returned were able to return to the community after a relatively short stay in the facility. Reasons for these returns have been for housing problems or non-criminal behavior problems. Compared to other similar programs, this is a very low and favorable return rate.

3. CRS reintegration agents serve as both supervision agents and case managers, which is consistent with evidence-base practice. In the supervision role, staff are well-trained to assess risk and monitor and supervise for community safety using a tier supervision continuum. In the case manager role, staff help clients to access community resources and use motivational interviewing and other strategies to help clients reduce their risk to reoffend and step down to lower levels of care and prepare for eventual full discharge.

4. The 10-1 client to agent ratio in CRS allows for an appropriate level of supervision and case management.

5. CRS uses the Acute-2007 risk instrument to assess acute client risk. Supervision levels are reviewed at least quarterly and adjusted according to each client's risk, needs, and progress.

6. CRS has brokered a wide range of community resources to help clients successfully reintegrate into the community. For example, over half of clients have full time jobs and several clients do volunteer work.

7. CRS has developed a broad range of community housing options to meet various client needs. These include half-way houses, shared living arrangements, adult foster care, and independent apartments.

Areas for Further Development

1. Although MSOP has a high success rate of safely integrating clients back into the community, all programs that work with high risk individuals should expect and plan for how to deal with untoward events, such as a sexual reoffense. MSOP should develop a response and communication plan to address untoward events. This plan should involve key MSOP staff and partner agencies.

2. The auditors support CRS's plan to implement and utilize a stable dynamic risk assessment tool, such as the Stable-2007 or SOTIPS, to help assess client ongoing supervision and treatment needs and measure client progress. The auditors support CRS's plan to continue to use the Acute-2007 to assess client risk factors that can change quickly.

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

At the time of the present site visit, 88 clients were residing at the CPS program. About half of these clients were in Phase II of the program and the other half were in Phase III.

At the time of the present site visit, 44 clients had been approved to enter the CPS program and were awaiting available beds.

Strengths

1. CPS is now considered a separate program within the MSOP. The CPS director oversees both clinical and operations staff within the program.

2. CPS clients now receive several services onsite rather than within the St. Peter secure perimeter. CPS has its own visiting room, holds its own AA and NA meetings, and provides basic medical services onsite. This greatly reducing the number of clients in CPS that need to be escorted into and back out of the perimeter for services. Consequently, staff resources are being used more wisely and facility safety is enhanced.

3. CPS clinical and operations staff are working collaboratively and continue to improve program functioning. For example, staff from both departments are represented on all CPS committees, attend and have facilitation roles in all therapeutic community meetings, and participate in community reintegration pre-planning and post-debriefing groups.

4. CPS operations staff oversee individualized program plans (IPP).

5. CPS has revised the relapse prevention plan format so that is simpler, clearer, and more behavioral.

6. CPS has continued to improve the process of helping clients plan and debrief community outings and ensure that the outings are linked to therapeutic goals. Improvements in the process, such as including operations supervisors in groups, have markedly increased the percentage of outing requests that the review committee approves. Overall, clients reported feeling very supported by the process and felt safe discussing their successes as well as struggles.

7. Clinical staffing levels are good. At the time of the present review, 92% of clinician positions were filled, which continues to be slightly better than previous years. One of the two clinical supervisor positions is vacant as is the one CPS psychologist position. Maintaining clinical staffing is an extremely common challenge in sex offender civil commitment programs.

8. Several clients volunteered that they have found arousal management sessions particularly beneficial.
9. Advanced CPS clients (N = 4) now visit and stay overnight at the Moose Lake program twice a year. These visits highlight the progress that many clients have made, instill hope that change is possible, and provide education about St. Peter programs. Staff and clients were very positive about these visits.

Areas for Further Development

1. Provisionally discharged clients can further benefit from enhanced transitional education as they prepare for what to expect on provisional discharge and placed in the community. More education about housing, employment, and other resources can be shared to better prepare clients for community placement.

Note. A few additional CPS "Strengths" and "Areas for Further Development" overlap with the Conventional Program (CP) and Alternative Program (AP) are noted hereafter.

III. Clinical Services at St. Peter: Conventional Program (CP) and Alternative Program (AP)

At the time of the present site visit, 95 clients were residing in the AP and 111 clients were residing in the CP.

Strengths

1. Over the past several months CP and AP have finalized and implemented the Client Tier Level System. The Tier system provides clear written guidelines to increase access to programming opportunities for clients who demonstrate prosocial behavior and support a positive therapeutic community. The Tier system has been very well received and is easily understood by staff and clients.

2. The AP has finalized policy and implemented the Positive Support Rule (Minnesota Rule 9544), under which staff must use positive supports in place of restrictive interventions when providing services to people with a developmental disability as defined by statute. The program provided well received computer-based and small group staff training on how to implement the rule. Continuing training has included how to respond to a variety of case scenarios. Approximately 20 clients on Pexton units receive services under the rule. Among the challenges implementing the rule is that some clients residing on some Pexton living units are governed by the rule whereas other clients are governed by the BER disciplinary system. This causes some confusion among clients and staff.

3. The AP refinement committee has made considerable progress in updating its program. Particularly noteworthy changes are that the program is markedly increasing emphasis on skill teaching and practice, simplifying treatment manuals to meet the learning needs of Paxton clients, increasing the number of groups provided and reducing the length of groups, and holding morning and afternoon therapeutic unit meetings five days a week.

4. The AP continues to refine its assessment process to identify the most appropriate community placement paths for clients in its program. For example, the AP has identified several clients for whom the most appropriate step-down plan would be to bypass placement in CPS and be placed directly into the community placement in a supported setting such as a group home or adult foster care.

5. Overall, the relationships between operations and clinical were collaborative but not without minor conflict on a few units. However, there is a good process in place for identifying and resolving conflicts. For the most part, clinical staff check in with operations staff before and after groups and individual sessions. Both clinical and operations staff attend therapeutic community meetings. In the AP, clinical staff take the lead facilitating these meetings in the morning and operations staff take the lead facilitating these meetings in the afternoon.

6. Operations supervisors typically work during the day on second shift, but now take turns approximately once each week staying through much of late afternoon and evening third shift. The goals are to enhance training and supervision for third shift front line operations staff and support a positive therapeutic treatment milieu.

7. Recreation staff are well integrated across all MSOP programs and in particular the AP. Recreation staff facilitate at least one group per week on each of the Pexton units that focus on skill building and practice.

8. The program has implemented the CREST conflict resolution program to teach clients and staff skills to help clients solve problems in a pro-social manner without staff intervention. Overall, staff and clients report positive results.

9. MSOP has developed a new training coordinator position and has provided a variety of training opportunities for CP, AP, and CPS staff. In particular, several staff found training on case conceptualization very beneficial.

10. MSOP is providing EMDR treatment to clients to address trauma issues. The auditors support MSOP's plan to implement Cognitive Processing Therapy (CPT) as another empirically-based trauma treatment to its menu to treatment services.

11. At the time of the present review, all four (100%) clinical supervisor positions in the CP and AP were filled and 88% of clinician positions were filled. This is a relatively high staffing rate and similar to previous years. Two of the three treatment psychologist positions were vacant.

12. Overall, gains that the program has made in the AP, CP, and CPS to improve the therapeutic functioning of treatment groups has been maintained.

    a. Clinicians regularly held pre-group planning meetings and post-group de- briefings.
    b. Client check-ins were typically brief.
    c. With very few exceptions, clinicians appeared to be engaged with clients in a manner that was respectful, fair, firm, warm, empathetic, and directive.
    d. Clinicians supported the development of safe and supportive positive group cultures.
    e. Clinicians regularly used motivational interviewing approaches.

f. Clinicians regularly supported client-to-client interactions, as opposed to conducting individual treatment in the group setting.
g. Clients regularly referred to their treatment plans and dynamic risk factors.
h. Clinicians regularly helped clients relate current individual issues with dynamic risk factors.
i. Client and staff challenges to each other were done in a respectful manner.

Areas for Further Development

1. Many clinicians across the CP, AP, and CPS continue to struggle' to complete paperwork in a timely manner. MSOP should continue to address this serious and difficult problem. In addition to recommendations made in previous site visit reports, MSOP should reexamine how often various types of documentation are required to be completed. For example, rather than preparing quarterly reports and treatment plans every three months, these documents could be prepared every four or every six months and likely have no negative impact on the provision of treatment services.

2. The audit team again recommends that CP, AP, and CPS reduce the frequency that clients routinely use group check-ins to self-report sexual thoughts and behaviors that are non-problematic or are base-line. Client logs of their sexual thoughts and behaviors are available for staff to check periodically and can be used for polygraph testing.

3. Particularly in the AP, the audit team stresses the importance of simplifying treatment manuals to meet the learning needs of clients. For many AP clients, the focus should be on teaching a small number of concrete risk reduction and management skills. Skill teaching and practice should follow an evidence-based approach (e.g., define the skill, identify usefulness of the skill, model the skill, practice the skill, give feedback, prescribe out-of-group skill practice). Teaching one skill at time is generally recommended, especially for the AP population, which means that several successive groups would be devoted to teaching a particular skill.

4. MSOP should be credited with helping a significant and increasing number of clients progress to CPS and provisional release status. However, the audit team again recommends that the MSOP review the average amount of time it takes for a reasonably well-motivated client to complete each phase of the program and the total program. Such a review should ensure that services provided are clearly linked to helping clients prepare for successful release to the community and that services are delivered efficiently. Again this year, clients consistently volunteered, and several staff agreed, that the program overall is slow and lengthy and can be repetitive. In particular, several clients and staff expressed concern that criteria to progress from Phase II to III are relatively subjective and not clear. Benchmarks for identifying reasonable program timelines include comparisons with other similar sex offender civil commitment programs and reviewing the menu of assignments and activities that are typically required of most clients in the current program design to ensure that they are necessary. Although as a group, MSOP staff appeared to be very competent, assessment and treatment services could be delivered more efficiently and with a greater sense of urgency to help clients be successful in and moving through program Phases in a timelier manner.

5. The audit team again recommends that the MSOP consider administering the Sex Offender Assessment psychological test battery (which is now used to make later-stage Phase progress decisions) earlier in the treatment program to identify specific treatment targets and responsivity issues so that they may be addressed earlier in the treatment process. Additionally, the MSOP should ensure that the tests used in the test battery are clearly relevant to the referral issues.

6. A small number of clients commit indecent exposure and public masturbation offenses in the facility on a regular basis. MSOP should actively pursue criminal prosecution of clients who commit sexual offenses in the facility. Criminal prosecution is a logical consequence for these behaviors and sends a message that these behaviors will not be tolerated in the facility. It is also a way to protect staff and clients from being exposed to these behaviors.

7. The AP should evaluate the costs and benefits of implementing the Positive Support Rule for all clients on each Pexton unit on which any clients subject to this rule reside or simply across all Pexton units. As previously noted, among the challenges implementing the rule is that some clients residing on some Pexton living units are governed by the rule whereas other clients are governed by the BER disciplinary system and this causes some confusion among clients and staff.