MINNESOTA SECURITY HOSPITAL
TREATMENT PROGRAM TASK FORCE

REPORT TO
COMMISSIONER, DEPARTMENT OF PUBLIC WELFARE
JANUARY, 1978

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MINNESOTA SECURITY HOSPITAL
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INTRODUCTION

"$100,000 OF THE APPROPRIATION FOR STATE HOSPITALS IS AVAILABLE TO DEVELOP PLANS FOR A NEW SECURITY FACILITY FOR 150 TO 160 RESIDENTS TO BE LOCATED ON THE ST. PETER STATE HOSPITAL CAMPUS. THE COMMISSIONER OF PUBLIC WELFARE SHALL SUBMIT THE PLAN TO THE LEGISLATURE BY JANUARY 16, 1978."

Laws of Minnesota, 1977
Chapter 453, Sec. 2, Subd. 4

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In response to the above direction, the Minnesota Department of Public Welfare, through its office of Policy Analysis and Planning, conducted an extensive review of the Minnesota Security Hospital during the summer and fall of 1977. Their findings are summarized in their general report, "Minnesota Security Hospital: Program Assessment and Design Alternatives".

During this same period, a fourteen member Task Force, representing a broad diversity of professional interest and expertise, was appointed by the Commissioner of Public Welfare. The charge given to the Minnesota Security Hospital Treatment Program Task Force consisted of two sections:

A. *Treatment Program Review. Recommend treatment methods appropriate for the various categories of patients at the Minnesota Security Hospital; indicate selection criteria for these programs; estimate staffing requirements and expected length of treatment; and based upon available research data predict probabilities of successful outcome for each category.*

B. *Patient Release Activities. Review Minnesota Security Hospital policies and procedures for allowing patients off-grounds privileges and prepare a report with recommendations to the Commissioner of Public Welfare.*

The first section identified programmatic issues needing resolution during the process of planning a new security facility; the second part related to an immediate departmental concern about security measures in the present Security Hospital. Although somewhat disparate, it was felt that both sections should be addressed by a single panel of experts. A subcommittee was appointed which subsequently prepared a separate report that was reviewed by the Task Force and submitted to the Commissioner. (Addendum #1)

Additional subcommittees dealt with legal, program, and outcome issues. Their written and/or verbal reports were presented by the subcommittee chairmen to the Task Force. (Addendum #2)

At the first of eleven meetings held between September 6, 1977 and November 10, 1977, the Commissioner requested that the Task Force concern itself with both present and future programming for persons needing secure facilities, and to consider the possible role of other state hospitals as part of the total resource system.

A partial list of topics reviewed and discussed by the Task Force includes:

1. Descriptions of current Minnesota Security Hospital programs, staffing, and patient populations.

2. Demographic and statistical reports.

3. Sex offender treatment programs in Minnesota and other states.

4. Referral patterns and community attitudes toward the Minnesota Security Hospital.

5. Historical perspectives on the present program.

6. Minimum security units in open state hospitals.

7. Definitions (legal, diagnostic, treatment, programs versus facilities).

8. Outcome studies and treatment research.

9. Proposed statewide forensic assessment program.

10. Secure treatment programs for women and adolescents.

11. Release criteria.

12. The prediction and control of dangerousness.

13. Geographic location as it affects Security Hospital treatment programs.

14. Proposed models for treatment classifications.

15. Selection of clients for the Department of Public Welfare and the Department of Corrections.

Scope of the Task Force's Recommendations

After several meetings it became apparent that the Task Force probably could not, within the time allotted, make detailed recommendations about model treatment programs as had been requested by the Department. Lacking both agreed-upon national norms for such a facility and definitive research on treatment outcome, it was decided to concentrate on major boundary issues that (1) regulate the flow of patients in and out of any security facility, (2) set the tone of the institution, (3) determine what courts and other agencies might reasonably expect of the program, and (4) define the separate roles of Corrections and Welfare in the client-sorting process. The specifics of treatment program planning for a new security facility were, by necessity, left to Department staff.

RECOMMENDATIONS

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1. *There should be a centralized maximum security facility at St. Peter for assessment and treatment of persons for whom the Department of Public Welfare has case responsibility.*

The concept of the centralized maximum security facility for assessing and treating dangerous persons whose mental functioning is apparently deranged or diminished can itself be challenged. It is a truism that merely establishing a facility of any kind invites usage, and historically maximum security treatment facilities have been particularly vulnerable to over-usage by society. Some members of the Task Force raised the question, "Should there be a security facility in Minnesota?" and urged that this was a propitious time in Minnesota history to consider new alternatives.

The majority of members was not convinced, however, that the difficult and dangerous population served by the present Security Hospital could be adequately handled in small decentralized units or in a less secure physical environment. The majority also maintained that although the prediction of dangerousness has been generally discredited in recent years, there will continue to be mentally ill and dangerous individuals who need long term treatment programs. Extended confinement of this group in small units scattered throughout the state was considered to be inhumane and anti-therapeutic.

Although not included in the Commissioner's charge to the Minnesota Security Hospital Treatment Program Task Force, the question of where a new facility should be located was raised by several Task Force members. Three issues - community acceptance of a maximum security facility, the ready availability of key mental health specialists, and the proximity of the institution to urban population centers and rehabilitation resources - were quickly identified as pivotal program concerns.

The Task Force did not attempt to organize a separate study relating to site selection. The topic was discussed at some length during two meetings. The final vote on this recommendation was not unanimous and reflected the Task Force members' strongly divergent opinions about the location of a proposed new facility.

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2. *The maximum security facility should be an integral part of a DPW security program.*

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The question, "Should there be a security facility?" also forced definitions of "security facility" and "security program". It was the Task Force's conclusion that a security facility should comprise only one facet of a comprehensive DPW security program. It was urged that equal attention be paid to the development of a continuum of security levels in other parts of the DPW system that would be coordinated with the maximum security facility.

After considerable debate, particularly around the question of including "custody" as an element of the treatment facility's services, the Task Force adopted the following definitions:

Security Facility

A security facility is one element of a security program. It is a professionally staffed treatment facility with secure perimeters designed to safely and humanely contain adults considered dangerous to others and in need of assessment, treatment and management.

It is a self-contained facility of adequate size and design to accommodate a variety of individuals in need for the following types of services on a long or short term basis:

1. Court assessments requiring maximum security.
2. Assessment and treatment, with varying degrees of supervision and security.
3. Long term therapeutic management under conditions of maximum security.

Security Program

A security program is a system designed to deal with mentally ill persons whose current behavior has been identified by the criminal justice system and/or mental health system, using the criteria found in the statutes, rules and regulations of the State of Minnesota, as needing assessment and/or treatment and management under highly controlled and restrictive conditions. This system would include a spectrum of physical and program-

matic controls ranging from supervised physical segregation to supervised community living; from crisis intervention to long term programming; from a small locked unit in an open hospital to a large self-contained closed facility; from intensive individual treatment to a program of therapeutic management.

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3. *Assessment and treatment, not custody, should be the primary mission of the Department of Public Welfare security program.*

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To accentuate this point of view, the Task Force took a strong position that a new facility's architectural design must reflect its basic mission and philosophy, i.e., assessment and treatment. Security precautions and custodial responsibilities, although necessary in some instances, should be considered an adjunct to the therapeutic process and not ends in themselves. This is in sharp contrast to the traditional role of correctional institutions whose primary mission is to provide appropriate environmental controls for persons convicted of crimes. In those settings the protection of society and execution of court ordered sentences are of principal concern while treatment programs receive adjunctive status.

The Task Force recommended that the name of the Minnesota Security Hospital be changed to "Minnesota Security Evaluation and Treatment Center" to clarify that the institution's functions extended beyond the usual medical hospital.

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4. *The present overcrowded conditions at the Minnesota Security Hospital, together with projected future service demands, require strong legislative support for improved staffing and facilities if acceptable standards are to be maintained.*

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Several times during the course of its deliberations, the Task Force was made aware of the overcrowded conditions at the Minnesota Security Hospital. Serious questions were also raised about the adequacy of current staff-patient ratios, particularly in view of the highly disturbed patient population confined to that institution. In the opinion of mental health professionals on the Task Force, Minnesota Security Hospital staffing patterns do not meet usual minimum standards set for conventional psychiatric treatment programs. These concerns were summarized in a motion adopted by the Task Force: "The numbers of staff at the present time and the adequacies of the physical plant at the present time are below that which is required to meet the legislative mandate which has been impressed upon this facility."

Strong legislative support for improved staffing will be necessary if acceptable standards are to be established and maintained.

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5. *Treatment programs and living arrangements for adult women should be included in any new security facility.*

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As an interim measure four years ago, the Department of Public Welfare established a five-bed locked unit for mentally ill and dangerous women at Anoka State Hospital. Prior to that time the only alternatives for such individuals were the open state hospitals or correctional institutions.

Occupancy on the women's unit has varied from three to five. The combination of very limited quarters and minimally secure perimeters make this unit unsuitable for long term programming and/or confinement of dangerous women. These limitations have dissuaded the Department of Corrections from using the unit although they estimate that up to ten women in the Shakopee facility need in-patient psychiatric care at any given time. With

the observed national trend toward female involvement with violent crimes, it is expected that the demand for institutional care will increase.

The Task Force recommended that the DPW security facility serve women in the same categories as men (i.e., needing a secure setting for treatment), both because there are presently no comparable resources for women, and because a controlled coeducational facility was considered to have a more normalizing influence on both sexes. Only one living unit for females is suggested because of the expected small numbers. However, these women will need the full range of service programs provided for men. Additional information about programs for women is contained in a statement from Dr. John Benninghoff, Chief Executive Officer at Anoka State Hospital. (Addendum #3)

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6. *Secure treatment programming for adolescents is not included in the Task Force's recommendations.*

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There was insufficient time for the Task Force to make an in-depth study of treatment programs for adolescents. Consequently, the membership endorsed the following statement: "The issue of programming for adolescents was not overlooked or ignored but should not be included in the current Task Force planning." The Task Force was apprised of a concurrent Department of Public Welfare project specifically addressing the issue of secure treatment programs for adolescents.

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7. *The present sex offender treatment program at Minnesota Security Hospital should be continued and evaluated as a pilot project.*

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After only one year's operation, it is too early to judge the success or failure of the Minnesota Security Hospital sex offender treatment program. The Fort Steilacoom project (Addendum #4), after which it is patterned, has apparently been operating successfully for seventeen years

but the Task Force advised against basing a Minnesota program upon those outcome studies. Major research flaws severely compromise the usefulness of their data as a justification for a full scale replica in Minnesota.

The current census in the Fort Steilacoom project is now over 200. Pressures to expand have become so intense that program quality has been significantly compromised.

For the foregoing reasons, the Task Force recommended that the Minnesota Security Hospital unit be given an opportunity to prove its effectiveness as a "pilot program". This status will place a moratorium on premature expansion and conserve state resources until the efficacy of this approach has been adequately researched.

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8. *The Minnesota Security Hospital sex offender treatment program should undergo continued evaluation. If indicated, future expansion under the auspices of the Department of Public Welfare should not be limited to either public or private agencies.*

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The scarcity of scientifically valid outcome data comparing various methods for dealing with sex offenders influenced the Task Force to adopt a conservative posture. Until it can be shown that certain types of treatment, for example, are at least as effective in reducing recidivism as mandatory prison terms or other correctional approaches, cautious experimentation is advised.

If preliminary studies indicate that existing pilot programs are effective, the development and evaluation of new or additional treatment programs for sex offenders, in both public and private agencies, should be encouraged in order to speed up the process of comparing treatment methods as well as to eventually treat more sex offenders than is now possible. Any plans for a new security facility should address questions of space and flexibility for potential expansion of sex offender programs.

The Task Force recommended that all existing and new programs be considered pilot projects, and that provision should be made to evaluate their effectiveness. Task Force members repeatedly expressed concern over the present lack of resources for evaluating the whole range of treatment programs at the Minnesota Security Hospital, and recommended that staffing and

space allocations should be provided for on-going program evaluation. It was also recommended that the program evaluation be conducted by an outside agency.

The report of the Legal Subcommittee also urged that any plans for a new security facility include the potential for expansion of the sex offender treatment program, in case (as expected) the need for such expansion is shown and as effective treatment methods are demonstrated.

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9. *The sex offender statute (246.43) should be amended to permit the court: (1) to order inpatient, as well as outpatient, treatment as a condition of probation; and (2) discretionary power in sentencing offenders to either the Department of Public Welfare or the Department of Corrections.*

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The background for this recommended change in the Minnesota sex offender statute is contained in the report of the Legal Subcommittee (Addendum #2).

In summary, the Subcommittee felt that an amendment to Minnesota Statutes 246.43, Subdivision 6 would accomplish the following, as stated in its report:

a. Courts would have greater sentencing flexibility.

b. The amendments would permit more explicit recognition by the courts and Department of Welfare of the limited facilities now available in the state for the treatment of sex offenders.

c. The amendments would give courts the ability to require either inpatient or outpatient treatment as a condition of probation.

d. Courts would be given increased ability to make disposition of an individual who may not in fact be an appropriate candidate for sex offender treatment through their ability to "review" recommendations for treatment made by the Commissioner of Welfare.

e. It is likely that if inpatient treatment were made a condition of probation, the individual would be more highly motivated to participate in the treatment program, since noncooperation could result in his being sent to a correctional institution.

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10. Although noting strong minority dissent on the Task Force, no changes are recommended in the psychopathic personality statute.

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This portion of the Legal Subcommittee's report was vigorously opposed by several members of the Task Force.

The necessity and the utility of Minnesota Statute 526.10-526.11 - affirmed as constitutional in 1940 by the U.S. Supreme Court - coupled with its restrained use in Minnesota courts were key arguments by the majority for continuing this statute in its present form.

Opponents cited the statute's remarkably inclusive definition of "psychopathic personality", its assumptions about personality types and the prediction of dangerousness, and its less-than-rigorous standards of evidence. The Task Force minority concluded that the Minnesota psychopathic personality statute is so threatening to individual constitutional freedoms that it should be repealed. These members maintained that persons considered "psychopathic personalities" should be processed through regular criminal justice channels and if convicted, placed under the jurisdiction of that system.

The final vote was 6 in favor of the statute and 4 against. Four members of the Task Force were not present when the final vote was taken.

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11. Minnesota Rules of Criminal Procedure, Rule 20, should be amended explicitly to indicate the District Courts' discretionary power to preside over civil commitment proceedings established in Rule 20.01, Subd. 4 (2) and 20.02, Subd. 8, when it would be more appropriate and expeditious.

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The intent of this recommended amendment is to allow the courts greater flexibility in dealing with certain cases under Rule 20. This will encourage better use of judicial resources and also remove unnecessary delays that occur when cases are transferred from District Court to Probate Court for commitment hearings. (Legal Subcommittee Report, Addendum #2)

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12. *An adequately funded statewide system should be established by the Department of Public Welfare to provide better coordination of forensic activities currently shared by the state hospitals, courts, mental health centers, welfare departments, and private agencies.*

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The court system regularly uses the Minnesota Security Hospital and a variety of other facilities for assessing and treating clients under its jurisdiction. In some areas of the state there is a shortage of professionals with specialized forensic training who can perform assessments directly or effectively assist the court in arranging the client's transfer to the most appropriate outpatient or inpatient facility.

In the Task Force's opinion, the use of the Security Hospital, state hospitals and other mental health facilities will be optimized by the introduction of specially trained regional assessment teams to work with the courts where needed. A description of the proposed statewide forensic assessment system is included in Addendum #5.

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13. *To facilitate effective Task Force input into the Minnesota Security Hospital planning process, arrangements should be made for the members to meet with the Commissioner of Public Welfare to discuss these recommendations.*

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A meeting of the Task Force and the Commissioner of Public Welfare was held on December 14, 1977, to discuss the recommendations.

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14. *Recommended changes in Minnesota Security Hospital procedures for granting off-grounds privileges to patients are submitted as a separate subcommittee report.*

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The report of the Subcommittee that reviewed the Security Hospital's current policies and procedures for granting off-grounds privileges to patients was received by the Department on October 12, 1977 (Addendum #1).

Discussion

Programs for Secure Facility

A. TREATMENT PROGRAMS AND THEIR EFFECTIVENESS

Several members of the Task Force were already knowledgeable about existing treatment methods and programs in various parts of the world. Members of the Treatment Subcommittee and the Effectiveness Subcommittee were also provided with additional materials, including abstracts from computerized literature searches requested from the National Clearinghouse for Mental Health Information (NIMH) and the National Criminal Justice Reference Service (LEAA).

As reported by their respective chairpersons, both subcommittees generally agreed that, for the types of residents of concern to the Task Force, (1) there were few treatment programs which were stable, clearly defined, and with a semblance of measurements, (2) existing programs varied widely in their approaches, often with little similarity and with no agreement as to the most effective methods, and (3) what little impact data was reported was of questionable value for judging the effectiveness of any given program or for comparing programs.

With the exception of medications used to treat specific conditions such as psychosis, depression, anxiety or mania, it was agreed that there is essentially no solid evidence that any particular treatment modality or program is better than any other or has (or does not have) a significant effect upon the dangerous or illegal behavior of those persons ordinarily sent to a secure treatment facility.

Among the reasons given for this state of affairs were the following (all do not necessarily apply to any given program):

(1) Lack of comparability of programs.

(2) Admission criteria which are unclear or bias outcome studies by excluding significant segments of the potential resident population.

(3) Lack of specificity about the treatment methods, or failing to hold the treatment program constant over a given period of time.

(4) Inadequate follow-up after treatment to assess residents' condition and legal status.

(5) Lack of appropriate comparison groups (groups with other treatments or no treatments).

(6) Varied program objectives.

(7) Inadequate record system.

(8) Lack of resources or administrative support to maintain the program as designed.

(9) Insufficient resources or administrative support to mount and maintain an evaluation of the program.

The implications of the above for the purposes of the Task Force are:

(1) recommendations about a secure treatment program and facility must necessarily come from the combined subjective experience and judgment of Task Force members rather than from any existing evidence favoring specific programs.

(2) given the lack of such evidence, new facilities must be planned with maximum flexibility in order to adapt to whatever programs or treatments emerge as effective, and

(3) programs for the new Minnesota secure facility must include followup of patients, and resources (staff, equipment, space) for evaluating the impact of the program.

B. TREATMENT PROGRAMS FOR THE DPW SECURE FACILITY

The types of residents considered by the Task Force to be appropriate for admission to the maximum security facility were those who had been examined by the Regional Assessment Team and (1) found in need of long-term treatment in a secure facility; or (2) needed additional evaluation and/or short-term treatment but were considered too dangerous to reside in a minimum security facility; and (3) persons transferred by other state hospitals or the Department of Corrections for long-term treatment available at the secure facility. It was agreed that in general the secure facility should accept only those persons for whom treatment was available and appropriate (with the expectation that the courts would send others to the Department of Corrections).

The Task Force considered several methods of categorizing the above persons in ways which would also define treatment programs for those groups. Among the categories discussed were legal status and types of commitment,

the degree of security required, psychiatric diagnoses, types of treatment required, and the problems or behavior causing institutionalization. However, data from Minnesota Security Hospital showed little relationship between these dimensions and the types of treatment programs needed (one possible exception was classification by primary problem, but a detailed analysis was not possible within the allotted time for study). As has already been mentioned, the literature provides little or no agreement as to the types of treatment programs elsewhere which might serve as a guide.

Staff analysis of present and projected MSH populations resulted in a classification system which was a combination of the type of service needed and the security requirements. It was believed that this classification (summarized below from the general report*) would provide a reasonable basis for projecting staff and space requirements for these groups while at the same time allowing for the programmatic and spatial flexibility which the Task Force considered to be of utmost importance. It should also be pointed out that a resident would ordinarily move from one unit to another according to the stage of his treatment and the nature of his condition and behavior.

The eight treatment units are as follows:

1. Admissions/Assessment Unit.

   This unit would house those persons needing security while being examined or observed, including those with acute psychosis, certain sex offenders, and others who are anti-social or who require behavior management during the assessment period. A sixty-day limit on this unit is recommended.

2. Unit for Basic Behavior Development (High degree of control and same security provisions as the Admissions/Assessment Unit).

   Residents with known severe behavior management problems who are unpredictable, present security problems or may require close medical management. Their treatment would typically be concerned with increased self-care, responsibility, social and communication skills, and self-control so that transfers to a less restrictive setting would be possible.

3. Unit for Basic Behavior Development (Low degree of control with security precautions limited to control of exit from the building).

   Persons stabilized at a low functioning level or who may have a chronic psychosis but whose behavior is ordinarily predictable. Though their potential may appear limited, they may respond to programs to improve basic self-care or social/occupational skills. Typical programs on this unit would be similar to those on the preceding unit except for the extent of controls necessary.

*Minnesota Security Hospital: Program Assessment and Design Alternatives.

4. Intermediate Behavior Development Unit (Building security only).

   Less seriously disabled persons who are fairly stable and responsive to higher level treatment/training. Programs would involve the development of social and occupational skills for more independent living, limited medical management, and off-unit educational, recreational, and vocational activities.

5. Pre-Discharge Unit (Building security only).

   Persons awaiting release as they complete the final phases of their treatment programs prior to discharge, parole, or transfer to a halfway house setting. Focus would be on vocational and occupational skills, continuing self-control and self-confidence, and increased contacts with community resources.

6. Intensive Treatment for Sexually Aggressive Behavior (Building security only).

   The Task Force recommended the continuation of the present sex offender program on a pilot basis, provided that it, like all other programs, is continuously evaluated for effectiveness. This evaluation should be conducted by an independent agency and legislative appropriations should be sought for that purpose.

   Present information indicates that most sex offenders require little medication, are generally functioning at a relatively high level, and are physically active. They require a variety of treatment modalities, including vocational counseling, sex education, individual and group therapies, and various recreational activities, as well as improvement in social skills, self-understanding, self-control, and work skills.

7. Chemical Dependency Unit (Building security only).

   Although persons from other units will be involved in chemical dependency treatment, this unit is for those requiring a 24-hour-a-day program, either on temporary transfer from another unit or as an admission for chemical dependency as the primary problem.

8. Women's Unit (Building security only but with capacity for restriction within unit).

   A single unit is suggested, rather than the same range of units suggested for men, because of the small numbers expected, even though it is likely that women will need the full range of programs provided for men. This means that the women's unit would need to be especially flexible within itself in order to provide those services, if any, which cannot be programmed in conjunction with the units for men.

C. PROGRAM EVALUATION FOR THE DPW SECURE FACILITY

The Task Force was impressed with the scarcity of security treatment programs which are being adequately evaluated for outcome. As a result, little is known about the extent to which treatment helps the different types of persons going to a secure facility, which are the best candidates for treatment, or which treatments are likely to be the most effective.

The Task Force recognized that adequate evaluation of programs is technically difficult and fairly expensive. Nevertheless, the cost of effective evaluation is considerably less than the wastefulness of implementing treatment programs of unknown effectiveness.

Therefore, the Task Force recommended that resources be provided for the evaluation of the effectiveness of programs at the DPW security facility. The Task Force also recommended that this evaluation be conducted by an independent agency or organization.

The Task Force did not detail the resources necessary for adequate program evaluation. However, it recommended that the following be integral parts of the process:

(1) Adequate data collection system.

(2) Clerical and evaluation personnel to operate the data collection system.

(3) Personnel for followup of residents in and out of facility.

(4) Funds and personnel for analyzing data on periodic or ongoing basis.

(5) Personnel and machinery for communicating results to program managers and administration so that programs can be modified as indicated by the findings.

MINNESOTA SECURITY HOSPITAL
TREATMENT PROGRAM TASK FORCE

Subcommittee Report to the
Commissioner of Public Welfare

Subcommittee Members: Thomas Stienessen
Loring McAllister, Ph.D.
Howard Johnson

This report is in response to the Commissioner's request for a subcommittee of the Minnesota Security Hospital Treatment Program Task Force to review that institution's current policies and procedures for granting off-grounds privileges to patients. Informational materials prepared by the Minnesota Security Hospital staff were made available to the subcommittee members in advance of their organizational meeting at the Centennial Office Building on September 1, 1977. (See attached MSH reports.) Present at the first meeting were Mr. Johnson, Dr. McAllister, and Dr. Young. The Commissioner's charge to the subcommittee was discussed and necessary preparations for the site visit were made.

On September 12, 1977, the full subcommittee convened at the Minnesota Security Hospital, toured the facility and held a two hour meeting with Dr. Sheppard, Mr. Littig and Mr. Andros of the hospital staff. Barbara Gill from the Department of Public Welfare Attorney General's office and Dr. Young were also present.

Hospital procedures for assigning patients to one of four security levels - maximum, moderate, minimum and *minimum - were reviewed. It was pointed out that newly admitted patients are classified as maximum security until the staff makes an independent assessment of each case. Modifications of that status are then made, depending upon the clinical findings.

Security levels are regularly reviewed by the treatment team as part of the case management process and on other occasions as special circumstances indicate.

All MSH patients are potential candidates for off-grounds privileges. Achieving this status depends upon a number of factors. Observed behavior of the patient in the hospital setting is a heavily weighted factor. Legal status and medical diagnosis are generally less so.

Patients classified as moderate security are not allowed to leave the facility without staff accompaniment.

Minimum and *minimum security patients are sometimes permitted unsupervised visits. Prior to the episode this summer there had been one serious incident involving an unescorted patient in the past five years. MSH statistics reveal that a sizeable number of patients are engaged in off-campus activities and visits.

Hospital policies specify involvement of various community entities in planning for unsupervised visits. The notification of Mankato State College

security personnel in those instances where patients were attending classes was not specified in policy. Agreements between MSH and Mankato State College on this subject have been negotiated recently.

In response to a subcommittee query about mandatory community involvement in all case-planning for off-grounds privileges, Dr. Sheppard indicated that this was being done for unsupervised visits and certain other cases. But as a required procedure for all off-grounds activity it would hurt the treatment program. Outside persons are not always interested nor knowledgeable enough about all MSH patients to warrant their mandatory participation.

The present overcrowding at MSH has been detrimental to the treatment program in a number of ways, including too-early transfers to other institutions and exclusion of some appropriate admissions, but in the staff's opinion there has been no significant lapse in off-grounds security precautions because of the large census.

Chronic staff shortages at MSH over the years have resulted in a relatively low priority being assigned to research activities, including research on off-grounds incidents.

Based on a review of MSH written materials and a site visit to the hospital, the subcommittee makes the following recommendations:

1. As part of the treatment and rehabilitation program at MSH, supervised and unsupervised visits should continue to be an available option for individual case planning. This would include visits to home, work, school, and other appropriate rehabilitation activities.

2. The criteria for placing patients in each level of security should be spelled out in written form.

3. The relationship between security levels and eligibility for unsupervised visits should be specified.

4. There should be additional written policies concerning the process and criteria for allowing patients to leave the hospital on unsupervised visits.

5. The process by which patients are considered by the team for assignment to security levels should be in written policy form.

6. A flow chart outlining the steps from maximum to *minimum security should be prepared, indicating decision points, responsibility for each decision, provision for resolving team disagreements, and veto processes (if any).

7. The subcommittee felt that the medical director should retain the prerogative for making all final decisions in matters of patient treatment and security.

8. A report summarizing and analyzing serious incidents precipitated by patients off-grounds should be prepared and updated periodically for the use of MSH and DPW central office staffs.

MINNESOTA SECURITY HOSPITAL
TREATMENT PROGRAM TASK FORCE

REPORT OF

LEGAL SUBCOMMITTEE

Subcommittee Members: Judge Allen Oleisky
Paul Lindholm
Charles G. Sheppard, M.D.
Thomas Jensen

Your subcommittee met on October 19, 1977, at the Hennepin County Government Center. All members were present.

The subcommittee meeting was devoted to consideration and discussion of the legal issues raised by the operation of Rule 20 of the Minnesota Rules of Criminal Procedure; Minn. Stat. Section 246.43 ("sex-offender treatment") and Minn. Stat. Section 526.09, 526.10 and 526.11 ("psychopathic personality statutes"). The subcommittee so limited its deliberations on the basis of its view that the issues raised by those court rules and statutes are of primary concern to the Task Force in its general deliberations concerning the patients and program at the Minnesota Security Hospital.

On the basis of its deliberations, your subcommittee submits the following report and recommendations:

I. Rule 20 -- District Court Proceedings.

A. Discussion.

As the Task Force is aware, the provisions of Minn. R. Crim. P. 20 ("Rule 20") establish procedures to be followed in cases where the defendant in a criminal matter may be either incapable of understanding the nature of the proceedings or participating in his defense (i.e., "incompetent to proceed" -- Rule 20.01) or not guilty of the offense charged by reason of mental illness or mental deficiency (the "insanity defense" -- Rule 20.02). As the Task Force knows, competency to proceed and the insanity defense separate matters which should not be confused; they are discussed together here for the sake of convenience and brevity.

The procedure mandated by Rule 20 in the case of an individual who may be incompetent to proceed and who is not under civil commitment at the time of the criminal proceedings is generally as follows. When the issue of competency to proceed is raised, the court suspends the progress of the proceedings and, assuming the court is satisfied that there is probable cause that a crime has been committed by the defendant, appoints a qualified professional (a psychiatrist, clinical psychologist or qualified physician) to examine the defendant. The examiner makes a report to the court which states an opinion as to the defendant's competency to proceed. A hearing may or may not be held contesting the findings of the examiner's report. In the

event the defendant is found incompetent to proceed by reason of mental illness or mental deficiency, the court "...shall cause civil commitment proceedings to be instituted against him..." As a general rule, this would mean the institution of commitment proceedings in the probate or county court.

In cases where a defendant has been found not guilty of a criminal offense by reason of mental illness or mental deficiency, the court is directed by Rule 20.02 to "cause civil commitment proceedings to be instituted against him..." Again, this would usually mean proceedings in the probate or county court.

B. Recommendation.

The subcommittee recommends that Rule 20 be amended explicitly to permit the district courts to preside over the civil commitment proceedings established in Rule 20.01, subd. 4 (2) and 20.02, subd. 8. Such an amendment should be worded to permit the district court, in its discretion, to hold the civil commitment hearing or to transfer the proceedings to probate or county court if that procedure would be more expeditious or appropriate under the circumstances.

There are several reasons underlying the subcommittee's recommendation:

1. The recommended amendments to Rule 20 would allow for greater flexibility and thereby permit better use of judicial resources.

2. In some counties of the state, transfer of the proceedings to the probate court might result in delay which could be avoided if the district court were to in effect sit as a probate court and hold the civil commitment hearing.

3. The recommended amendments could also help insure uniformity in the treatment of criminal defendants who are found incompetent to proceed or not guilty of a crime by reason of mental illness or mental deficiency.

II. The Sex Offender Treatment Statute -- Minn. Stat. Sec. 246.43.

A. Discussion.

In cases where an individual is convicted of certain sex crimes, the provisions of Minn. Stat. Section 246.43 require the court to order a presentence examination of the convicted person for the purpose of determining whether he could benefit from specialized treatment. The Commissioner of Welfare is given the responsibility of making the ultimate recommendation to the court as to whether or not a particular individual is well suited for treatment.

As the statute is now written, courts have little choice in the disposition of individuals for whom "specialized treatment" may be appropriate.

> If it appears from said report (of the Commissioner of Welfare) that the commissioner recommends specialized treatment for ... (the

> individual's) mental and physical aberrations, the court may either place him on probation with the requirement as a condition of such probation, that he receive outpatient treatment in such manner as the court shall prescribe, or commit him to the commissioner under this section.

Minn. Stat. Section 246.43, subd. 6.

Several problems or potential problems concerning the sex offender treatment program at the Minnesota Security Hospital have been brought to the attention of the Task Force. Among them: (1) the program is filled to capacity; (2) it often becomes difficult for staff to treat a patient in the program effectively when the person feels he is guaranteed "easy time" at the Security Hospital as opposed to "hard time" in prison; and (3) the Security Hospital itself often lacks sufficient control in determining who is or is not an appropriate candidate for its sex offender treatment program. In addition to these concerns, some members of the Task Force have at least raised the question of whether sufficient data exists to even determine whether sex offenders, as opposed to other convicted persons, more appropriately belong in a treatment rather than a correctional setting.

The subcommittee does not feel the repeal of Minn. Stat. Section 246.43 is an appropriate consideration at this time, especially given the limited amount of time and data with which the Task Force has had to work. However, the major concerns which have been expressed concerning Minn. Stat. Section 246.43 and the sex offender treatment program could be addressed by amendments to the statute.

B. Recommendations.

1. Amendment of Minn. Stat. Section 246.43, subd. 6.

The present wording of Minn. Stat. Sec. 246.43, subd. 6 has been set forth above. The subcommittee recommends that the provision be amended to read:

> If it appears from said report that the commissioner recommends specialized treatment for his mental and physical aberrations, the court may place him on probation with the requirement as a condition of such probation, that he receive INPATIENT OR outpatient treatment in such manner as the court shall prescribe, or THE COURT MAY SENTENCE HIM TO THE COMMISSIONER OF CORRECTIONS IN THE MANNER PROVIDED BY LAW.

The proposed amendment to Minn. Stat. Section 246.43, subd. 6 would effect several changes from present procedure. First, such an amendment

would clearly give courts the authority to provide for inpatient treatment as a condition of probation. In such a case, the individual's satisfactory participation in an inpatient treatment program would be made a condition of probation. Thus, if such an individual proved to be an improper subject for sex offender treatment, the Security Hospital or whatever inpatient facility to which the person was sent for treatment would have a mechanism by which the individual could be removed from the treatment program and placed in a correctional setting -- i.e., the institution of proceedings to revoke probation.

The proposed language which would give courts the option of sentencing a convicted sex offender to the Commissioner of Corrections even where the Commissioner of Welfare has recommended treatment in effect gives the court the opportunity to review a recommendation for treatment rather than be bound by such a recommendation as is now the case. It is possible that the court, based upon its knowledge of an individual as developed in the course of the criminal trial, could determine that specialized treatment is not appropriate, notwithstanding the recommendation of the Commissioner of Welfare. In such a case, the court would be authorized to sentence the individual in the same manner as had treatment not been recommended.

The subcommittee feels that an amendment to Minn. Stat. Sec. 246.43, subd. 6 would accomplish the following:

a. Courts would have greater sentencing flexibility.

b. The amendments would permit more explicit recognition by the courts and Department of Welfare of the limited facilities now available in the state for the treatment of sex offenders.

c. The amendments would give courts the ability to require inpatient or outpatient treatment as a condition of probation.

d. Courts would be given increased ability to make disposition of an individual who may not in fact be an appropriate candidate for sex offender treatment through their ability to "review" recommendations for treatment made by the Commissioner of Welfare.

e. It is likely that if inpatient treatment were made a condition of probation, the individual would be more highly motivated to participate in the treatment program, since noncooperation could result in his being sent to a correctional institution.

2. Assuming that the Department of Public Welfare will continue to be responsible to provide treatment for certain sex offenders, it is important that any new or remodeled security hospital have the physical capabilities for expansion of existing sex offender treatment programs.

The subcommittee recognizes that the current sex offender treatment program at the Security Hospital is a "pilot program" which cannot be rapidly expanded in scope. However, adequate provision must now be made

for the eventual expansion of that program if the philosophy that certain sex offenders should be treated in a hospital setting rather than incarcerated in a correctional institution is not altered by the legislature.

III. Psychopathic Personality Statutes -- Minn. Stat. Sections 526.09-526.11.

A. Discussion.

Minn. Stat. Sec. 526.09, the operative provision of the psychopathic personality statutes cited above, provides:

> The term "psychopathic personality," as used in sections 526.09 to 526.11, means the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons.

Minn. Stat. Sec. 526.10 generally provides that the same substantive and procedural safeguards provided in the Minnesota Hospitalization and Commitment Act (Minn. Stat. ch. 253A) apply in proceedings brought pursuant to the psychopathic personality statutes; Minn. Stat. Sec. 526.11 establishes the rule that the existence in any person of a "psychopathic personality" does not in itself constitute a defense to a crime (i.e., the mere fact that an individual is found to have a psychopathic personality does not mean the individual is "insane").

The psychopathic personality statutes were enacted in 1939. Only the provisions of Minn. Stat. Sec. 526.10 have been amended since that time.

The statutes were enacted as a result of the report of a special committee commissioned by Governor Stassen. It is clear that the purpose of the statutes as envisioned by Governor Stassen and the committee was the prevention of sex crimes. Referring to the then-existing laws as they related to "psychopaths," the committee in its report to the legislature noted:

> A serious limitation in present procedure is the inability of officials to deal with such persons without waiting for definite, and sometimes horrible, criminal acts to be committed. A serious limitation in present procedure is the inability of officials to deal with such persons before they commit criminal acts.

1939 Journal of the House, 1392, 1396.

The Governor's committee went on to recommend further study of the problem of dealing with psychopaths (Id. at 1396-97) and although no recommendation as to new facilities was made, the committee did note that

> ...In the development of a long-time (sic) program, it is probable that additional facilities and new types of institutional treatment will need to be provided.

Id. at 1396.

The constitutionality of the psychopathic personality statutes was challenged soon after their passage. In State v. Probate Court, 287 N. W. 297 (Minn. 1939), the state supreme court upheld the validity of the statutes. In the course of its opinion, the court interpreted the provisions of Minn. Stat. Sec. 526.09:

> ...It can reasonably be said that the language of Section 1 (526.09) of the act is intended to include those persons who, by a habitual course of misconduct in sexual matters, have evidenced an utter lack of power to control their sexual impulses and who, as a result, are likely to attack or otherwise inflict injury, loss, pain or other evil on the objects of their uncontrolled and uncontrollable desire. It would not be reasonable to apply the provisions of the statute to every person guilty of sexual misconduct nor even to persons having strong sexual propensities. Such a definition would not only make the act impracticable of enforcement and, perhaps, unconstitutional in its application, but would also be an unwarranted departure from the accepted meaning of the words defined.

The opinion of the Minnesota Supreme Court was affirmed by the United States Supreme Court in State of Minnesota v. Probate Court, 309 U. S. 270 (1940).

Apparently, the psychopathic personality statutes have been used sparingly in this state. At present, three of the patients at the Security Hospital were committed pursuant to those statutes, and there are only a few cases involving the statutes which have ever reached the state supreme court.

B. Recommendations.

The subcommittee does not recommend repeal or amendment of the psychopathic personality statutes. The data which has been presented to the Task Force seems to indicate that there are people in society who are not mentally ill, who may or may not have been convicted of a sex crime and who, for the protection of society, must be institutionalized for significant periods of time. Based on past history, it does not appear that the psychopathic personality statutes have been used by officials for purposes other than which they were intended. As long as officials recognize that those statutes must be used to institutionalize an individual in only those cases which meet the criteria set forth by the court in State v. Probate Court, there seems to be no sufficient reason to recommend their repeal or amendment. It should also be noted that the psychopathic personality statutes contain provisions which would seem to guarantee persons alleged to have a "psychopathic personality" adequate procedural and substantive safeguards.

It should be noted also that on the basis of information given the Task Force, it appears that mixing psychopaths with a population of mentally ill individuals often causes serious problems since the mentally ill can often be manipulated and put to disadvantage by the individual who, although adjudged to have a psychopathic personality, is not mentally ill. Therefore, this subcommittee would recommend that any new or remodeled security hospital facilities be adequate to allow staff to segregate the mentally ill from those with a psychopathic personality to a greater degree than is now the case. As was recognized in 1939, institutionalization of the sexual psychopath can give rise to a need for "additional facilities and new types of institutional treatment."

November 1, 1977

STATEMENT - NEEDS FOR MENTALLY ILL & DANGEROUS WOMEN IN MINNESOTA

The section for MI&D women for Minnesota has been housed "temporarily" at Anoka State Hospital for several years. When I arrived at Anoka State Hospital 15 months ago, this was a separate locked 5-bed section on the end of the locked ward in the Miller Building. The women housed in this section were in virtual solitary confinement with little or no program available. Initially I attempted to alleviate this problem by ending the physical segregation of these women and integrating them into the general population of this 20-bed locked ward. This resulted in some improvements in program and social interaction for these patients.

There still remain two basic shortcomings, which I feel can only be resolved by establishing a female section in a true security hospital. First, we do not have the physical security or staffing to handle a truly dangerous woman. The building is simply a security screened locked ward and, contrary to popular opinion, the fence does not provide any additional security. The ward staff is predominantly female and cannot manage a large, very assaultive person. Fortunately, we have not had such a woman recently, but the possibility is there and there are currently no alternatives available. Secondly, we cannot provide appropriate long-term program needs within this small locked ward. Because the ward is generally programmed for short-term stays and is in a small area, women needing long-term program must be able to utilize the full resources of Anoka State Hospital's open hospital programs to get appropriate programming. Fortunately, most women residents are able to go off the ward for programming as they are not major management problems. However, one current resident from time to time requires ward restriction for security reasons due to past history of two murders and serious institutional fires. For prolonged periods of time this patient does not get appropriate long-term residential programming. At any time circumstances could result in more patients being in this situation and again there are no alternatives available.

The small number of women involved makes taking a look at statistics not too meaningful. Five beds have been adequate with population ranging from 3 - 5 over the years. Of these only a few are actually committed as MI&D. Most are committed MI and transferred from other open hospitals for management and control.

Projection of population for a separate female section in a security hospital is difficult. Over the last year, I have received about one call a month regarding a security type program for women. In most cases, due to limitations of program and security at Anoka State Hospital, these referrals were felt to be inappropriate. I have also had input from one State Senator that Corrections feels the need for a program to treat mentally ill females who are at least questionable in appropriateness for open hospital. For these reasons, I would suggest that if a full security program for MI&D women is available, the population would rise to that of a small treatment ward.

I would like to apologize for the anecdotal nature of my report. I do not know how any more specific data can be gathered at this time. It is clear on a case by case basis that a few women are not getting their full right to treatment in the current "temporary" MI&D Women's Section at Anoka State Hospital. Even though this is only a very small minority of people, I feel it is important that a permanent program be developed to accommodate their needs.

John C. Benninghoff, M.D.
Chief Executive Officer/Medical Director
Anoka State Hospital

TREATMENT CENTER FOR THE SEXUAL OFFENDER
PROGRAM SUMMARY

Western State Hospital
Ft. Steilacoom, Washington

LEGAL FRAMEWORK OF PROGRAM

The 1951 "Sexual Psychopath Law" RCW Chapter 25, Sections 71.06.010-140 allows Superior Courts to commit persons to state mental hospitals for 90 days' evaluation and treatment until "safe to be at large." In 1966 the Department consolidated this responsibility at one institution, Western State Hospital.

TREATMENT'S PRIMARY GOAL, THE PROTECTION OF SOCIETY

The sexual psychopath statute recognized that sexual offenders could not be effectively treated in prison, and hence society could not be protected in the long run by the mere imprisonment of sexual offenders. The hospital program includes the three elements essential to rehabilitation: custody, specific and systematic re-education in responsible sexual behavior, and gradual reintegration to the community.

SECURITY AND TREATMENT

The program places great responsibility upon the offenders, as well as staff, to provide effective custody. This approach is successful, reducing escapes to a rate which compares favorably with adult correctional facilities. In addition, offenders with two or more years of prior incarceration and an escape history are screened out early in the 90-day observation and returned to the committing court as inappropriate to have in residence at the hospital.

TREATMENT PHILOSOPHY

The program believes that deviant sexual behavior is learned and can be displaced by more rewarding and responsible ways of meeting sexual and emotional needs. Most sex offenders are compensating for feelings of inadequacy, inferiority, or insecurity. Their offenses only temporarily reduce these feelings. Treatment, therefore, demands rigorous self-examination and intense involvement with others under constant expectations for honest and responsible behavior.

THE OFFENDER POPULATION

As of July 1975 the program had 230 offenders in residence (38 in observation, 105 in full-time inpatient treatment, 11 on work release, and 76 on outpatient followup treatment). Three were women. 80% were involved with minors, mostly pre-adolescent or younger girls. Physical force with the victim was used in less than 40% of the cases, including the 20% committed for rape. About 1/2 of the offenders were married. Over 1/2 had previous convictions. Over 1/3 have a serious alcohol problem. One half have superior intelligence and most are high school graduates.

ORGANIZATION OF OFFENDERS INTO GUIDED SELF-HELP GROUPS

Responsible behavior can only be learned by being given responsibility. The offenders are therefore organized into small self-help groups of approximately 15, and these function under very close staff supervision. The entire program is organized around these groups in terms of custody, treatment, and administration. Staff establishes standards, teaches, guides, provides clinical expertise, overall administration and program development, and community relations.

TREATMENT OBJECTIVES

The offender must earn his way to freedom, not by doing "time" but by establishing patterns of responsible behavior. He must accomplish four basic objectives (1) recognition of his antisocial behavior patterns; (2) understanding of the origin and development of these patterns; (3) acceptance of responsibility for his deviant behavior and for changing it, and; (4) application of new patterns of behavior while at the hospital and after release.

STATEWIDE FORENSIC ASSESSMENT SYSTEM

PROBLEM

The quality of forensic assessment services available to courts in various Minnesota jurisdictions is noticeably uneven. Some courts have ready access to highly qualified forensic professionals and an array of sophisticated psychiatric facilities; others must rely on infrequent contacts with mental health generalists whose only regional psychiatric resource is a state hospital. This is undoubtedly one factor which contributes to the highly variable patterns of Security Hospital utilization by courts throughout the state. The result is a significant number of Security Hospital beds being occupied by individuals that could be safely assessed in less secure settings. This overusage diverts the time of hospital staff from more seriously ill and dangerous patients and inflates the demand for maximum security beds. By way of comparison, other states such as Tennessee have found that almost all court assessments ordered on "not guilty by reason of insanity" pleas and "incompetent to stand trial" questions can be performed outside the hospital setting.

To encourage the appropriate use of all assessment and treatment resources in Minnesota, including the proposed new security facility, the Task Force endorsed in principle the concept of a statewide forensic assessment system under DPW auspices. Basically, it would involve training and employing forensic evaluators in each area of the state, perhaps in conjunction with mental health centers, who would assist the courts in designating the most appropriate resource - jail, mental health center, closed unit of a state hospital, Minnesota Security Hospital, etc. Presumably most of these assessments could be done without further referral but in those instances where the client needed specialized services and security precautions, the team would coordinate arrangements for residential assessment and/or treatment in a nearby hospital. The small percentage needing long-term (over 30 days) residential assessment and treatment or who were considered too dangerous to remain in a minimum security unit would be referred by the team to the maximum security facility.

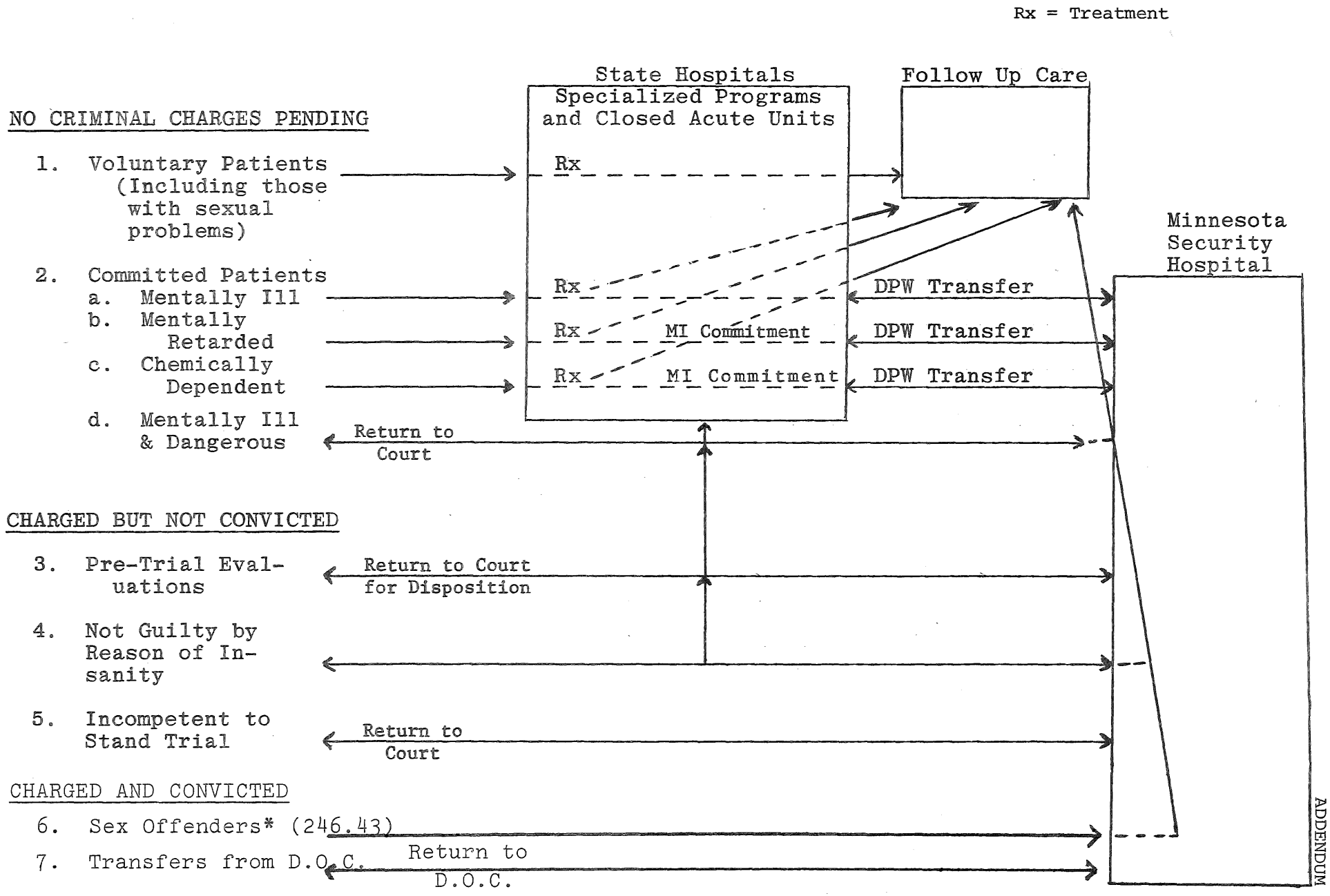
This forensic assessment system is predicated upon the assumption that selected state hospitals would maintain small, well staffed minimum security units for short-term (up to 30 days) treatment of psychotic persons considered dangerous to themselves or others, and short-term (up to 30 days) assessment of persons considered minimal security risks.

It is essential that such a statewide system be administratively organized to permit the regional teams flexibility in working with the courts and mental health centers while under the supervisory direction of the state system that controls state hospitals and the maximum security facility.

Consideration should be given to standardization of assessment criteria and uniformity of referral policies through a centralized program for training forensic evaluators. Provision will also have to be made for the differing types of court services available in metropolitan versus outstate areas.

Ronald C. Young, M.D.
Medical Director
Department of Public Welfare

RESIDENT FLOW TO AND FROM MINNESOTA SECURITY HOSPITAL



*Sentence stayed, sentenced with commitment to Commissioner of Public Welfare, sentenced with dual commitment to Commissioner of Public Welfare and Commissioner of Corrections.

ADDENDUM #6