LEGISLATIVE REPORT

SEX OFFENDER TREATMENT FUND

Submitted By:

MINNESOTA DEPARTMENT OF CORRECTIONS
MINNESOTA DEPARTMENT OF HUMAN SERVICES
MARCH 1993

Pursuant to 1992 Laws, Chapter 571,
Article 8, Section 7

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Introduction

The report was compiled in response to a legislative directive to provide information on existing funding sources for sex offender programming, coordination of those funding sources, current and future needs of sex offender programming in the state, assessment criteria for evaluating sex offenders, recommendations on the manner in which to effectively administer the sex offender treatment fund, and the status of the sex offender program at the adolescent correctional facility at Sauk Centre.

Two needs assessments were conducted as part of this legislative report. One of the needs assessments (appendix A) was sent to all court administrators, directors of court services, and directors of community corrections act counties. There is a total of 87 counties in Minnesota, and of those 87, 51 counties or 59 percent responded to the questionnaire. A map identifying responding counties is located in appendix B.

Two questions in the needs assessment dealt with the sex offender services used by counties and whether the county saw a need for more sex offender services in their area. These responses identifying counties with needs can be found in appendix C.

Another needs assessment (appendix D) was sent to sex offender service providers. Thirty responses were received and the data collected was included in this report.

From all the information gathered from counties, it became obvious that each county administered and tracked its financial resources quite differently. In fact, several counties were unable to provide any type of financial information as to whether it dealt specifically with the amount of monies used to fund sex offender programming or the source of the money used to fund sex offender programming.

In addition, many counties were unable to report the number of misdemeanor convictions for sex offenses that had occurred in their county. Thus, it was quite difficult to determine the actual number of misdemeanor convictions to assist in providing an estimate for actual number of misdemeanant sex offenders being convicted and then referred to sex offender specific programming.

Another area of concern is the disparity between the number of complaints forwarded by the police to the number of convictions resulting from those complaints. While a defendant has the right to negotiate to a lesser plea, this plea does not necessarily translate into the defendant being less dangerous because his/her attorney was able to "strike a deal." For example, in St. Louis County for the past two years there was a total of 538 complaints forwarded from the police to the county attorney. Of this number, 44 adults and 22 juveniles were convicted of a sex offense.

While developing a consolidated treatment fund for sex offenders is a sound idea, allocating money for this system may be premature. In some ways the sex offender treatment fund does parallel the chemical dependency, however at this time there are numerous differences between the two. These differences which are identified below suggest that major funding for sex offender specific services while needed may not be the most financially prudent approach to undertake at this time.

1. At the time of the inception of the consolidated chemical dependency fund the cost of providing chemical dependency services was well known;

2. There was a better understanding of the numbers of chemically dependent (CD) individuals in need of services;

3. The CD fund had six years of data from the Drug and Alcohol Normative Evaluation System as a basis for their cost estimates and the most effective nature of the chemical dependency treatment system;

4. The regulatory licensing system was in place at the inception of the fund;

5. The criteria for determining the level of care/intervention by rule was in place at the inception of the fund;

6. The CD service delivery system was fully developed at the inception of the fund;

7. An educational system to certify CD counselors to ensure quality of care was in place at the inception of the fund; and

8. Sex offenses are not grounds for a medical diagnosis and therefore certain funds are not available for reimbursement of services.

The sex offender treatment fund is an excellent idea and in the long run it will prove to be more cost effective than simply incarcerating sex offenders. While there will always be a need to incarcerate a portion of sex offender, by placing the emphasis on providing structured supervision and programming in the community monies will be saved and the money saved can then be invested in other programs benefitting the family and the young. At this time sex offender services does not have the data or history that the CD services do. However early on in their existence, it is quite likely that the CD system was in a similar position .

Sources and coordination of funding

Most of the counties responding to the needs assessment were unable to report the amount of monies they had spent on sex offender treatment. Several counties provided estimates but had no factual information to support their estimates. Counties such as these listed below were able to provide the following information regarding funds spent on sex offender programming:

County	1988	1989	1990	1991
Anoka	151,693	101,008	81,015	164,465
Cottonwood	3,850	3,850	3,850	3,850
Dakota (adult)		12,302	7,941	30,382
Dakota (juv)	56,530	85,434	44,797	200,196
Hennepin	884,715	1,146,440	1,204,863	1,541,930
Nicollet		5,362	52,271	56,326
Ramsey	135,391	201,513	262,746	374,646
Redwood	1,908	347		
Washington			89,838	123,023
Watonwan	6,809	4,032	9,908	39,605
Wright	46,639	199,866	240,028	120,256
Total	1,287,535	1,760,154	1,997,257	2,654,679

Sources of funding also varied from county to county. Most counties used local tax dollars, social service monies, grants from the Department of Corrections, offender self-pay, county levy dollars, private insurance or a combination of these to fund sex offender specific programming. In most counties corrections agencies must rely on social services monies to finance sex offender specific programming and often the resources are not there to adequately meet the demands for services.

A review of the information provided by service providers suggest that the majority of clients who participate in sex offender programming receive some type of financial assistance from the list above.

County Administration

Minnesota Statutes Section 241.67, subdivision 6 reads: "A county may use up to five percent of the money allocated to it under subdivision 4 for administrative costs associated with the sex offender treatment fund, including the costs of assessment and referral of persons for treatment, state administrative and reporting requirements, service development, and other activities directly related to sex offender treatment. Two or more counties may undertake any of the activities required under this section as a joint action under section 471.59. Nothing in this section requires a county to spend local money or commit local resources in addition to state money provided under this section, except as provided in subdivision 7.

One of the main problems in collecting this information was that most county probation and social service counties are not operated in like fashion. Thus, to implement this legislation without making one county entity primarily responsible for assigning the responsibilities may have resulted in havoc in some counties.

Recommendations: To ensure that the fund operates more uniformly across the state, the following statutory language changes are recommended:

Amend the language so that the county board determines which county agencies or contracted entities are involved in the operation of the sex offender fund.

Amend the language to change the basis of the administrative allocation from the amount of the county allocation to the amount of the allocation the county uses for sex offender treatment.

Remove references to assessment payments for to avoid conflict with other law relating to payment for sex offender assessments.

Maintenance of effort

Minnesota Statutes Section 241.67 subdivision 7 makes it a condition for counties receiving an allocation from the sex offender fund to agree not to reduce the level of funding provided for sex offender treatment below the average annual funding level for calendar years 1989, 1990, and 1991. Thus counties would have to spend average money they spent in those three years prior to having access to the fund. Implementation of this subdivision has the following issues:

As indicated in an earlier section of this report, many counties have not maintained accurate financial records to provide information regarding the amount of money spent on sex offender specific services. Thus, these counties may have access to the fund immediately and as a result it may appear that these counties are being rewarded for below average record-keeping.

Some counties have refused to pay or have paid very little for sex offender specific services, whether it be for assisting individuals in paying for programming or in establishing sex offender services in their region. Under the current maintenance of effort language, since these counties did not spend any resources in those three years they will have access to sex offender funds immediately. Thus, those counties which have made an effort to cultivate resources and be responsible in assisting individuals in sex offender specific programming are penalized because they must now spend their average annual funding before having access to the fund.

Another incident that happened in a few smaller counties in greater Minnesota was the placement of a juvenile in an expensive residential placement. This placement inflated their costs for over 18 months. Thus, these counties based on the formula would be required to pay the average of those three years before having access to sex offender funds.

Recommendation:

A review of all these scenarios suggests that this method does not ensure equity of funding for all counties. Based on both the needs assessment and meeting with county representatives, it is recommended that a county share format be implemented. The county share would require each county to pay ten percent of the costs. The sex offender fund would then pay 90 percent. The county would continue to have access to the fund until the allocation for that county was exhausted. At that time, the county would be responsible for all of the payment. These percentages also take into account the amount that the individual client is able to pay based on the sliding fee scale. This plan to implement county share guarantees more funding equity over time.

Special project grants and start-up grants

Adult: $150,000 was allocated to provide sex offender specific programming for individuals placed on supervised release. Those agencies receiving contracts with the Corrections department to provide services were: Alpha Service Industries, La Oportunidad, Reentry, and 180 Degrees.

Adolescent: $350,000 was allocated to provide for start-up and expansion monies for sex offender services with emphasis given to greater Minnesota. At a meeting on July 13, 1992, it was decided that the money would also fund high risk juveniles in residential treatment. At the time of the writing of this report, three juveniles had been placed in residential treatment with the cost being $100,000. Grants to provide sex offender specific service were awarded to the following agencies: Anoka County Juvenile Center, Metropolitan Community Mental Health Center, Lutheran Social Services, Central Minnesota Mental Health Center, Arrowhead Regional Corrections, West Central Community Services Center, and Itasca County Human Services.

Several counties that responded to the needs assessment stated that there was a need for increased services in their areas. See Appendix C for a geographical listing.

While many counties requested more services in their areas, simply starting a new program does not guarantee that it will survive fiscally unless the services are also covered in the grant. An overall estimate on the amount of funds needed to adequately establish a effective sex offender network is quite difficult to calculate. The difficulty stems from there not being an adequate tracking system that records information about sex offenders and the programs that provide services. In addition, fiscal record keeping does not appear to provide a realistic picture of the amount of resources currently being spent in the area of sex offenders.

In responses from service providers, the majority of professionals cited the need for more outpatient services for sex offenders.

Many of these areas may already have existing mental health centers in their regions. Thus, the space may already be available and the added expense would be in recruiting and training professionals to provide sex offender specific services.

Information from service providers

As was mentioned earlier, a needs assessment was conducted to gather information from professionals working in the community with sex offenders. The data their responses provided was helpful.

The majority of service providers believed the three most critical items to providing sex offender services were: increased financial resources to cover treatment costs in the community, attracting qualified therapists, and providing quality aftercare.

Programming priorities identified by service providers if faced with limited funds were: sex offenders who were either dual diagnosis (i.e. chemically dependent, mentally ill, and/or developmentally delayed,or patterned), age of offender, severity of offense, and type of offender (i.e. situational child molester, incest, situational rapist, etc.).

Most service providers believed resources should be spent on the following age groups which are listed in order of priority: adolescent (12-18 years old), young adult (18-22 years old), adult (23 and over) and children (6- 12).

According to the majority of the respondents, priority should be given to incest perpetrators, situational child molesters and situational rapists. In addition, most respondents believed priority should be given to felony convictions instead of gross misdemeanor and misdemeanor defendants. In regard to the type of research service providers believe is useful, the majority identified follow-up research as being most beneficial. Biomedical research was identified as the least helpful.

In a report from the Minnesota Council on Child Caring Agencies on students discharged from a variety of service agencies in 1990, of the agencies responding none were specifically designed to provide sex offender specific programming. In 1990, 736 students were discharged. Of those 736, 21 percent or 122 were identified as having sexually assaultive behavior. Another three percent or 15 were involved in prostitution and another 36 percent or 194 were identified as having some type of problem relating to their sexual behavior. Thus, 60 percent or 331 juveniles were identified as having some type of sexual problem. These numbers do not reflect the total number of individuals who are developmentally delayed, mentally ill, or mentally retarded who are sex offenders. Based on the responses to the needs assessments and this report, very few sex offender programs offer services for the developmentally delayed, mentally ill, or mentally retarded sex offender.

Juvenile Sex Offender Program at Minnesota Correctional Facility-Sauk Centre

The juvenile sex offender program in Sauk Centre will accept its first clients on March 10, 1993.

Program Structure and Content:

The structure of the program will be a modified positive peer culture strengthened by more cultural development and staff direction. The programming will resemble other sex offender programs in the state but will also include innovative techniques such as imagery, artwork, tourneying and behavioral practice.

Program Length:

As it exists now at Sauk Centre, the grid system is used to assign a juvenile's length of stay at the facility and what is expected from them during their stay. Thus, the sex offender program will be expected to utilize that system but the length of the program is dependent on the individual needs of the juvenile.

Selection Criteria:

A juvenile may be considered for placement at the Sauk Centre program if the following conditions are met:

1. Juvenile has failed to complete a court ordered residential sex offender program.

2. Juvenile has been court ordered to complete inpatient sex offender programming, but cannot gain admission due to denial of the offense, age (too old), aggressive/assaultive behavior, or previous program failure.

3. Juvenile is committed as a sex offender and, following the sex offender assessment, may be admitted to the program as the most appropriate placement given the circumstances of the case.

Training:

Staff selected to establish the sex offender program at Sauk Centre have been involved in rigorous training. The first training experience for the new staff was a special Sexual Attitude Re-assessment Seminar (SARS) designed for persons working with sex offenders.

The staff then spent two weeks at a training program at the University of Kentucky at Louisville. This training program followed by six months on- the-job-training will result in the staff receiving certification as Juvenile Sex Offender Counselors.

Two additional weeks of training are scheduled prior to the program start-up. Consultants for this training are: Dr. Gary Lowe, Dr. Janice Bremer, Dr. Robert Faas, and Pete Galvin.

Medical Assistance

Responses on the needs assessment as to the best manner in which to access Medical Assistance funds in the provision of sex offender services were quite negative and not that informative. In general, medical assistance funding cannot be used specifically for funding of sex offender treatment, because a sex offender does not automatically indicate a medical diagnosis or a need for medical treatment. Currently and in the future, medical assistance payments may be made only when the offender:

1. has a medical diagnosis relevant to the offender services needed;
2. is eligible for medical assistance; and
3. receives the services from a medical assistance enrolled provider

Recommendations: Medical assistance is not provided on the basis of the person's offender status. The inclusion of medical assistance in consolidation with other funds for sex offender treatment is not recommended.

SEX OFFENDER TREATMENT; PILOT PROGRAM

The in-depth description of the University of Minnesota research project is in Appendix F.

The proposal indicates a budget of $83,550.00. The original allocation by the legislature was for $75,000.00. However, the University of Minnesota Program in Human Sexuality's budget was for $83,550.00. Due to the importance of this study, the Department of Corrections was able to allocate more financial resources to the study.

This study compares the effectiveness of Provera against the effectiveness of Prozac R in the treatment of sex offenders. The study includes a comparison of the effectiveness of these medications against a placebo in a double blind crossover design.

Subjects for the study are volunteers from the University of Minnesota sex offender program. A total of 24 subjects will be studied. All are pedophiles (nonincest) who are treatable on an outpatient basis. Each subject will undergo a six-week trial of each medication and the placebo. A six-week "wash out" period occurs between each crossover.

Psychological testing and interviewing occurs at the beginning of the study, as well as throughout progression of the study. In addition, a penile plethysmographic assessment of each subject is conducted at the beginning of the study and once more during the study.

At the conclusion of the study, the subjects and the investigators are debriefed. The subjects are given options regarding continuation of medication, continuation in the treatment program, etc.

This study is not intended to compare the effectiveness of pharmacotherapy versus the effectiveness of psychotherapy. It studies the effectiveness of Provera versus Prozac R in enhancing the effectiveness of psychotherapy.

Costs of implementing the sex offender treatment fund

The estimated figures for funding the type of sex offender fund the 1991 legislature developed are located in Appendix E. The figures were based on information gathered from a variety of sources and caution should be used when reviewing them. It was quite difficult to develop a cost estimate statewide due to the lack of consistent record keeping in both the financial and criminal arena. The development of estimates was further compounded by the lack of reliable data from service providers and county officials regarding length of stays, level of care, and assessment techniques.

RECOMMENDATIONS:

1. Implement a tracking system for sex offenders. Currently there is no adequate tracking system in place for tracking delivery of funds or services in the area of sex offenders. Also, there is not an adequate means of tracking the number of individuals adjudicated or convicted of a sex offense or sex related offense and the disposition of those cases.

2. Continue to fund existing grants and allocate additional money for grants to start new programs in areas of the state requesting assistance and subsidize existing programming budgets statewide. The Department of Corrections will monitor the delivery of these services and allow the program to implement innovative techniques. As part of the agency's responsibility for receiving this state money, they will be required to provide descriptive program information, numbers served, numbers and qualifications of staff, failure rates, assessment tools utilized, length of stay, follow-up data etc. This data will be used to define effective sex offender programming, provide direction in the development of standards to license programs and provide figures to estimate the number of sex offenders needing sex offender specific services.

3. Postpone the four sets of rules certifying vendors and the rules administering the fund until further program evaluation is accomplished and more data is collected.

4. The number of clinicians with experience in providing sex offender specific services is quite small. There is no formal training opportunity established for sex offender therapists. Thus, the development of formalized training for clinicians choosing to enter the field would be beneficial to program effectiveness.

5. Currently the Department of Corrections has four staff (one director, one clerk IV, and two corrections program and policy monitors working in the Sex Offender Services Unit. Two of these positions are to sunset on June 30, 1993. The current staff monitor contracts/grants, chair the advisory committees that are establishing the standards for sex offender programs, educate/train correctional staff, probation officers, and the public, administer the sex offender assessment fund, develop and enhance correctional sex offender programs, provide technical expertise to community agencies wishing to establish sex offender programs, present to county administrators on funds available and the manner in which to access funds. In addition to these responsibilities, it will be necessary to develop a data collection format and begin implementing this collection device. With all that is being required of the Department, it is essential to continue funding for existing staff and to increase number of staff when the recommended data collection system becomes operational.

APPENDIX A

QUESTIONNAIRE

1. What funds are currently used to purchase services for adult sex offenders who are on probation in your county?

2. What funds are currently used to purchase services for adolescent sex offenders who are court-ordered to participate in sex offender specific treatment?

3. Which service providers are currently used by your county to treat sex offenders?

4. Please list the different ways adolescent sex offenders are dealt with in your county. For example;

   court-adjudication
   social services-Chips

   If juveniles are dealt with outside the criminal justice system; i.e., "chips," how many are there?

5. How much money has your county spent in 1988, 1989, 1990, 1991 on treating sex offenders in your jurisdiction? (This figure will not be used to determine maintenance of effort as it currently reads in the law. Both departments believe that the existing language is not the most equitable way to determine a county's responsibility of sharing the cost of the fund. The figure will provide an estimate of the cost of establishing such a treatment fund for sex offenders.)

6. Does your region of the state need more sex offender services? If so, explain.

7. How many misdemeanor/gross misdemeanor convictions in your county involved sexually deviant behavior? Please try to break down your figures into the following categories:

   _____window peeping
   _____exposing
   _____obscene phone calls
   _____terroristic threats
   _____disturbing the peace (if sex related)
   _____other (please specify)

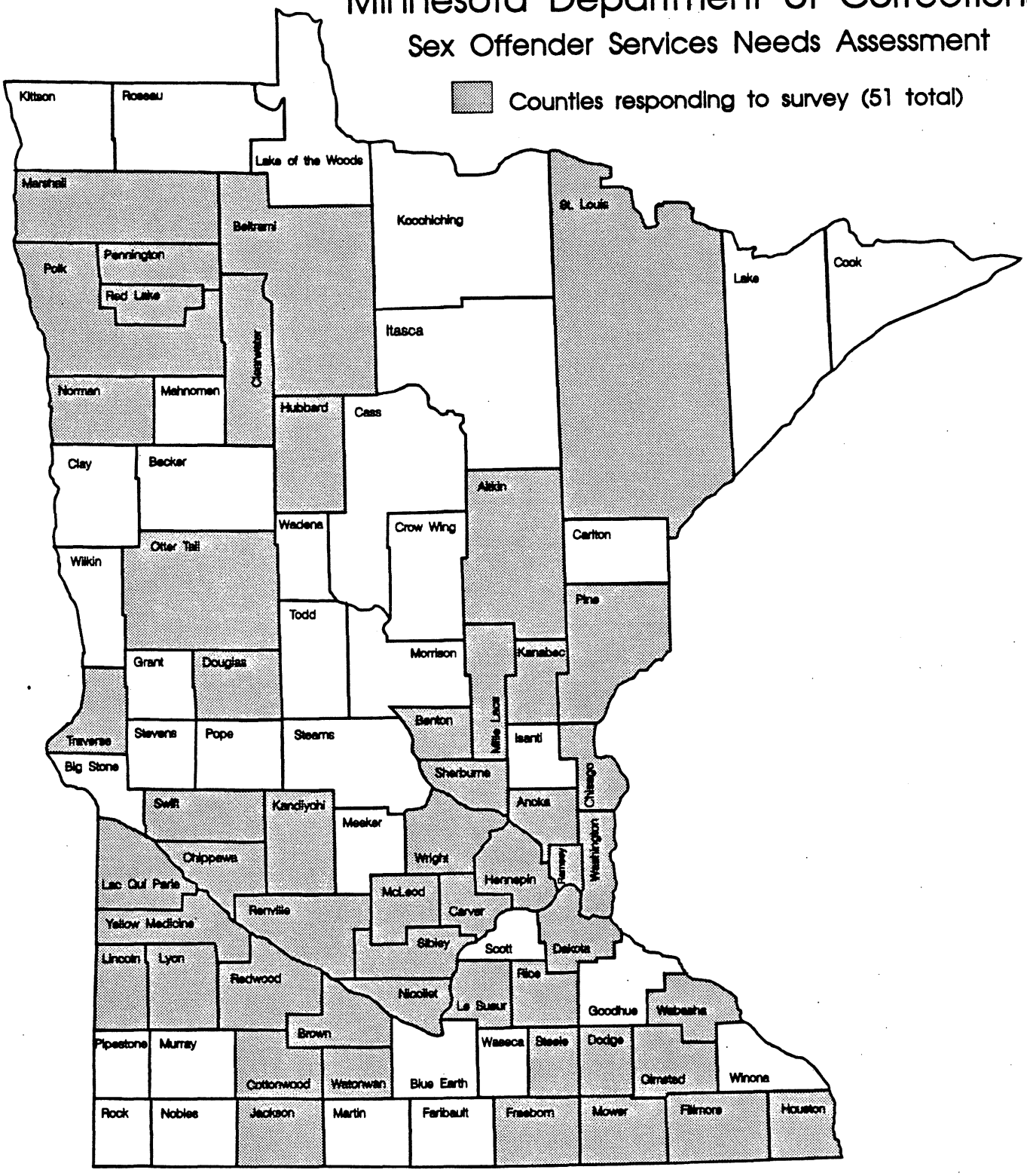
8. What methods in your county are currently used to coordinate funding for sex offender services?

9. Does your county have any recommendations regarding medical assistance program changes or waivers that will improve the cost-effective use of medical assistance funds for sex offender treatment? If so, please list.

APPENDIX B

Minnesota Department of Corrections

Sex Offender Services Needs Assessment

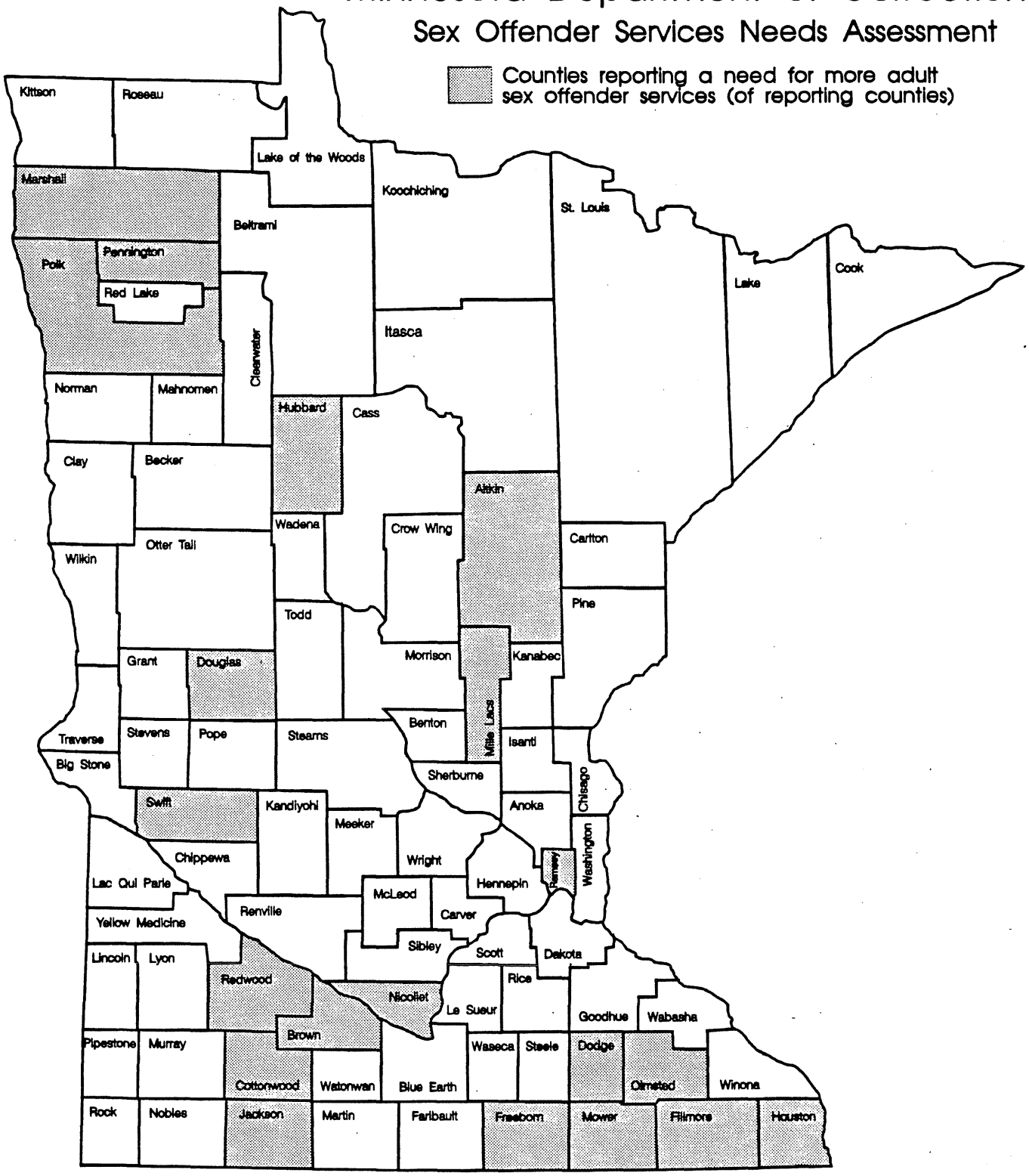


APPENDIX C

Minnesota Department of Corrections

Sex Offender Services Needs Assessment

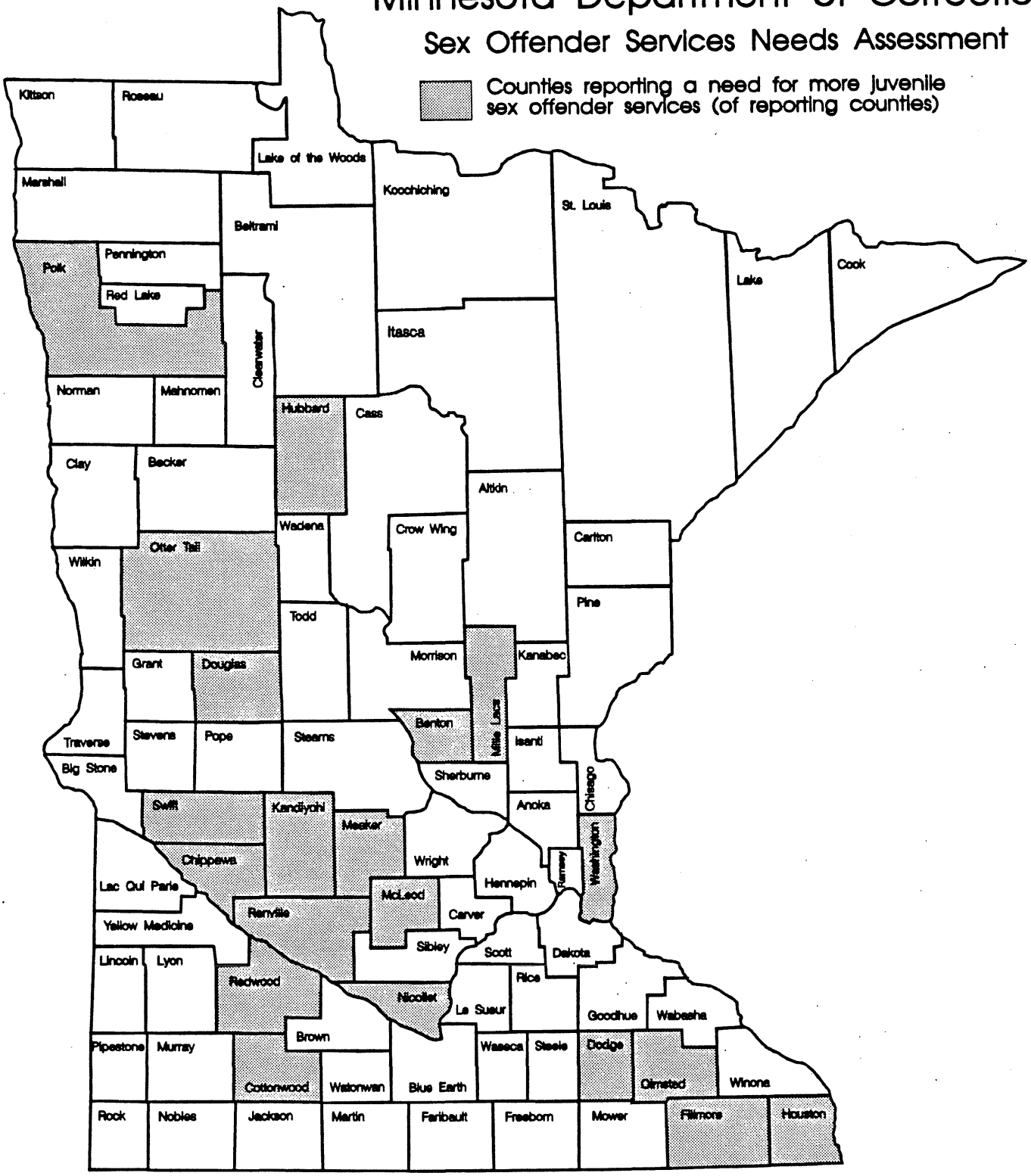
Counties reporting a need for more adult sex offender services (of reporting counties)



Minnesota Department of Corrections

Sex Offender Services Needs Assessment

Counties reporting a need for more juvenile sex offender services (of reporting counties)



APPENDIX D

QUESTIONNAIRE FOR SERVICE PROVIDERS

1. How many sex offenders does your agency currently provide services for?

____ male children ____ female children ____ mentally retarded
_____ male adolescents ____ female adolescents ____ developmentally disabled
____ male adults ____ female adults

2. Of those population listed above, how many are:

____ adjudicated (juveniles)
____ court ordered (adult)
____ volunteer (both)
____ other (please specify)

3. What type of services does your agency provide and what are the costs of these services? If your agency's fees are based on therapist level of education and/or licensure, please enclose information.

TYPE	COST
_____ individual	_____
_____ group	_____
_____ couple	_____
_____ victim	_____
_____ spouse/partner	_____
_____ family	_____
_____ assessment	_____
_____ medication	_____
_____ other	_____
Residential:	
_____ per diem	_____
_____ average length of stay	_____

4. Does your agency utilize a sliding fee scale?

_____ yes _____ no

If so, please enclose a copy of the scale with this questionnaire.

5. What percentage of your clients receive assistance in paying for their treatment costs?

Private insurance _____ County funds _____
Medical assistance _____ Other _____

6. What do you see as being the most critical item necessary to provide sex offender services? (Please rank in order of priority.)

____ attracting qualified therapists
____ aftercare
____ increased financial resources to cover treatment costs in community
____ increased financial resources for pilot programs
____ increased number of residential beds
_____ better training for professionals in the area of sex offender treatment
____ other (please explain)

7. Given limited funds, how would you rank the following needs in terms of priority for funding? Rank the category first, then within each category, rank the subcategories in terms of priority in the category.

_____ Age of Offender
(rank items below in terms of priority)
_____ child (6-12)
_____ adolescent (12-18)
_____ young adults (18-22)
_____ adult (23 and over)

_____ Type of Offense/Offender
(rank items below in terms of priority)
_____ chemical dependency
_____ mental illness
_____ DD/MR
_____ patterned
_____ other

_____ Aftercare

_____ Vocational/Employment/ Assessment/Training

_____ Type of Vendor
_____ mental health center
_____ community service agency
_____ independent or private practice
_____ other

Target Populations
_____ child molester, situational
_____ incest
_____ child molester, patterned
_____ rapist, situational
_____ rapist, patterned
_____ mixed offender
_____ other

_____ Severity Level of Offense
(rank items below in terms of priority)
_____ misdemeanor
_____ gross misdemeanor
_____ felony

_____ Research Projects
(rank items below in terms of priority)
_____ biomedical treatments
_____ follow-up research
_____ program evaluation
_____ other

_____ Adjunct Services

_____ Regional Needs
_____ metro
_____ greater Minnesota
_____ couples therapy
_____ family therapy
_____ other

_____ Service Level
_____ outpatient
_____ residential

Add any priority categories you believe are important which are not listed here.

APPENDIX E

TOTAL COSTS
OF
SEX OFFENDER FUND

ANNUAL TREATMENT	$7,424,199
ANNUAL DOC*	$1,286,570
DHS** FY94 (FY93 $278,206)	$ 339,078
TOTAL	$9,049,847

*Department of Corrections
**Department of Human Services

ESTIMATED COSTS OF SEX OFFENDER SERVICES

	ANNUAL COST	AVERAGE MONTHS	ANNUAL ADMITS	TREATMENT SLOTS	ANNUAL COST
Treatment Cost					
Inpatient					
juvenile	$48,728	12	40	40	$1,949,120
adult	24,090	12	100	100	2,409,000
Outpatient					
juvenile	4,910	16	400	533	2,618,667
adult	4,910	16	425	567	2,782,333
Total Treatment			965	1,240	$9,759,120

Revenue	% COVERED	% OF CLAIM PAID	NUMBER COVERED	ESTIMATED RECEIPTS
Insurance	26%	60%	322	$1,522,423
MA Federal	11%	80%	136	858,803
Private Pay	10%	30%	124	292,774
			583	$2,673,999

Public Cost	% SHARE	NET COST
State	90%	$6,681,779
County	10%	742,420
Payment System		339,078
		$7,424,199

OUTPATIENT SEX OFFENDER TREATMENT
PROGRAM DESIGN AND ESTIMATED FEES PER CLIENT
(JUVENILE AND ADULT)

50 group therapy sessions per year 50 x $45.00	$2,250.00
24 individual counseling sessions per year 24 x $65.00	1,560.00
intake, testing, assessment	600.00
associated collaborative services (court testimony, family and community contacts, coordinating with other agencies	500.00
TOTAL PER YEAR PER CLIENT	$4,910.00

ADULT OUTPATIENT COMMUNITY PROGRAMS

Number of sex offense convictions (data from Sentencing Guidelines Commission)

1988	677
1989	688
1990	771
1991	726

Approximately 220 per year sentenced to incarceration (new offenses excluding supervised release violators)

Therefore, the budget estimates are based upon 525 offenders sentenced to community-based treatment. 100 to inpatient, 425 to outpatient.

There is currently very limited bedspace available in communities. This is probably due to the expense of inpatient treatment, as well as community resistance to placement of programs in the community.

For the purposes of budget discussion, the estimated per diem for inpatient programming is based upon the one community-based inpatient program in Minnesota (Alpha Human Services) which currently operates a facility in Minneapolis and has a capacity of 23.

Per diem	66.00 per day
	x12 months
Cost	$24,090.00

It is significant to note that the estimated per diem for adult sex offender inpatient treatment is about equal to the average per diem for incarceration in Minnesota Correctional Facilities.

If it could be determined that offenders sentenced to inpatient treatment would otherwise be sentenced to incarceration, the net expense to the state would be equalized. This is based upon the provision that the sentence to incarceration and sentence to treatment are equal in length. If the treatment sentence is shorter than the incarceration sentence, then the net result to the state is an economic gain.

JUVENILE OUTPATIENT COMMUNITY PROGRAM

-Number of juvenile sex offender petitions in 1991. (Data from Minnesota Statistical Analysis Center, Minnesota Planning.)

	Certified as Adult	Corr. & etc.	Prob. Only	Prob. + Tx	Prob. + Other	No Court Action	Unknown	Total
Rape	6	34	90	30	81	43	1	285
Other Sex Offenses	1	26	119	22	91	45	0	304
Total	7	60	209	52	172	88	1	589

Leaving out the unknown disposition case and the 88 no-court action cases, 500 cases remain.

Assuming the remaining 500 cases would benefit from sex offender treatment and reduced recidivism would occur as a result of that treatment, this estimate of funds needed is based upon funding treatment for 400 in community outpatient, and 40 in community inpatient.

JUVENILE INPATIENT COMMUNITY PROGRAM

Per Diem Average			
Hennepin County Home School	12-18 months	$211.00	
Leo A. Hoffmann Center	11-16 months	116.00	
NEXUS		125.00	
Anoka County		82.00	
Average per diem			$ 133.50
			x365
			$ 48,728.00

As noted above, the average per diem is a result of averaging a broad range. When the highest per diem is taken out of the calculation, the annual expense per client decreases nearly ten thousand dollars per year.

COST OF DEPARTMENT OF CORRECTIONS SEX OFFENDER SERVICES UNIT

PROMULGATION OF RULES:

There are five rules to be promulgated in regard to the sex offender treatment fund:

1. Adult outpatient program
2. Adult inpatient program
3. Juvenile outpatient program
4. Juvenile inpatient program
5. Administration of the sex offender treatment fund

The Department of Human Services' manual on rulemaking estimates each rule to require four-to-six thousand employee hours to promulgate one rule.

5,000	hours per rule
5	rules
25,000	hours

25,000 hours of labor results in a need for approximately 13.5 staff for a twelve-month period, 9 staff for an eighteen-month period, or 6.5 staff for a twenty-four month period. (Calculated by assuming 46 weeks of project specific activities per person per year. 1840 hours.)

PROGRAM AND POLICY MONITOR:

(FY93) $41,530.00 + $10,382.00 =		$ 51,912.00
		13.5
		700,812.00
Rents	4,000 x 13.5	54,000.00
Communications	812 x 13.5	10,964.00
Travel	1,200 x 13.5	16,200.00
Supplies and Equipment	1,900 x 13.5	25,650.00
		$106,814.00

INSPECTIONS, LICENSING, AND MONITORING OF SEX OFFENDER PROGRAMS:

Estimates of 25-50 programs throughout the state, based upon 1,000 offenders in programming.

Assuming the number of offenders in each program ranges from a low of 20 to a high of 40, the number of programs ranges from 25-to-50.

Based upon the Department of Corrections Victim Services Unit's experience and the Department of Corrections Community Corrections Program's experience, the number of programs one staff person can monitor ranges from a low of ten to a high of twenty. This range is caused by differences in complexities of programs and degree of monitoring required.

Therefore, provided assumptions regarding number of offenders and number of programs is realistic, the number of program monitoring staff ranges from 1.5 to 4.5.

This report projects a need for 4.5 positions due to the legislative directive to conduct outcome-based evaluations of each program. Due to this additional aspect of program monitoring, there is a need for each staff to monitor fewer programs.

PROGRAM AND POLICY MONITOR:

(FY93) $41,530.00 + $10,382.00 =	$ 51,912.00
	4.5
	233,604.00
Rents	18,000.00
Communications	3,654.00
Travel	5,400.00
Supplies and Equipment	8,550.00
	$ 35,604.00

SEX OFFENDER ASSESSMENT FUND:

The issue of sex offender assessments needs considerably more focus than this unit is currently able to provide.

A program monitor position should be assigned to this fund on a full-time basis.

PROGRAM AND POLICY MONITOR

(FY93) $41,530.00 + $10,382.00 =	$ 51,912.00
Rents	4,000.00
Communications	812.00
Travel	1,200.00
Supplies and Equipment	1,900.00
	$ 7,912.00

SEX OFFENDER SERVICES UNIT DIRECTOR:

(FY93) $47,600.00 + $11,900.00 =	$ 59,500.00

DEPARTMENT OF CORRECTIONS ESTIMATED TOTAL COSTS

Rules Promulgation	
Staff	$ 700,812.00
Support	106,814.00
Inspection, Licensing, Monitoring	
Staff	233,604.00
Support	35,604.00
Assessment Fund	
Staff	51,912.00
Support	7,912.00
Management	
Staff	62,000.00
Support	7,912.00
Clerical	
Staff (2)	60,000.00
Support	20,000.00
TOTAL	$1,286,570.00

COST OF VENDOR INVOICE PROCESSING AND COLLECTION ACTIVITY
(DHS)

OBJECT CODE	OBJECT NAME	FY94 BUDGET	FY95 BUDGET	COMMENTS	BIENNIUM TOTAL
1	Reg-Classified	$225,767	$225,767	1	$451,534
2	Reg-Unclassified	$ 0	$ 0		$ 0
10	Rents	$ 27,493	$ 28,573	2	$ 56,066
11	Advertising	$ 0	$ 0		$ 0
12	Repair	$ 0	$ 0		$ 0
14	Printing	$ 5,560	$ 5,560	3	$ 11,120
16	Professional Services	$ 3,000	$ 2,000	4	$ 5,000
17	Data Processing	$ 29,250	$ 0	6	$ 29,250
18	Purchased Services	$ 27,390	$ 0	2	$ 27,390
20	Communications	$ 5,685	$ 3,941	2	$ 9,626
21	Travel In-state	$ 6,660	$ 6,660	2	$ 13,320
22	Travel Outstate	$ 0	$ 0		$ 0
29	Fees	$ 500	$ 500	5	$ 1,000
30	Supplies	$ 5,505	$ 5,205	2	$ 10,710
40	Equipment	$ 2,268	$ 0	2	$ 2,268
Total		$339,078	$278,206		$617,284

Comments

1 Salary Plan July 1992 = 25% Fringe
2 Budget guidelines
3 Monthly billing statements, invoices, and placements
4 Legal services
5 Employee training
6 Computer software, upgrade and supply

CLASSIFICATION	FY93 MINIMUM ANNUAL	FY93 FRINGE BENEFITS (25%)	FY93 SALARY & BENEFITS	FTE'S	FY93 TOTAL SALARY & BENEFITS
Account Clerk Sr.	$ 23,177	$ 5,794	$ 28,971	2	$ 57,943
Coll Office	$ 25,474	$ 6,369	$ 31,843	2	$ 63,685
Systems Analyst	$ 35,663	$ 8,916	$ 44,579	2	$ 78,013
Data Entry	$ 20,901	$ 5,225	$ 26,126	1	$ 26,126
Total	$105,215	$26,304	$131,519	7	$225,767

*

Programming	@ .50 FTE
Systems Development	@ .25 FTE
System Operations	@1.00 FTE

APPENDIX F

PHARMACOTHERAPY TREATMENT OF SEX OFFENDERS

A Research Proposal

I. Statement of the Problem

Today, one in five adult males incarcerated in Minnesota has been convicted of a sex offense. Well aware that crimes in this area are on the rise and that the incarceration and rehabilitation of sex offenders costs the state millions of dollars, taxpayers are demanding more effective prosecution and more effective treatment programs.

Unfortunately, too little is known about what is truly effective in treating sex offenders. In particular, biomedical research has been long neglected owing to the strong taboos in our society concerning this area of inquiry. The Program in Human Sexuality, a research and education unit of the University of Minnesota's School of Medicine, is proposing a research project that will add crucial information to our understanding of sex offenders and their rehabilitation.

II. The Program in Human Sexuality, Department of Family Practice and Community Health, University of Minnesota Medical School

The Program in Human Sexuality (PHS) is in a unique position to carry out research in the area of sex offender treatment. The Program in Human Sexuality was established in 1970 to conduct research and provide education within the Medical School of the University of Minnesota and to provide service to the public.

During the mid-1970's, PHS began studying and treating sex offenders. Since then, it has developed and operated an outpatient sex offender program and conducted various studies on sex offender personality disorders and treatment outcomes.

PHS researchers are familiar with the techniques and methods used to study and measure the psychological and physiological aspects of normal and deviant sexual arousal, and have years of clinical experience using a variety of psychological and pharmacological treatment methods with this population. PHS is also equipped with the necessary trained personnel to conduct and supervise sophisticated research in this area.

PHS has collaborative relationships with a number of relevant Medical School departments; in particular, the Department of Psychiatry. In addition, PHS enjoys collegial relationships with personnel within the state's sex offender treatment programs. We can coordinate resources for conducting this University-based research.

PHS enjoys international recognition and respect for its innovative research in human sexuality and is recognized for its leading role in developing new treatments for sex offenders. In recent years, PHS has organized three international conferences on the treatment of sex offenders.

III. Current and New Treatments for Sex Offenders

1. Untreatable

These individuals suffer from psychopathic personalities with psychotic and sociopathic features. These individuals cannot be treated given current psychiatric knowledge and the necessary solution is long-term incarceration.

2. Offenders whose sexual disorders and associated psychiatric disorders are treatable within a safe and protected environment

These are individuals with insufficient control over their offending behavior who must be treated in a protected environment until they can be safety transferred to outpatient psychotherapy or less restrictive settings. These individuals can be treated in inpatient correctional facilities, released upon completion of sex offender treatment, and monitored through probation.

3. Offenders who have sufficient control over their offending behavior and whose sexual and psychiatric disorders are amenable to outpatient treatment

These individuals can be given stayed sentences with long probationary periods requiring successful completion of outpatient sex offender treatment and probation monitoring.

Obviously, not all sex offenders can be treated. However, various treatment programs exist for individuals who can be treated in inpatient or outpatient settings. We can improve existing programs by conducting research on some of the newer developments in the treatment of sex offenders. The most promising new development in sex offender treatment involves an understanding of biomedical factors of the sex offender and the use of pharmacological treatments.

IV. Proposed Research Project

PHS is prepared to carry out innovative pharmacological treatment studies for sex offenders. The paragraphs below describe the initial study we are proposing. It is our hope that this initial study will lead to further studies on biomedical aspects of sex offending and sex offender treatment.

PHS plans an initial controlled drug study using the existing pharmacotherapies which have shown promise in increasing treatment effectiveness. Anti-androgens, such medroxyprogesterone acetate (MPA) (Depo Provera R or Provera R), have long been used to drastically reduce the male sex hormone in sex offenders and can be an effective adjunct to sex offender psychotherapies. In fact, very recent studies indicate that sex offenders treated with a combination of psychotherapy and anti-androgens are less likely to relapse than those who do not take anti-androgens. While these studies are promising, there are many problems associated with treatment using MPA. The greatest problem is the willingness of patients to take Depo Provera which is a long-acting form of Provera and must be administered intramuscularly. There are potential demasculinizing side effects (e.g., decreased beard growth, decreased fertility and lowered sexual drive) that cause patients to hesitate taking this medication, resulting in noncompliance problems. There have been reports that Provera (administered orally) has less problems with side effects and patient acceptance. Patient acceptance of a medication is an extremely important variable to consider when evaluating drug effectiveness with sex offenders. Therefore, while MPA is indicated as a useful pharmacotherapy as an adjunct to sex offender treatment, there has not been an adequately controlled anti-androgen study conducted on the sex offenders in this state using subjects from our corrections system and treatment centers. Finally, and most importantly, there has been only one double blind treatment trial with MPA. This study's conclusions are limited by an adequate follow-up period, lack of information on relapse rates and small numbers (seven patients completed the six week trial.)

We plan to study the efficacy of oral Provera as an adjunct to psychotherapy for these reasons: oral Provera is associated with higher patient acceptance; oral Provera is comparable to other oral medications; oral Provera was used in the only other MPA study. This study would be the first of its kind... to assess the effectiveness of oral Provera compared to another pharmacologic agent in a double blind placebo controlled study. This study will be conducted using volunteers who meet a well-defined criteria set forth in the design of the study.

Fortunately, in addition to the anti-androgens, other pharmacological agents show promise in the treatment of this population. In clinical practice and preliminary research, we have found that the fluoxetine hydrochloride (Prozac R), typically used for treating depression and obsessive-compulsive disorder, also helps sex offenders reduce their deviant sexual drives and urges and increase their control over acting on these impulses. Prozac R is a potent serotonin reuptake inhibitor. This medication has few side effects, which encourages drug compliance and enhances the ability to conduct placebo controlled, double blind studies. Therefore, we propose to compare the use of fluoxetine to MPA.

We plan to carry out these studies beginning in August 1992 and to report the results of these studies to the legislature by February 1, 1993. The first stage of this grant would fund the development of the study designs and protocols and to gain human subjects approval. It is anticipated that the study could begin in December 1992. The second stage of the study would be implementation and the third stage would include data analysis and reporting of results. The proposed budget for this study includes the necessary personnel and costs for the drug trials and appropriate laboratory tests. If these trials indicate positive results, we would hope to conduct more long-term drug studies and further basic research on the biomedical aspects of treating sex offenders.

Study Design

This study is designed to compare the effectiveness of MPA (Provera R) which acts as an anti-androgen with the anti-depressant (Prozac R) in the treatment of sex offenders (specifically pedophiles.) This study will compare these two medications against a placebo in a double blind cross-over design. All subjects will be currently involved in sex offender treatment and for ethical and theoretical reasons, subjects will not be asked to discontinue treatment during the study period. While this confounds the study design, we feel it is the most ethical way to perform this study and it would fit with the reality that one would never treat a sex offender with medication alone. We also plan to limit the enrollment of subjects in this study to pedophiles (nonincest type) who are treatable on an outpatient basis. These are patients who are most likely to be considered for pharmacologic interventions. These patients will be interacting with the environment and therefore these trials will represent a more accurate real life test of improvement through pharmacotherapy. The first study will look at short-term effectiveness. If proven effective, longer term outcome studies will be designed and implemented. We would like to stress that this study is designed to compare with effectiveness of MPA and fluoxetine in enhancing the effectiveness of standard psychotherapy. It is not a study of pharmacotherapy versus psychotherapy.

MPA (Provera) is used as an oral contraceptive in women and has been used in men for the treatment of paraphilias, gender dysphoria, and testosterone dependent cancers. In males, MPA reduces the production of testosterone/lowers the level of testosterone in the blood system. As a result, men report less sexual drive. Provera R has been chosen because many clinicians in the United States and Canada who are treating sex offenders have reported that oral administration of Provera R

rather than the intramuscularly administered Depo Provera R insures greater compliance among patients with fewer reported side effects.

Fluoxetine hydrochloride is a medication that has been found effective in treating depression and obsessive-compulsive disorders. Side effects that have been reported include a lowering of sexual drive. The pharmacological action of fluoxetine hydrochloride is presumed to be linked to its inhibition of central nervous system neuronal reuptake of serotonin. The mechanism of lowering sexual drive is not known. Decreased paraphilic interest may be the result of the fluoxetine's side effect of reducing sex drive or as a result of treating the sex offender's depression, anxiety, or obsessive-compulsive disorder (which has been hypothesized to be one of the causes of the individual's deviant sexual arousal pattern or their inability to control unwanted [societally prohibited] sexual urges.)

Methodology

This is a double blind cross-over placebo study design, with three six-week trials of the medications or placebo, separated by two six-week "wash out" phases between cross-over trials.

Twenty four adult males between the ages of 18 and 45 years, who meet the diagnostic criteria for pedophilia (302.20) as defined in the American Psychiatric Association's Diagnostic and Statistical Manual - Revised (DSM-III-R) and who have been tried and convicted of a sexual assault crime involving a nonfamilial minor will be randomly assigned to one of three study conditions. Pedophiles were chosen for this study because (1) it is important to study a homogeneous population of sex offenders; (2) they exist in sufficient numbers to find participants for the study; and (3) the importance of finding more effective treatments for pedophiles who offend against minors is of grave concern to the community. The following are the inclusion criteria for the study:

1. Males, Ages 18-45
2. Meet DSM-III criteria for pedophilia-attraction to children (up to and including 13 years of age) who are unrelated to the pedophile and are not living with the offender.
3. Charged and convicted: sexual assault with minor
4. In treatment for sex offense
5. Usual acceptance criteria for treatment in an outpatient sex offender treatment program
6. Willing to name someone as an outside informant to rate any effects of medication

The exclusion criteria will be:

1. Concurrent diagnosis of major depression or psychosis according to DSM-III-R criteria
2. Medical contraindications to taking any medications involved in this study
3. If currently on psychotropic medication-no contraindications to stopping medication for period of study
4. Not on any medication to control endocrine disorders
5. Active chemical dependency
6. History of use of weapons or violence

Participants will be recruited from the patient population of the Sex Offender Treatment Program at the Program in Human Sexuality and Alpha Human Services. All

pedophiles who are currently in treatment at either facility will be offered the opportunity to participate in the study. Each prospective participant will be told of the nature and procedure of the study and the potential benefits and risks. If prospective participants indicate a willingness to participate in the study and meet inclusion/exclusion criteria, they will be given a detailed informed consent form and the research staff will be available to answer any questions or concerns before entering the study and throughout the course of the study.

The study conditions will vary by sequence of drugs administered. However, each subject will receive Provera R, Prozac R, and a placebo at some point in the study. Each subject will be their own control, but the randomized cross-over design will allow for statistical analysis of possible order effects.

Participants will be recruited from outpatient sex offender treatment programs to engage in a six-week trial of Provera R, a six-week trial of Prozac R, and a six-week trial of placebo with a six-week "wash out" period during cross-over between each of the three trials. The sequence of receiving the medications and placebo will be randomly altered among patients, some receiving Provera R first, some receiving Prozac R first, and others receiving placebo first. Patients and investigators will be blind to the order of administration. Patients will be seen by one of the investigators on a weekly basis during the study to complete a semi-structured interview and to complete some paper and pencil questionnaires. These interviews and questionnaires will be designed to monitor medication effects and obtain self-report data on sexual urges and behavior.

At the beginning of the study, several base-line measures will be obtained. These will include sexual activity, sexual drive, sexual urges, fantasy patterns, anxiety, depression, and nonsexual obsessive-compulsive behaviors. These measures will be repeated at weekly interviews throughout the study. A complete psychiatric inventory of comorbid psychiatric disorders will be administered at the beginning of the study to help rule out any contraindications for study participation as well as for descriptive purposes. Participants will be administered the Hamilton Anxiety and Depression Scales, the Beck Depression Inventory, and the Yale-Brown Obsessive-Compulsive Scale. These scales have all been standardized and are considered reliable and valid measures of anxiety, depression, and obsessive-compulsive symptoms, respectively. The semi-structured interviews will contain ratings of sexual fantasies, drives and urges, subjective accounts of anxiety, and obsessive-compulsive behavior. At the end of each drug trial, the subject will be asked what medication they think they were taking. The subject's "informant" and investigator conducting the ratings will also be asked to "guess" what medication the subject was taking.

At the beginning of the study, each participant will be tested in a penile plethysmograph laboratory at the Program in Human Sexuality to evaluate their physiological sexual arousal patterns. This standardized test will be repeated at the end of the first drug trial. Therefore, each participant will take this test twice during the period of the study. This test is not repeated frequently throughout the study to avoid problems of desensitization of the test stimuli and to reduce burden on the subjects. However, in this manner, we will be able to compare psychophysiological measurements of sexual arousal of each of the drug conditions.

At the beginning of the study, each participant will receive a physical and psychiatric examination to insure safety and to make sure the patient fits the study inclusion/exclusion criteria. Blood will be drawn at the beginning of the study and after each of the three drug trials. This blood will be analyzed for a Complete Blood Count (CBC) as a standard screen (to rule out infections, anemia, or other

hematolgic disease), free testosterone level (to measure testosterone levels and to rule out endocrine disorders), and prolactin (to rule out endocrine disorders and as a measure of stress.) A urinalysis will also be conducted to measure glucose levels (to rule out diabetes) and to conduct a drug screen. If there are any irregularities, further laboratory studies and examinations will be conducted. A brief physical, blood pressure, urinalysis and blood draw (including drug screen) will be conducted by a physician after each of the three six-week drug trials of the study. Medication evaluations (including blood pressure checks) will be conducted to study and assess for complications or serious side effects and to insure safety. It should be noted that in a previous study using the same dosage of Provera R, physicians were unable to correctly "guess" whether subjects were in a placebo or Provera R trial on the basis of side-effects (Hucker, personal communication.) We therefore do not expect the blind to be broken by this procedure.

At the beginning of the study, participants will identify an "informant" who will be asked to participate in the study. This adult informant should be someone that they are living with (e.g., spouse/partner) and/or who knows them and their sexual offending behavior and pattern quite well (e.g., therapy group member.) A separate human subject consent form will be read and signed by the "informant" before entering into the study. At the beginning of the treatment, the informant will be asked to provide general ratings about the subject's level of anxiety, depression. The informant will again be asked to rate the individual on the aforementioned areas after each six-week period of the study as well as their perception of whether the subject has taken the medication as prescribed and has noticed any benefits or adverse consequences.

The dosage for Provera R will be 200 mg./day (orally self-administered in the morning.) The dosage for Prozac R will be 60 mg./day (orally self-administered in the morning.) All medications and the placebo will be prepared by the pharmacist and properly disguised.

Participants will be paid $25 for entering the study and $75 for completion of the study. Informants will be paid $30 at the completion of the study. No charges will be assessed to the subjects for physical exams, psychiatric evaluations, medications, laboratory tests, etc. Payment to participants is intended as an inducement to increase participant compliance and decrease attrition rates, in order to counter-balance the demanding data reporting procedures and time required for this study. If at any time the participant wishes to discontinue the study, they will be able to do so without any penalty or negative repercussions to their treatment plan. Participants will be discontinued from the study if they report greater psychological disturbance or any serious adverse side effects or medical complications as evaluated by the psychologist, physician, and medical evaluations throughout the study. Subjects will also be monitored by a psychologist in the Sex Offender Treatment Program at the Program in Human Sexuality who will not be blind to the study protocol and will terminate subject participants if there are any clear negative consequences (e.g., subject reoffends, standard treatment is compromised.)

At the conclusion of the study trials, the blind will be broken to the participants and to the investigators. The participants will be debriefed and offered the options of: (1) continuing one of the active medications under a longer-term outcome evaluation study; (2) continuing the medication of their choice under medical supervision (at their expense); (3) discontinuing medication and continuing standard sex offender treatment.

Protocol and Procedures Summary

Each participant will be involved in the study for 30 weeks. This study is a double blind cross-over placebo design involving two medications (Provera R and Prozac R.) Drug Treatment #1 will be administered for six weeks and then subjects will have a six-week "wash out" cross-over period, then receive Drug Treatment #2 for six weeks, then have a six-week "wash out" cross-over period, and then receive Drug Treatment #3 for the final six weeks. One of the drug treatments will actually be a placebo. The subjects will be randomly assigned to one of three treatment conditions varying in sequence of administration of the drugs and placebo.

Design Summary

Recruitment and Explanation of Study
Assessment and Acceptance into Study
Obtaining Informed Consent and Initial Payment to Subject
Randomize Subjects into Three Treatment Conditions which Vary Sequence of Drug Administration
Six-week Drug Treatment #1
Second Plethysmograph Assessment
Six-week "wash out" and cross-over
Six-week Drug Treatment #2
Six-week: "wash out" and cross-over
Six-week Drug Treatment #3
Debriefing/Reveal Treatment Sequence/Final Payment

V. Personnel

Eli Coleman, Ph.D. will be the principal investigator for this project. Dr. Coleman is an associate professor and director of the Program in Human Sexuality in the Department of Family Practice and Community Health, University of Minnesota Medical School.

Nancy Raymond, M.D., is an assistant professor and psychiatrist in the Department of Psychiatry, University of Minnesota Medical School. Dr. Raymond will be a co-investigator and conduct the psychiatric evaluations and monitor the patients regarding their medications.

S. Margretta Dwyer, M.A., will conduct penile plethysmography assessments. Ms. Dwyer is an instructor and coordinator of the sex offender program at the Program in Human Sexuality, University of Minnesota Medical School. She has extensive experience in conducting this examination and the assessment is a routine examination which is conducted on all sex offenders who have been treated at the Program in Human Sexuality. Ms. Dwyer will also act as a nonblind reviewer of the study who will monitor data in an ongoing fashion and terminate subjects from the study if there are any untoward consequences (e.g., a subject is re-offending, interference in the psychotherapy process, etc.)

J. Paul Federoff, M.D., is an assistant professor at the University of Toronto and a psychiatrist at the Clarke Institute of Psychiatry in Toronto, Ontario, Canada. Dr. Federoff has particular expertise in designing pharmacological studies with sex offenders and paraphiles. He will consult with the investigators regarding the design and strategies for study implementation and evaluation.

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